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# VARIATIONS ON THE THEME OF THE REFLECTIVE TEAM

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"Why did we hide our reflections on families?"
Tom Andersen [1].

**reflective team**
**family therapy**
**co-therapy**

**Summary**

*The present study aims to deepen the understanding of the role and usefulness of reflection in family therapy. The reflective process—particularly in the form of the Reflective or Reflecting Team method—was conceptualized by Tom Andersen as a therapeutic philosophy grounded in systems theory and social constructionism. Just as families require new perspectives to facilitate change, the therapeutic system itself benefits from dialogue and supervision as means to uncover new solutions and to consider alternative viewpoints. In this sense, conversation becomes a central healing tool. Following an introduction to the topic, developed through a review of relevant literature, the authors present a transcript of a conversation between two female family therapists, conducted during a session in which the family was present as listeners. The text concludes with a dialogue that summarizes and validates the reflective process.*

## Introduction

The person, worldview, and professional practice of Tom Andersen have had – and continue to have – a profound and enduring influence on the field of psychotherapy, particularly among practitioners working with families and couples. One notable testament to this influence is a volume dedicated to his legacy [2], in which 40 psychotherapists from four continents offer tributes acknowledging his distinctive presence, theoretical contributions, and clinical work. In his review of this publication, Raphael J. Becvar [3] observes that Andersen's ideas embody an ethos of deep respect, curiosity, and care in relation to others. Similarly, John Shotter [4], in a reflective piece on Andersen—whom he characterizes as a thoughtful and

introspective wanderer—emphasizes Andersen's transformative impact on the philosophical foundations of psychotherapeutic practice, urging that "we must do something more than merely commemorate his achievements; we must find a way never to forget them."

Tom Andersen's approach to psychotherapy, particularly his method involving the reflecting team, continues to resonate especially strong with Polish psychotherapists, notably those who had the opportunity to attend his workshops held in Kraków. Participants in these workshops frequently highlighted Andersen's remarkable capacity to establish close, authentic connections; his attentive and nuanced listening; and his sensitivity, humility, and directness. These qualities fostered a profound sense among participants of being genuinely seen, heard, and understood by him [5].

In presenting his evolving perspective on the reflecting process, Tom Andersen emphasized that, in its early stages, he located the origins of reflection primarily in the intellect. Over time, however, he increasingly acknowledged the centrality of emotional experience, as well as the significance of bodily sensations. In the context of interpersonal relationships—particularly within the psychotherapeutic relationship—Andersen regarded presence and mindful awareness of the other, of oneself, and of the shared relational space as essential. Cultivating such presence, he argued, requires a particular mental stance, which he referred to as the "beginner's mind" or "original mind." This is not a state of possessing knowledge, but rather one of *not knowing* and of being open to learning. Andersen maintained that every encounter between individuals involves mutual influence: each word spoken, gesture made, or movement expressed holds the potential to alter one's thinking. These sequences of interaction become material for reflective processes within psychotherapy. Such interpersonal engagement necessitates a deceleration of dialogue and an attunement to the experience of shared presence.

Tom Andersen's approach to therapy was inspired by the works of many authors. Among the most important are Harold Goolishian, Harlene Anderson, Gregory Bateson, Humberto Maturana, Mikhail Bakhtin, Lev Vygotsky, and Adel Bülow-Hansen. Shotter notes that, following his meetings with Goolishian, Andersen took notes, which he later shared with Shotter in preparation for their joint workshop. Some of these notes convey the essence of constructivist thinking [4], which served as the theoretical foundation for Andersen's method. It is worth quoting a few lines from these notes: "You don't know what you think until you say it. We need to talk to find out what we think. If you want therapy to proceed quickly, you must act slowly. You must participate in as many professional conversations as possible, especially with those who think completely differently from you. When ideas are spoken aloud, they are no longer yours" [4].

Another significant figure was the physiotherapist Adel Bülow-Hansen. Observing her work, Andersen noticed that before each movement of her hands, she paid close attention to the person's response to her touch. If it was inappropriate—too strong or too weak—the person's body would immediately signal this through muscle tension, facial expressions, or vocalizations. The essence of Bülow-Hansen's approach was to find the *right* touch, one that would bring about change and relieve physical pain. Andersen saw a meaningful analogy in psychotherapy. Drawing on Bateson's idea that change begins when a difference is maintained within conversation, he introduced the concept of the so-called *optimal difference* [6, 7, 8].

When people encounter what is familiar and already known to them, they typically remain unchanged. Conversely, when they are confronted with something too far removed from their experience, they may shut down in an effort to protect their sense of integrity. This dynamic underscores Andersen's exceptional sensitivity to signs of discomfort, his attentiveness to the expectations of conversation participants, his acceptance of those who choose not to speak, and the deliberately slow pace of dialogue—all of which allow space for reflection throughout the interaction. Such a carefully facilitated meeting creates conditions in which meaningful descriptions can emerge, potentially sparking ideas for change. According to Andersen, change is evident "in movement, in language, in the way we talk"; it is "something we do at every moment of the day without even noticing it" [4].

Andersen was attentive not only to the information provided by clients but also to his own emotional and physical responses. This dual awareness enabled him to formulate thoughts and convey meaning in subsequent exchanges—not through random words, but through language carefully chosen from many possible alternatives. His engagement with clients from diverse backgrounds, along with his ongoing reflection on their needs and the effectiveness of the support offered, led him to develop a psychotherapy approach centered on the use of a reflecting team. In the later stages of his work, Andersen adopted a broader term to describe the reflecting process.

## The reflecting team and the reflecting process

The practice of involving other therapists as observer-participants in family therapy sessions, within the systemic approach, emerged in part from the Milan school's concept of neutrality [9]. In this therapeutic model, a pair of therapists—typically a man and a woman—conducted the session while two additional team members observed the interaction through a one-way mirror. The observers could communicate with the therapists via an internal telephone system, relaying questions or comments that the therapists would then pass on to the family. The principle of neutrality did not signify passivity or detachment; rather, it entailed maintaining an alliance with all family members and avoiding the formation of coalitions. Interventions from the observing therapists were intended to help the leading therapists resist being drawn into the family's relational patterns or "family games." The entire therapeutic team engaged in discussions about the family before the session, during breaks, and afterward. Consistently adopting the perspective of social constructionism, which posits that there are as many descriptions of a situation as there are observers, Andersen proposed a revolutionary yet straightforward modification to the way therapeutic conversations were conducted, with the goal of generating the greatest possible number of perspectives. He eliminated the use of the one-way mirror and invited additional therapist-observers to participate directly in the session. These observers, while listening to the interaction between the therapist and the family, formed what became known as the reflecting team. In the final part of the session, the reflecting team shared their comments and reflections on the family's situation. This approach created space for multiple new descriptions to emerge, offering family members the opportunity to select the perspectives and insights they found most useful. The removal of the mirror was a significant gesture

toward flattening the hierarchical structure within the therapeutic setting. By ensuring that all conversations took place in the presence of those seeking help, Andersen promoted transparency and inclusivity in the therapeutic process.

The modification that involves opening a dialogue and introducing mutual listening and reflection is of immense significance. After a session conducted by the therapist(s) and observed by a team of invited therapists (the reflecting team), family members take on the role of observers and listeners to the conversation within the reflecting team. Following this, the family is invited to share thoughts and reflections that arise in response to the team's discussion. This conversation within the reflecting team, which focuses on the dialogue between the family and the lead therapist, must adhere to several key principles. To be effective, the conversation should be "sufficiently unusual," meaning it must strike an optimal balance between respecting the family's existing understanding and introducing fresh perspectives from the team. The language, pace, and rhythm of the conversation should be accessible and family-friendly. Adopting a hypothetical style of speech creates space for family reflection and allows for the possibility of rejecting the team's perspective, while maintaining the notion of multiple viewpoints. The reflecting team's dialogue should avoid judgments or criticism, focusing instead on presenting diverse perspectives in a neutral and constructive manner. When a reflecting dialogue is incorporated into family therapy, four parallel conversations can occur: the internal dialogue of the clients, the internal dialogue of the therapists, the external conversation between the therapists and the clients, and the external conversation among the therapists, which the clients listen to. This process necessitates slowing down the pace of the conversation and increasing the participants' tolerance for silence.

## Research on the reflecting team

A comprehensive overview of the literature on the reflecting team is provided in the article by Harris and Crossley [10]. The authors conducted a meta-analysis of publications spanning 20 years, up to 2019. Drawing on carefully selected sources, they examined both the beneficial and challenging effects of the reflecting team on therapeutic practice. The introduction of such a team can strengthen the therapeutic alliance, thereby facilitating the achievement of therapy goals. Direct exposure to the reflecting team allowed families to witness the emergence of new ideas and potential solutions, while the presence of multiple specialists contributed to a diversity of perspectives on the same issue.

The emergence of alternative ways of thinking was generally perceived as beneficial. Clients appreciated the use of simple language and the delivery of content in a warm, understandable manner. Listening to professionals engage in a non-judgmental and committed discussion about the conversation itself provided families with reassurance and hope, supporting their continued engagement in therapy. Family members found it particularly helpful when the reflecting team was composed of a diverse group in terms of professional experience, age, gender, and cultural background. Hearing a discussion about themselves, rather than receiving information directed at them personally, was perceived as less confrontational for families—even when the team's reflections were challenging to process.

However, in some cases, clients viewed the reflecting team as a strange and unfamiliar practice. Some reported discomfort due to the direct presence of additional individuals or experienced a sense of excessive exposure when sharing intimate details of their lives with people they had not previously met and with whom they had not yet formed a therapeutic relationship. In approximately one-third of the studies reviewed, clients described listening to the reflections as unpleasant, with the information sometimes perceived as confusing or overwhelming. Nevertheless, in most cases, these initial feelings of strangeness and artificiality diminished over time, enabling clients to engage with and eventually appreciate this new mode of communication within their relationships.

An interesting finding from the analysis was that when the reflecting team's conversation focused exclusively on the family's strengths and emphasized their resources, it could be met with skepticism and concern. Family members occasionally expressed fear that their suffering, as well as their doubts about their actions and decisions, were not being fully acknowledged or understood. Clients typically enter therapy with the expectation of addressing their reported difficulties and wish to discuss them openly. In summary, the primary condition for the reflecting team's effectiveness is the creation of a safe and supportive environment for clients, while its most significant outcome is the restoration of hope. Further studies on the usefulness of the reflecting process [9, 10] have provided valuable insights into the perspectives of both therapists and clients.

Constable et al. [11] analyzed and categorized the conversations of four reflecting teams, focusing not only on the content of the statements but also on the length of individual speaking turns. The study employed a mixed-methods approach, combining quantitative and qualitative analyses. The duration of the reflecting conversations ranged from 3 minutes and 10 seconds to 5 minutes and 40 seconds. The categorization process was objectivized, and each category was illustrated with supporting quotations. Based on transcriptions of reflecting team conversations, the researchers identified 11 distinct categories of statements: 1) noticing something mentioned during the session, 2) expressing curiosity about the family's emotional state, 3) using metaphors, 4) proposing previously unconsidered ideas, 5) sharing expert knowledge, 6) suggesting possible actions or experiments, 7) highlighting positive aspects, 8) commenting on previously discussed topics, 9) noting changes, 10) reflecting on their own emotional responses, 11) sharing personal experiences.

Building on previous research, Hicks et al. [12] developed a questionnaire to assess the perceived usefulness of therapists' reflections. Participants in family therapy were asked to evaluate both individual reflections from the reflecting team and the overall therapeutic session using a five-point scale. Additionally, they were asked to rate their perceived level of improvement since the beginning of therapy, using a Likert scale ranging from "much worse" (-4), through "the same" (0), to "much better" (4). The study gathered responses from 24 participants engaged in family therapy. Reflections rated as most useful included those that identified and emphasized themes or events emerging during the session, shared expert knowledge, and offered positive feedback. Reflections considered as least useful included the use of metaphors and the sharing of therapists' own experiences or emotions. Overall, the reflecting team's participation in the session was assessed as beneficial for the family. A key practical implication of the study is the importance of tailoring reflections to

the specific family and creating space within the session to collaboratively explore which types of reflections are most helpful—those best suited to the family's unique needs.

The description of this psychotherapy method highlights the substantial content-related and organizational demands associated with the reflecting team approach. This raises an important question: Can elements of the reflecting team model be integrated into routine clinical practice without the involvement of additional therapists, while still preserving its core principles? This consideration is particularly relevant given Andersen's emphasis on the reflective process as primarily an attitude rather than a rigid procedure. In family therapy, it is crucial to integrate research findings, focus on what is most beneficial in the reflecting process, and strive to reduce potential ambivalence associated with the presence of a reflecting team.

The following clinical case illustrates how the reflecting process can be implemented in family therapy conducted by two psychotherapists.

## Clinical illustration

The family therapy process, presented here through selected excerpts, spanned four years. It was initially conducted by a single psychotherapist and, after two years—due to formal circumstances (a change in the lead therapist's employment)—was continued by two psychotherapists. This transition was communicated to the family in advance and discussed collaboratively. The therapy involved a mother and her daughter. At the time of enrollment, the daughter, C., was 15 years old, and the mother, M., was 51. The primary reason for initiating family therapy was the occurrence of mutual physical and verbal violence. Additionally, C. was engaged in individual therapy for a diagnosed obsessive-compulsive disorder (OCD). Over the course of the first two years, symptomatic improvement was observed in relation to C.'s OCD. However, mutual violence persisted and continued to cause suffering, despair, disappointment, and guilt for both M. and C. Prior to concluding the initial two-year stage of family therapy, a clinical team meeting was held to review the therapeutic setting and to determine the appropriate matching of therapists for the next stage. The team decided that future sessions would be conducted by two therapists, a pairing intentionally designed to reflect the family constellation in terms of age. At this stage, the team proposed incorporating elements of the reflecting process into therapy by introducing a "conversation about the conversation" between the two therapists. This intervention was intended to serve as a model for M. and C., encouraging reflection and potentially disrupting the destructive arguments that continued to harm their relationship—conflicts that also regularly emerged during therapy sessions. There was also hope that involving therapists representing both the mother's and the daughter's generations would foster a deeper sense of being understood for each family member. The initial phase of therapy focused on establishing a therapeutic relationship and building a strong alliance. During this stage, we revisited the transition between therapists, providing space for the clients to express their thoughts and emotions. Feelings of uncertainty, mistrust, and potential anger or sadness related to the departure of their previous therapist were acknowledged and normalized. Together with the family, the primary goals of therapy were identified

as follows: to end the cycle of violence; to support the daughter's separation–individuation process; to facilitate the resumption of inhibited developmental trajectories during adolescence; to differentiate the enmeshed emotional experiences of mother and daughter; and to neutralize family loyalties that were constraining the daughter's growth. Additional objectives included addressing dynamics of parentification and double binds (e.g., M: *I want you to be independent, I'm tired of you—but I don't know how I'll manage without you*), strengthening the mother's capacity to express her individual needs, and supporting her in working through the experience of empty nest syndrome.

In the next stage of therapy, we proposed the introduction of a therapist dialogue, inviting the clients to listen and subsequently share their thoughts and emotional responses. This intervention was introduced following a session in which M. and C. once again raised the issue of messiness and recurring arguments over scattered belongings.

**Example of a reflecting dialogue between therapists:**

Fragment 1:

T1: There is a great deal of sadness and fear in this relationship. I had the impression that the anger about the mess is easier to express than the sadness. So, in a way, the mess becomes necessary.

*(Mother laughs)*

(*Silence, 18 seconds*)

T2: I was thinking that in those moments of sadness, when you argue, you are actually emotionally close to one another. But in moments of anger, you seem to grow more distant.

T1: This distancing and anger—I'm not sure if you agree with me, Bogusia—but I believe that this anger creates some distance, which is also necessary.

T2: And which might be essential for each of them to have their own space.

T1: This illustrates two distinct functions of anger.

Fragment 2:

T1: I have a hypothesis that there is a painful bond between the mother and daughter, and that their intentions are very positive—they genuinely want this relationship to be good, friendly, and full of understanding. However, something shifts in their actions, in their behavior, and it becomes painful.

T2: I also have the sense that both the mother and daughter speak about each other with great care. However, something occurs in the process that transforms this care into something that causes pain.

T1: Mhm. And the mess is merely what's visible on the surface—the mess that becomes the topic of conversation. Perhaps these discussions serve to highlight just how much they need each other.

### How the reflecting dialogue between the therapists worked

Initially, when the reflecting dialogue was introduced for the first time, both the mother and daughter reacted with surprise, but also with interest. As therapy progressed, the therapists' conversations became a regular component of the sessions and were received by the family with curiosity and intrigue, as evidenced by their nonverbal reactions and verbal feedback. The inclusion of the therapists' dialogue shifted the dynamics of the session, increasing M. and C.'s engagement in the therapeutic process. As listeners, the clients were temporarily relieved of the pressure to respond immediately, defend themselves, or correct perceived inaccuracies. This created space for deeper reflection. Over time, their initial defensive posture gave way to a more contemplative and open stance. When the therapists invited discussion about the clients' emotional and cognitive responses to the reflecting dialogue, M. and C. reported a shift in how they perceived the therapists—viewing them as more involved and attuned. This perceived reduction in hierarchical distance contributed to a more egalitarian therapeutic relationship. As a result, M. and C. developed a stronger sense of co-creation and co-authorship in the sessions. The emotional atmosphere became more intimate, promoting openness and trust. The dialogue between the therapists served as evidence that multiple perspectives could coexist while still maintaining a positive relationship.

### Summary in the form of a dialogue between therapists

B: Let's discuss the introduction of a reflective dialogue during family meetings. Andersen emphasized the significant differences between speaking about a family in their presence and discussing them when they are not able to hear the therapists' conversation.

A: When speaking in front of the family, we're more careful with our choice of words and observe closely how what we say affects them.

B: Our aim is to ensure clarity in our communication. In striving for precision, reflection naturally emerges —*Am I expressing this correctly? Am I explaining it in a way that is clear?* We search for the appropriate term and description— what Andersen called the "sufficiently unusual" concept.

A: I find great satisfaction in looking for the right word to describe a phenomenon when working with a family. However, just when I believe I've found the perfect expression, I often realize that it doesn't quite resonate with the family. I've observed that patients tend to respond positively when I am able to step back from my initial description and adjust it based on the course of our conversation.

B: That kind of flexibility—where the therapist withdraws or revises their interpretation in response to the patient—actually strengthens the therapeutic alliance. Patients feel they have an influence on the therapist. I'm reminded of our earlier discussion about the nature of conversation itself, and a quote from Harlene Anderson comes to mind: *"Through conversation, problems dissolve."* We experience that in supervision too—how talking something through and listening to others in a creative, mutually stimulating process of reflection truly changes how we see and experience a problem.

A: That's one way to describe how psychotherapy works. It's difficult to explain to someone who has never been a patient what psychotherapy really is—particularly the kind where the therapeutic relationship itself is the healing factor.

B: Yes, it's an experience that's incredibly hard to define. Andersen once quoted Harry Goolishian: *"You don't know what you think until you say it."* Describing session events, narrating the therapeutic process, and observing how we impact patients are all essential elements of the healing journey.

A: I've been thinking about the role of silence in our work. In everyday conversations, silence is usually awkward and quickly filled. But in therapy, silence is allowed. Within it lies the possibility of reflection.

B: Exactly. That echoes what Andersen discussed—the importance of slowing down conversations. As you mentioned, this rarely happens in everyday interactions. Typically, when someone speaks, the other person feels compelled to respond immediately—often just to maintain the flow of the conversation and preserve the relationship.

A: And therapists also feel that pressure—not wanting to appear distant, abandoning, or even incompetent for remaining silent. But together with our patients, we can learn to tolerate silence, to be quiet together, to think, and to experience emotion in that space.

B: Yes, and that silence also existed in our sessions—one that our patients shared with us.

A: I'd like to bring up the age difference between the two of us, which was deliberately designed to reflect the family constellation. Our dialogue was intended to serve as a model for the mother and daughter. We don't need to agree on everything—differences of opinion don't have to threaten a relationship. The fact that we differ was visible; we acknowledged it, and while we had varying views on some matters, this didn't lead to conflict or rupture.

B: What you're describing—tolerating difference—is a key theme in the work around child–parent separation. The idea that *I don't think like the mother* doesn't evoke guilt or fear in me. But how do we introduce reflective dialogue between therapists to patients who might find it strange?

A: At first, it may indeed appear strange and will likely require explanation and research to understand how it functions, allowing space for people to discuss how they experience us talking about them in their presence. Over time, it became sufficient for us to make a simple gesture—turning our bodies toward one another—which served as a signal, both for us and for the family, that this was part of our shared dialogue.

B: I remember a patient from a different case who said he felt like he was watching a movie about himself. He described it as new and surprising, but also enjoyable.

A: Not all families are open to this format. Some might find it too unconventional. I believe its reception depends on the strength of the therapeutic alliance and the therapy's duration. I wouldn't attempt it with every family.

B: I am an enthusiast of reflective dialogue between therapists during sessions, and I increasingly incorporate it into my practice. Still, it's not a universal remedy or a method suitable for every patient.

A: I recall a patient with whom we also attempted reflective dialogue within her family, but she was highly defensive, anxious, and distrustful. Any deviation from the norm was interpreted by her as being directed against herself, which could be considered a contraindication.

B: A contraindication also arises from the hostility a patient may feel toward therapy. In such cases, I would proceed with great caution.

A: I am concluding that the level of personality integration in patients is a variable that may serve as an indication for the use of reflective dialogue.

B: Such a reflective dialogue between therapists essentially exposes everything from within. For some patients, this can be a positive experience that enhances their sense of security.

A: And the therapist's own emotional responses can also be used—not by disclosing them outright, but through mentalization and hypothesizing what the patient may have experienced.

B: And what about our feelings toward each other? When we speak, I observe you closely and wonder what you're thinking—whether my invitation to dialogue might be disrupting some internal continuity of yours.

A: I felt a kind of permission—not to respond if it didn't feel like the right moment for such an exchange. I sensed that I could allow myself simply to listen, without the obligation to reply.

B: Not everyone is always ready for such closeness, as reflective dialogue can be a very intense experience. The other person may not desire that level of intimacy. It is important to feel comfortable and not feel obligated to engage in the dialogue—and equally important that the other party accepts this naturally.

A: That requires mutual trust. The other therapist also needs to be psychologically integrated—not taking offense or feeling rejected depending on who initiates the dialogue and how it unfolds. This, too, becomes a model the family can learn from.

B: Mutual mindfulness, but also the courage—to engage or to refrain.

A: Again, I see clear benefits for the patients. They are not always ready for intense interaction and often communicate this through subtle, non-verbal cues. A significant amount of work is needed to establish a genuine sense of partnership and collaboration.

B: When therapists engage in dialogue, the family becomes the audience—the listeners.

A: Therapists may even begin to feel like part of the family system. That dynamic can bring them closer to the family.

B: Reflective dialogue can be helpful in emphasizing that we are all co-creators of what unfolds in psychotherapy.

A: While we already understand that reflective dialogue is not appropriate for all patients, what about the potential obstacles within the therapeutic team itself? There are certainly limitations to introducing this form of dialogue. One that comes to mind is rivalry between therapists.

B: Perhaps the rivalry between therapists—which can overshadow the focus on the family—stems from a need to present oneself favorably or to compare oneself with the co-therapist. This may, in turn, reflect a lack of confidence in one's own competencies.

A: A therapy free from competition is probably an idealized vision. But when rivalry escalates into hostility, it becomes truly harmful—and potentially dangerous.

B: What matters is the outcome of the comparison: whether it leads to curiosity and learning or to envy and conflict.

A: Another major obstacle is the belief that one's own perspective is absolutely correct. The ability to tolerate different interpretations is essential.

B: It is essential to reflect not only on what happens between therapists and patients, but also on what occurs between the therapists themselves.

## Conclusions

In recent decades, there has been a notable shift in approaches to working with families, particularly in the role of co-therapy. Clients are now invited to co-author the therapeutic process, which fosters shared responsibility for outcomes and, in turn, enhances their sense of autonomy, agency, and satisfaction. Within this collaborative framework, the choice of words, the therapists' language, and its attunement to the clients become essential. Equally important is the need to reflect on the impact of mutual interactions—the therapeutic bond that is formed through the alliance and the ongoing care for the relationship. The introduction of dialogical work or a reflecting team should be preceded by careful consideration of the hypothetical consequences of this approach, as well as the clients' readiness to engage with it. Only after such an analysis—ideally conducted within a broader therapeutic team and following supervision—should the course and purpose of the method be explained to the family. The timing of the introduction is also crucial; it should occur only after a therapeutic alliance has been sufficiently established. It is important to remember that the therapeutic relationship requires ongoing adjustment, monitoring, and repair in response to the natural and often subtle ruptures that occur in interpersonal contact [12]. This dialogical style of work also necessitates attention to the relationship and emotional climate between co-therapists—an area that should itself be subject to regular supervisory reflection.

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