The Effect of Supervision in Positive Psychotherapy Training

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SUMMARY

In this research we analyze experience and effectiveness (impact on psychotherapeutic practice) of supervision in positive psychotherapy training. The method we use for supervision has been designed according to a five-stage model (Braeuer H.G., 1997), adapted from the five stages of intervention in Positive Psychotherapy (Peseschian N., 1987). This technique is based on the concept that the professional difficulties of a therapist are intimately associated with the key to the solution of the patient's conflict. This key leads to the discovery of what the actual capabilities are, to why they are involved and to how the balance has been lost. This approach allows one the opportunity to establish dynamic equilibrium in life and to make progress toward the development of deep conscious identity and emotional maturity.

KEY WORDS

Positive psychotherapy, supervision, effectiveness

INTRODUCTION

Supervision is one of the most effective methods of psychotherapy training. Within the supervisory process an expert of interpersonal relationship helps the colleague who is starting his practice to be consciously and systematically aware of professional acts and behaviors in order to analyze and improve them.

The difficulties associated with the use of theoretical knowledge in practice are related to the inner conflict of the therapist. His inner conflict reflects an individual history of emotional maturity development (basic conflict) and reveals itself as an actual conflict in the present situation and within the process of supervision (incompetence in therapeutic situation, anxiety and different defenses in supervision). For supervision, this is not limited to the handing over of new knowledge, but involves elements of psychological development of the specialist (correction of the inner conflict, related with difficulties of professional practice). Those elements are naturally based on the ideas and methodology of the learning approach. The demarcation line between those two aspects of supervision can be defined by:

1. interacting objects
   a. psychotherapist - patient
   b. psychotherapist - supervisor

2. tasks difference
   a. analysis of a difficult case i.e. problem of the patient and enrichment of approaches to cure him/her
   b. correction of the inner conflict of the psychotherapist;

3. final results
a. enhanced quality of medical aid (therapy)
b. personal integration of the therapist

Although supervision and psychotherapy are parallel processes, they are linked systemically by the transference that is formed in both relationships. The initial stage of transference is unconscious
identification and imitation. Therefore, the relationship of the supervisor and supervisee becomes an active model of interaction that the psychotherapist will reproduce to some extent with the patient in order to help him establish authentic and effective relationships with himself and the world around him.

The main content of the modeling in Positive Psychotherapy is the humanistic concept of a positive image of man as intrinsically good and potentially capable of developing all his capabilities.

Internalization of this concept determines the change of self-image in the following four dimensions of emotional maturity:

1. belief in one's own capabilities ("I" concept);
2. capability to make decisions and act based not on the form but on the content of the partner's behavior ("YOU" concept);
3. openness toward diverse opinions, acceptance of other social groups (trans-cultural/trans-theoretical approach) ("WE" concept);
4. awareness of purpose and meaning of own actions and their results ("PRIMARY-WE" concept).

This maturity generates the dynamic equilibrium of four dimensions of reactions toward the conflict as well as the so-called character (the set of actual capabilities in different stages of their development).

As a result, anxiety levels can be significantly reduced and new solutions to the conflicts and symptoms they represented can be seen, built and implemented.

Supervision can be defined as a structured and determinate (through concrete experiences) type of consultation directed toward the improvement of professional skills, and the psychological processing or assimilation of a professional experience, particularly in situations involving conflict or stress

The expected results of supervision are:

1. solution of an actual conflict in the therapeutic situation (psychotherapist/inner conflict of the patient and effectiveness of the therapy);
2. development of emotional maturity factors that release the therapist to build an adequate therapeutic relationship with the patient.

MATERIALS AND METHODS

In order to evaluate the effects of supervision in Positive Psychotherapy training we undertook research that took place from 1999 through 2002. This research involved practicing psychotherapists who were being supervised within Positive Psychotherapy training (N=30), and 60 of their patients. The control group consisted of 30 patients who were treated by psychotherapists that had never been supervised.

Supervision took place in groups and some individual sessions. Therapy took place only in individual settings. The methodology of the supervision we used is based on the basic ideas, principles and techniques of the Positive Psychotherapy and some publications (U. Boesmann, 2001; Braeuer H.G., 1997; Remmers A., 1997) that were probated and adopted in our work.

Cases were presented in accordance with the Check List for supervision as assembled by Udo Boesmann (2001). Supervision in positive psychotherapy is according to five consecutive stages and similar to the therapeutic method of Dr. Nossrat Peseschkian (Peseschkian N., 1987; Braeuer H. G., 1997) and is described as follows.

1. OBSERVATION

A supervisee reports and reflects the case of psychotherapy (usually, once after every fours session of therapy). He receives support, acceptance and encouragement, and a chance to observe the situation that he presents (including disbalance of the conflict reactions model: body, achievements, contacts, fantasies/future) as reflected by the group's feedback.

2. INVENTARISATION

Both the supervisor and the group question the supervisee in order to

a. clarify imbalances of actual capabilities that are involved in the interrupting conflict(s) of
- emotional/physical life of the patient
- practical implementation of the method by the psychotherapist

b. discover the basic conflict (described by model for modeling [7]) that charges the actual conflict with affect (differential analysis).

3. SITUATIONAL ENCOURAGEMENT of reviled capabilities reinsures the supervisee that he is capable of dealing with the situation and solving it professionally using new vision, conscious use of actual capabilities and alternative behavioral/emotional experiences in common cases offered by both the group and the supervisor in feedback.

4. VERBALIZATION involves the supervisor and group members verbalizing the content of the actual, basic and inner conflicts of the patient/therapist. The supervisee investigates the meaning and background of counter transference and defensive coping reactions that interrupted successful use of theory in practice. The therapeutic relationships of the colleague and his patient are viewed as a system. Therefore, the spontaneous emotional/behavioral reactions of the supervisee are considered a source of new therapeutic hypotheses and broadening of clinical tactics.

5. GOALS BROADENING

At this stage all participants enrich the vision of alternative therapeutic hypothesis, approaches, strategies and techniques of therapeutic interventions. Supervisor and group members support the therapist to see perspectives and to have the courage to continue to work with the case and to plan some interventions.

We used the Bielefeld Questionnaire of (Bielefelder Klientenerfahrungsbogen - BIKEB (Hoger D., 1993)) to measure the effectiveness of supervisory experience (modified form) and the client's

experience (subjective experience of change, reduction of the anxiety level, reduction of symptoms).

Content of changes evaluated by:
1. Wiesbaden Inventory of Positive Psychotherapy and Family Therapy (WIPPF) (Peseschkian N., Deidenbach H., 1988): balance of actual capabilities, balance of the conflict reactions model, model for modeling in basic situations.
2. Relationship Evaluation Questionary (Kirillov I., 2002): relationship with supervisor/therapist, model for modeling in relationships, change of 4 factors of emotional maturity.
3. Bielefeld Questionnaire (Hoger D., 1993) of client's experience: quality of relationship.

The level of actual conflict (therapeutic situation) resolution has been evaluated according to the data of anxiety reduction among the psychotherapists and by the effectiveness of the therapy in the experimental group in comparison with the control group of patients.

Inner conflict resolution of the supervisee is assessed according to the data received in this group regarding the effectiveness and dynamics of supervision.

Statistically, results were processed with Microsoft Excel. Arithmetic middling, error in mean and frequency of features manifestation were found for numerical values of scales. Statistic reliability of differences in results in first case were proved by the Student's t-criteria, and in the second case, by Pc^2.

The average age of the supervised psychotherapists was 36 ± 1.64 y.o.. Most of them (66,7%) have medical educations and work as MDs, and/or Psychotherapists. Clinical psychologists comprised 33.3% of the group.

The average length of service as a psychotherapist was 4.9 ± 0.63 years (including 3.9 ± 0.39 years using Positive Psychotherapy). The average length of professional education recorded was 6.0 ± 0.75 years. Eighty six plus percent (86,7 %) of the therapists in this research defined Positive Psychotherapy as the main method of their practice.

Average length of supervision – 10.7 ± 2.09 hours. Forty percent of the therapists were motivated by the desire to develop professional skills, seventeen percent needed it for certification, forty three percent cited both as motivating reasons.

The social status in the main (60 people) and the control (30 people) groups of the patients were similar. The average age in the main group was 37.9 ± 1.48 years and in the control group 37 ± 1.52 years. The main group consisted of women (57%) and men (43%), there were 53% and 46% correspondingly in the control group. In both groups patients were mainly high educated (main - 83%, control - 77%).

Among referral reasons for psychotherapy (first diagnose by ICD-10) are listed as follows (first figure – main group, second – control); F 3. – affective mood disorders (18.3%; 23,3%); F 4. - neurotic and stress related somatoform disorders (48.3%; 46.7%); F 51. - non organic sleep disorders (5%; 6.7%); F 98.5 - stuttering (3.3%; 0%); Z 56.6 - other physical and psychological

tensions at the workplace (syndrome of emotional burnout) (8%; 10%); Z 60.0 - problems. Related with adaptation and change of life-style (10%; 6.7%); Z 63.0 - were problems related with understanding among spouses and/or partners (7%; 6.7%).

All patients in both groups were treated with the methods of Positive Psychotherapy. The patients of the main group were treated by supervised therapists and the patients of the control group were treated by psychotherapists who had not been supervised.

DISCUSSION

Results of the survey revealed the following personal characteristics of the therapists before the supervision:

1) overemphasizing of some and ignoring of other actual capabilities combined with diffusion of estimations in a broad range of gradations

2) limited reaction in the areas of "contacts" and "future/fantasy" that leads toward the intensification of inner conflict and toward disorders related with "overloading" of available areas ("achievements", "body");

3) traumatic background of basic situation (low points in all 4 dimensions of model for modeling).

This data correlates with our assumption that actual difficulties arising in the professional practice of psychotherapists represent the inner conflicts of practicing colleagues (imbalanced development and inadequate estimation of primary capabilities). These dysfunctions are based on internalized experiences of basic situations of parental family/group and activated by actual conflict. Doubts in one's own competency arise and reveal themselves in symptoms of anxiety in the supervisory setting: feelings of danger, uncertainty, agitation, closed defensive behavior, physical tension.

Characteristics of actual capabilities development and evaluation of the basic situation that were found in the group of patients were similar to those among therapists. Differences appeared in misbalanced models of reactions; misbalances in the patient's group were distributed more evenly than among therapists. This fact can be described by the more diverse composition of the patient's group. The above-described characteristics cause conflicts that in the case of the patients were revealed by psychological and somatic disorders.

According to the data of the Relationship Evaluation Questionnaire (REQ) and BIKEB, supervised psychotherapists recorded significant improvement of relationships with supervisors through the course of supervision (scale 1 of REQ, scale 1 of BIKEB) and extending the modeling factor of relationship in supervision (scale 2 of REQ). These conditions were supported by feelings of comfort of the supervisee and the developing of his capability to unfold self (scale 2 of BIKEB).

The forming of trusting and safe relationships, supporting more profound self-discovery and the unfolding of self, had in most cases already taken place after the first session of supervision, and was followed by stabilization and further development.

We evaluated the following criteria of effectiveness of the first aspect of supervision (correction of therapist's inner conflict):

1. Increasing points were given by supervised therapists to factors of emotional maturity with maximal points in:
    - "I" dimension – self-esteem. This correlates with the thesis that within the supervision the psychotherapist should become aware of his limitations and possibilities and through this obtain a clear vision and identity with his professional role.
    - "YOU" dimension – the ability to collaborate, to understand the content and the context of symptoms and behaviors, to see their positive intentions and to build a five-step communication system with the patient that is the main pedagogical task for the supervision in positive psychotherapy – to develop "...affective sensitivity, cognitive mastering, behavior regulation" (after Straufi and Wittmann) [8].
2. Revaluation and relative equilibrium of primary and secondary capabilities.
3. Reduction of disbalance among the types of conflict reaction;
4. Moderate (after the first session) and significant (at the end of the course)
    - change of vision of professional problem and
    - progress in its resolution[1]
5. Significant reduction of factors of anxiety (scale 4 – safety and confidence; scale 5 – feeling of calming; scale 6 – physical relaxation of BIKEB) among psychotherapists in supervision within the very first session and then throughout the course.

Correction of the therapist's inner conflict leads to more conscious behavioral choices in the therapeutic situation. There is a chance for more adequate reaction and verbalization of counter transference. The arsenal of therapeutic behavior is broadened. This statement was proved in our research by the data of effectiveness of the second aspect of supervision (enrichment of theoretical knowledge and practical skills). The data (patient's feedback) in the group treated by supervised colleagues was compared to the data from the control group who were treated by not supervised psychotherapists.

1. Supervised psychotherapists more successfully ($p<0,05$) build trusting relationships with the patient and form their positive transference within a shorter time scale. According to the first scales of REQ and BIKEB, the change of the relationship with the psychotherapist was described by their patients of the main group as "significantly positive" versus "moderately positive" in the control group. By BIKEB measurements, the control group points for this scale reached the lower border of "significantly positive" values only at the end of therapy. In accordance with the collected results, supervised psychotherapists within the very first session already achieved a level of trust (scale 2 of REQ) and patient readiness to use the therapeutic relationships as models for self-help (scale 2 of BIKEB) that not supervised psychotherapists can build only by the end of the therapeutic course.

2. Supervised psychotherapists interacted significantly (statistically proved) more successfully than not supervised colleagues in correcting emotional maturity factors of their patients (figure1).

[1] By three scales of BIKEB: experience of change, general evaluation and general scale

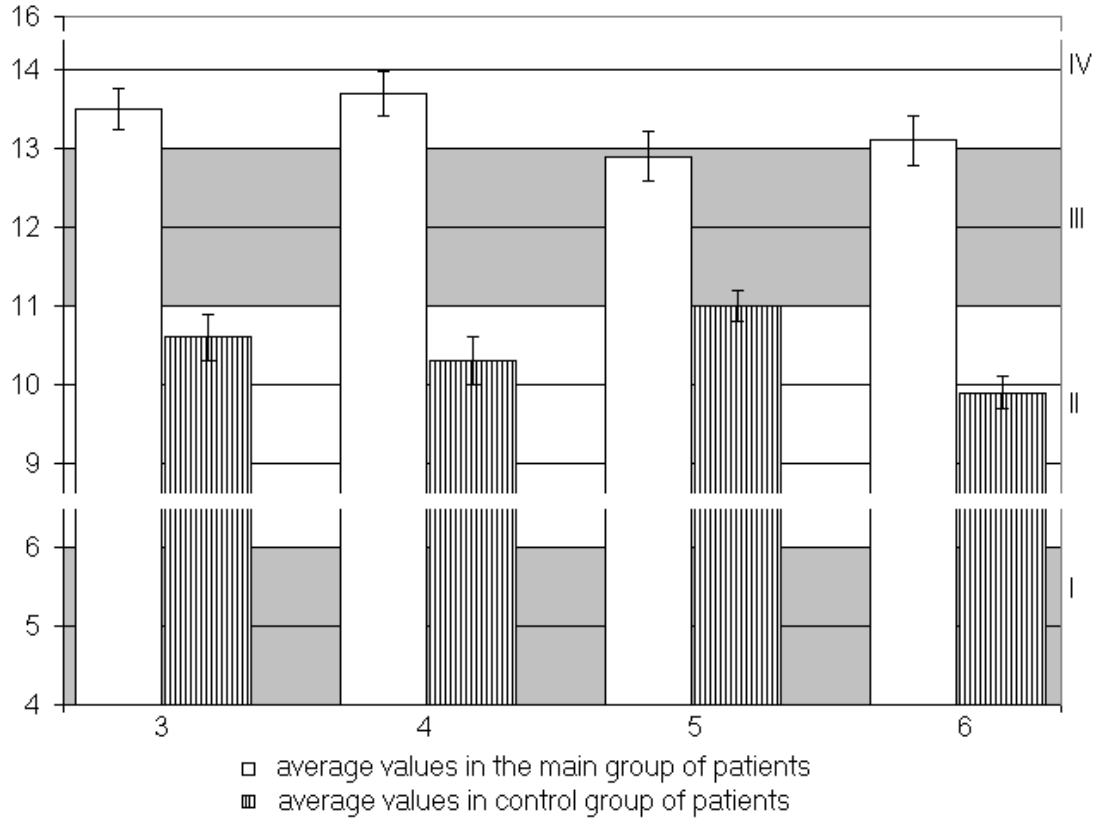

Figure 1.
Change of four factors of basic emotional maturity (points) in course of psychotherapy in main and control groups.

Scale 3 – change of basic trust
Scale 4 – change of capability to collaborate
Scale 5 – change of openness
Scale 6 – change of capability to know the meaning

Zone I – no change; zone II – insignificant change; zone III – moderate positive change; zone IV – significant positive change.

3. Supervised psychotherapists achieved statistically more significant positive feedback about experience of change through therapy (3 scales of BIKEB and 1 scale of REQ) from the patients of the main group (versus control group). Anxiety symptoms were reduced by the end of the first session in the main group (safety and confidence, feeling of calming, physical relaxation) in comparison with the control group where such changes were accomplished only at the end of the therapeutic course (figure 2).

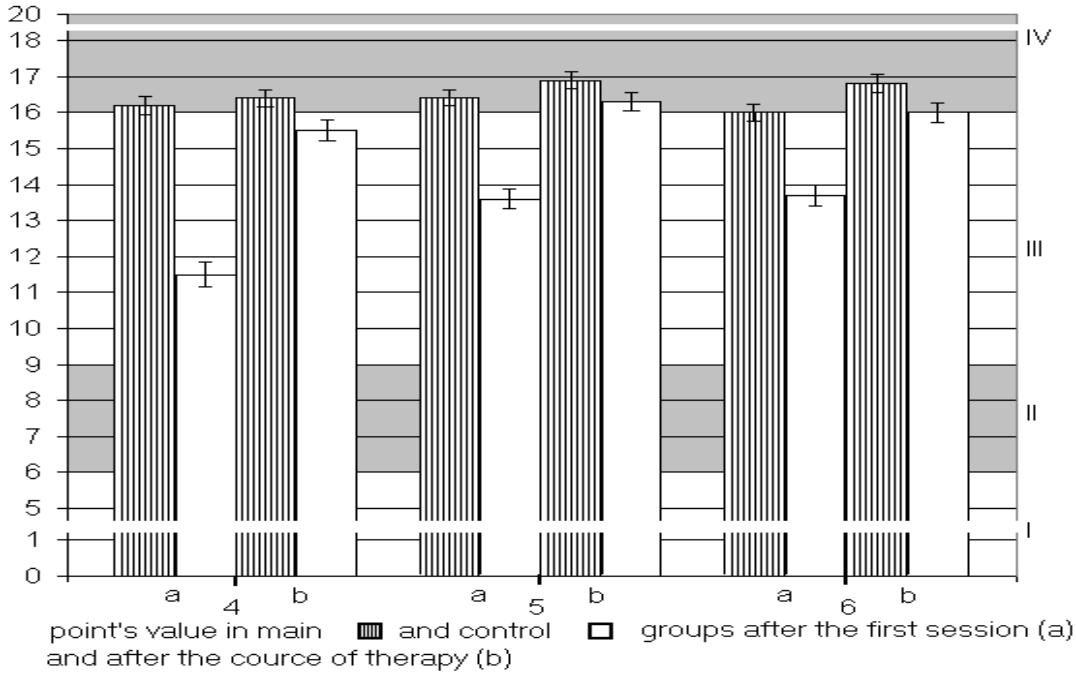

Figure 2.

Change of average point's value that characterize anxiety level (points) of patients in course of psychotherapy in main and control groups.

Scale 4 – safety and confidence;
Scale 5 – feeling of calming;
Scale 6 – physical relaxation.

Zone I – negative changes; zone II – insignificant changes (or no changes); zone III – moderate positive changes; zone IV – significant positive changes.

In the main group of patients, conflict reactions through "body" and "achievements" were significantly more corrected. It should be kept in mind that before therapy was undertaken, there was considerably more disbalance in this than in the same areas of the control group. Therefore, it seems more meaningful to look at these differences in context of the ratio harmonization observed in both groups involving 4 types of reaction towards the conflict.

In all groups of the supervision/therapy a significant displacement of the amount of main frequencies of point values given to primary and secondary capabilities in the optimal zone was to be noted. Simultaneously, the diapason of frequencies distribution was constricted. Modal scale also moved to the optimal zone. Mode amplitude was growing. Average point values moved from the zone of moderate deviations to the optimal zone, and the error in mean was reduced.

There was no accumulation of actual capabilities point values frequency in the right part of the optimal zone (12 points). Instead, this grade was reduced. It can be related to the practical observation that adaptation can be disturbed not only by insufficient development but also by overestimation of actual capabilities and by excessive attention to certain behaviors (such as excessive punctuality, obtrusive cleanliness etc). Therefore, adaptive changes can be presented

not only by the increasing but also by the decreasing of points. It would appear to be more fruitful to look for balanced development and actualization of actual capabilities.

There was also observed a significant difference in the level of actual capabilities correction between the main and control groups. However, because of the difference in quantitative composition of these groups we cannot claim this finding to be reliable. The fact of individuality of changes of actual capabilities makes changes within the group too diverse and complicates the analysis.

RESUME

1. Difficulties to use the psychotherapeutic theory in practice represent: a. the inner conflict of supervisee; b. lack of experience (knowledge and skills).
2. Supervision in positive psychotherapy is an effective tool to provide safe and comfortable setting for self-discovery and learning (development of self-esteem and professional identity; conscious professional mastering of affects; reaction and motivation/behavior balance; skill of positive usage of professional difficulties).
3. This profound changes and learning experience in supervision provide supervisee with increasing capability to build more productive psychotherapeutic relationship that significantly improve the quality of therapeutic outcomes that can be achieved in shorter time frame.

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