AMOUNT AND QUALITY OF SUPERVISION AS MODERATING FACTORS

BETWEEN COUPLE THERAPEUTIC ALLIANCE AND CHANGE

IN COUPLE THERAPY

Except where reference is made to the work of others, the work described in this thesis is my own or was done in collaboration with my advisory committee. This thesis does not include proprietary or classified information.

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Meetika Jindal, daughter of Tarsem and Sushil Jindal, was born November 24, 1980, in Bathinda, Punjab, India. She completed her high school education from Bal Bharati Public School in 1998. Upon completion of High School, she attended Indraprastha College for Women in Delhi University in Delhi, India and graduated with a Bachelor of Arts degree in Psychology in May 2001. She went on to complete her Master of Arts degree in Psychology with specialization in Clinical Psychology in May 2003. Immediately following graduation, she entered Graduate School at Auburn University, in Marriage and Family Therapy, in August, 2003. Meetika married Anurag Chawla, son of Ashok and Mridula Chawla on November 19, 2005.

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The purpose of this thesis was to examine the moderating effect of quality and quantity of supervision on the relationship between couple therapeutic alliance and change in couple therapy. The sample is collected from couples seeking couple therapy at a University based marriage and family therapy training clinic. The findings indicate that the therapeutic alliance is a significant predictor for the change in relationship satisfaction in couples from session one to session four. The moderating effects of the quality and quantity of supervision are not significant with the current sample. However, the trends are encouraging for future research. The findings need to be replicated with a larger sample size.

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TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

Therapeutic alliance has a positive relationship with client outcomes in research and practice. The predictive value of therapeutic alliance in the outcomes of therapy has been established in in individual psychotherapy (Hovrath & Symonds, 1991; Martin et al., 2000), couple therapy (Brown & O'Leary, 2000; Johnson & Talitman, 1997; Rait, 2000) and family therapy (Johnson et al, 2002).

In individual therapy, the positive relationship between therapy alliance and therapy outcomes has been implicated in different kinds of treatments. In alcoholism treatment, Connors et al. (1997) found a positive association between therapeutic alliance ratings and treatment participation and drinking outcomes during and after treatment in outpatient clients. Barber et al. (2000) found that the therapeutic alliance at session five or ten was strongly associated with prior symptom improvement in cases of generalized anxiety, chronic depression, or avoidant or obsessive-compulsive personality disorders. The therapeutic alliance has been found to be a significant predictor of further improvement even when prior change in depression was partialed out (Barber et al, 2000).

The concept of working alliance has been applied to couple and family therapy by Pinsof and Catherall (1986). They defined therapeutic alliance as the collaborative bond that exists in therapy between the therapist system and the patient system. In their

attempt to effectively adapt the alliance to relational counseling they borrowed key ideas from Bordin (1979) to conceptualize the working alliance. The components of working alliance were elaborated to be bonds, goals, and tasks. The *bond* between the therapist and the client characterized by mutual trust, acceptance and confidence establishes a positive attachment to the therapist. The therapist and the client endorse and value the same *goals* to be the target of intervention. *Tasks* can be understood as the in-counseling behaviors and cognitions that would help the client to reach his/her goals in therapy. In a well-functioning relationship, both the therapist and the client perceive these tasks as relevant and efficacious, each of them taking the responsibility to perform these tasks.

The therapeutic alliance has been found to predict the therapy outcomes in couple and family therapy. It explains significant variance in the change in the symptom distress scores in home-based family therapy for mothers, fathers and adolescents (Johnson et al., 2002). The association between therapeutic alliance and outcomes has been found in working with couples in the couple therapy (Johnson & Talitman, 1997; Quinn et al., 1997) as well as group therapy settings (Bourgeois et al., 1990). The tasks component of therapeutic alliance has been found to be the most predictive of outcomes in couple therapy (Johnson & Talitman, 1997). In comparing male and female scores of couples, Quinn et al. (1997) found that when both males and females reporting a positive relationship with the alliance and outcomes.

There are several factors that have been investigated that mediate the quality of therapeutic alliance. Family-of-origin distress affected quality of alliance for both men and women at session one and women at session eight (Knobloch-Fedders, Pinsof &

Mann, 2004). High marital adjustment has been found to be predictive of therapeutic alliance at session three (Mamodhoussen et al., 2005) and higher levels of marital distress, predictive of poorer alliance even at session one (Knobloch-Fedders, Pinsof & Mann, 2004). However, individual symptoms or individual psychiatric symptoms have not been found to predict the quality of alliance at any stage of therapy (Knobloch-Fedders, Pinsof & Mann, 2004; Mamodhoussen et al., 2005).

Within the literature there are few studies which evaluate variables which may moderate the therapy alliance. Raytek, McCrady, Epstein, and Hirsch (1999) found that experience of the therapist affected the strength of the alliance and affected treatment duration. It does not appear that there are any other studies evaluating the other key variables that moderate the therapy alliance. One such variable could be clinical supervision. Supervision can be conceptualized as a factor that assists therapists in managing multiple therapeutic alliances with the partners to have better client outcomes in therapy. However, research investigating the effect of supervision on the quality of therapeutic alliance is sparse. Even less is dedicated to the relationship between supervision, therapeutic alliance and client outcomes.

Bernard and Goodyear (2004) define clinical supervision as an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative. It extends over time; and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s) and monitoring the quality of the professional services offered to the clients. A certain amount of supervision is one of the core requirements for accreditation of

Marriage and Family Therapy training programs by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Support needs to be forthcoming to solidify its importance.

The literature that does exist highlights the parallel processes between the supervisory relationship and therapeutic relationship. Parallel processes have been discussed in terms of the similarity in the way clients present themselves in the session with the way the therapists present themselves to the supervisor (Friedlander et al., 1989).

The systemic supervision literature conceptualizes the similarity in terms of structure, processes as well as goals. The similarity in structure is that they are both dyadic. In supervisory relationship the goal is for the supervisor to help the therapist become more competent as a professional. On similar lines, the therapeutic relationship helps the clients to overcome the issues that bring them to therapy. The supervisory relationship has been understood to affect the therapeutic relationship. The ratings of the supervisees about the supervisory relationship are highly correlated with the client's ratings of the therapeutic relationship (Patton & Kivlighan, 1997).

Supervision can therefore be understood to be an important aspect of clinical training in marriage and family therapy. With the degree of emphasis supervision is accorded, one would assume that there is an interaction effect between supervision and therapy alliance which impacts client outcomes. Thus those who receive more supervision and greater intensity of supervision should demonstrate better client outcomes.

The impact of clinical supervision on client outcomes would be the acid test of supervision (Ellis & Ladany, 1997). To our knowledge there is no research in the field of marriage and family therapy that has studied the impact of supervision on client outcomes. Live supervision condition has been found to be associated with higher ratings of therapeutic alliance in individual psychotherapy as compared to videotaped supervision (Kivlinghan et al., 1991). We also know that certain emphasis in supervision is related to higher client satisfaction. The client satisfaction was higher in cases of client-centered supervision as compared to a mixed-focus supervision emphasis (Harkness & Hensley, 1991).

The present study attempts to create a better understanding of the dynamics of supervision affecting client outcomes in couple therapy. The goal of couple therapy is to improve the couple relationship; therefore, change in couple relationship satisfaction would be a representative measure of client outcomes. It would be important to determine if the amount and intensity of supervision affects the therapeutic alliance and thus impacts client outcomes.

For couple therapy, therapy alliance and relationship satisfaction seem to be related. Supervision seems to improve client satisfaction. However, we do not know whether the quantity and quality of supervision interacts with the therapeutic alliance to impact change in relationship satisfaction for the partners in couple therapy.

Hypotheses.

Hypothesis 1: The therapeutic alliance measured at the fourth session will have a positive impact on the change in couple relationship satisfaction for males and females.

Hypothesis 2: The quality and quantity of supervision will moderate the effect that the therapeutic alliance has on change in couple satisfaction for males and females.

II. LITERATURE REVIEW

The literature in the field of marriage and family therapy about the factors affecting client outcomes in couple therapy is limited. Therapeutic alliance has been found to be predictive of client outcomes in individual, couple and family therapy. One factor, the effect of which should be studied on relationship between therapeutic alliance and client outcomes, is supervision. Despite the emphasis on supervision in marriage and family therapy training, the research in the area of supervision is very limited. There are no studies in marriage and family therapy that address the effect of supervision on client outcomes. The present study attempts to create a better understanding of the dynamics of supervision and how it impacts the relationship between therapeutic alliance and client outcomes in couple therapy. The relevant literature available studying therapeutic alliance, supervision and client outcomes have been summarized in this chapter.

Therapeutic alliance and therapy outcomes.

The findings in the literature of individual therapy, couple therapy and family therapy have been summarized in this section.

Individual therapy. The findings have been replicated in several individual therapy studies with psychiatric samples that meet the diagnostic criteria including alcohol abuse, alcohol dependence, generalized anxiety, chronic depression, and avoidant

and obsessive-compulsive personality disorders. The findings from some studies and two review articles have been discussed from the individual therapy literature.

Connors et al. (1997) investigated the relationship between therapeutic alliance ratings and treatment participation and drinking outcomes during and after treatment in outpatient and aftercare clients. The participants met the primary Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.; DSM-III-R; American Psychiatric Association, 1987) criterion for a diagnosis of alcohol abuse or dependence (N=698 outpatient, and N=498 aftercare). The therapists included in the study were 40 in outpatient study and 35 in the aftercare study. The therapists and the clients completed the WAI after the second session. The drinking history and alcohol consumption were collected for pretreatment, 12 week treatment period and throughout the 12-month post-treatment were collected.

The results indicated that the therapeutic alliance consistently predicts treatment participation and positive drinking-related outcomes in outpatient alcoholic clients, whether the alliance was rated by therapists or clients. The relationship was found to exist even when a number of covariates including pretreatment drinking history were controlled. The findings were not replicated in the aftercare settings.

The positive correlation between therapeutic alliance, outcome and symptomatic improvement in early treatment was also found by Barber et al. (2000). The participants met the primary Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.; DSM-III-R; American Psychiatric Association, 1987) criteria for generalized anxiety (N=44), chronic depression (N=11), or avoidant (N=19) or obsessive-compulsive (N=14)

personality disorder. The patients filled out Beck Depression Inventory (BDI; Beck et al., 1988) and CALPAS at session 2 and 5. The results indicated that the therapeutic alliance at session 5 or 10 was strongly associated with prior symptom improvement. However, even when the prior change in depression was partialed out, therapeutic alliance was still found to be a significant predictor of further improvement in symptoms.

Two meta-analytic reviews in individual psychotherapy literature have implicated a moderate but consistent relationship between therapeutic alliance and client outcomes. Hovrath and Symonds (1991) in a meta-analytic study reviewed 24 studies examining the relationship between working alliance and outcome in psychotherapy. The studies have been conducted between 1981 and 1990. The sample size ranged between 8 and 144 in different studies reviewed.

Various measures were used in across the studies to measure working alliance like Working Alliance Inventory (WAI; Horvath and Greenberg, 1989), California Psychotherapy Alliance Scales (CALPAS; Gaston, 1991), Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley and Strupp, 1983), California Therapeutic Alliance Rating System (CALTARS; Marmar et al., 1989) and Therapeutic Bond Scale (TBS; Saunders et al., 1989). Similarly different measures were used in different studies to assess client outcomes like Symptom Checklist-90, Beck Depression Inventory, Social Adjustment Scale, etc. Different studies used client ratings, therapist ratings and observer ratings. They concluded that working alliance was a robust variable linking therapeutic process to outcome with a moderate effect size (ES) of 0.26. The clients' and observers' rating of alliance were more predictive of outcomes than the therapists' judgments.

Similar findings were established in another meta-analytic review by Martin et al. (2000). They reviewed seventy nine studies that focused on studying the relationship between therapeutic alliance with therapeutic outcomes and other variables. The studies included had been published between 1978 and 1996. The majority of the sample used in the various studies was outpatient population (n=59), however others (n=18) were more severely mentally disordered patients. Different instruments were used across studies to measure the therapeutic alliance like Working Alliance Inventory (WAI), California Psychotherapy Alliance Scales (CALPAS), Therapeutic Bond Scale (TBS), etc. The average reliability of these instruments was reported to be 0.79. The studies used either the ratings by patients, therapists or observers. The outcomes measures used were conceptualized as belonging to five different categories of Mood Scales, Symptom Scales, Global Scales, Specific Outcome Scales, and Termination Status.

The findings indicated a moderate but consistent relationship between alliance and outcomes ($r = 0.22$). The effect size was found to hold regardless of the number of variables posited to influence this relationship. The alliance ratings of patients, therapists and observers were found to have adequate reliability. The patients' ratings were found to be more consistent than therapists' or observers'.

Couple therapy. There are some studies in couple therapy that have established similar results with distressed and non-distressed samples. Johnson and Talitman (1997) studied the predictors of success in Emotionally Focused Marital Therapy. The sample included 34 couples who had cohabitated for at least 1 year, were alcohol or drug-free, had received no psychiatric or psychological treatment in the last one year, and scored

less than 97 on Dyadic Adjustment Scale (DAS; Spanier, 1976). Pretherapy measures included DAS, Miller Social Intimacy Scale (MSIS, Miller & Lefcourt, 1982), Attachment Questionnaire (AQ; West, Sheldon & Reiffer, 1987), Relationship Trust Scale (RTS; Holmes, Boon & Adams, 1990), Emotional Self-Disclosure Scale (ESDS; Snell, Miller & Belk, 1988), Affiliation (AFF) and Autonomy (AUT) subscales of Edwards Personal Preference Schedule (EPPS; Edwards, 1959). At the end of the third session, each partner independently completed Couples Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986). The therapist completed the ratings for the DAS factors for the couple. The four DAS factors are: Satisfaction, Consensus, Cohesion and Affectional Expression.

The results indicated that couples most satisfied after the 12 sessions of EFT and at follow-up were the ones who had positive alliance with the therapist. Therapeutic alliance was found to be more significantly related to couple gain in marital satisfaction at termination, $r = .48$, $p < .01$, and follow up, $r = .50$, $p < .01$. The tasks element of alliance was found to be most significantly related to outcomes. The tasks subscale accounted for 27% of the variance in couple posttreatment satisfaction level, $F(1,31) = 13.11$, $p < .008$ and 36% of the variance in the couple satisfaction level at follow-up $F(1,31) = 18.20$, $p < .008$. In other words, when the couple presented the problem in terms of lack of connection and an absence of accessibility and responsiveness, on similar lines as the tasks of EFT, the couple gains were found to be maximum in therapy.

In another study by Quinn et al. (1997), the positive relationship between therapeutic alliance and therapy outcomes was established in a sample from a

University-based Marriage and Family Therapy Clinic. The data was obtained from 17 couples who were administered appropriate form of IPAS (Pinsof and Catherall, 1986) depending on the modality of treatment: CTAS for couple therapy and FTAS for those seeking family therapy following the third session. The measure for therapy outcome was administered at the following of the termination session. The "treatment outcome" was comprised of two questions. The first question asked the client to indicate the extent to which the goals of therapy had been met. The second question asked the client to rate the extent to which they believe the changes made in therapy would last for the next 3 to 6 months. The ratings were recorded on a 5-point Likert scale ranging from "not at all" to "completely."

The findings indicated that there was a positive correlation between therapeutic alliance and outcomes of therapy. The findings also suggested a stronger association between alliance and outcomes for wives ($r=.74$, $p<.01$) as compared to the husbands ($r=.56$, $p<.05$). When the wives alliance score was higher than the husbands, the outcomes in therapy were reported to be more positive than when the husband's alliance scores were higher than the wife's scores.

Mamodhoussen et al. (2005) studied the impact of marital and psychiatric distress on alliance. Seventy nine couples completed French version of DAS and Psychiatric Symptoms Index or PSI (Ilfeld, 1976) at session one and French version of CTAS-r at session three. The reliability coefficients of .89-.91 have been observed for the French version of DAS. All therapists were trained in cognitive behavioral couple therapy and ranged from doctoral-level interns to clinicians with more than 30 years of experience.

The results indicate that marital adjustment predicts quality of therapeutic alliance at session 3. DAS scores were correlated to the total alliance scores for men (r=.43) and women (r=.48). Using simultaneous multiple regression, DAS scores predicted the alliance scores for men as well as for women. This relationship between alliance and marital adjustment was found to hold even when the education, number of children and psychiatric symptoms were controlled. However the psychiatric symptoms were not found to be related to alliance formation for either men or for women.

The relationship between the therapeutic alliance and therapy outcomes has also been found to hold in the group modality of couple therapy research. Brown and O'Leary (2000) studied therapeutic alliance as a predictor of continuing treatment and success in group treatment for Spouse Abuse in seventy husband-to-wife violent couples. They used DAS as a measure of global marital adjustment; Modified CTS (MCTS; Pan, Neidig and O'Leary, 1994) and Psychological Maltreatment of Women Scale (PMWS; Tolman, 1989) as measures for aggression. MCTS measures the frequency of use of various conflict tactics. PMWS was used as a measure of psychological maltreatment for women. The therapeutic alliance was measured by Working Alliance Inventory — Observer (WAI-O). It measures the quality of alliance between the client and the therapist using observer to code alliance rather than self-report.

The strength of alliance was found to be positively associated with treatment outcome as measured by decreased mild and severe forms of psychological and physical aggression. They found that husband's alliance was more predictive of the outcome than

wife's alliance. The relationship between alliance and outcome was stronger for mild aggressors than their severely aggressive counterparts.

Bourgeoius, Sabourin and Wright (1990) studied the predictive validity of therapeutic alliance in group marital therapy. They studied a group intervention on a sample of 63 couples who were French speaking White residents of Canada. The Couples Survival Program (CPS) was a marital group program aimed at improving communication skills through the use of modeling, role-playing, feedback and home-assignments. The measures that were collected before the first session included: DAS, Potential Problem Checklist (PPCL; Patterson, 1976), Marital Happiness Scale (MHS; Azrin, Naster and Jones, 1973) and Problem Solving Inventory (PSI; Heppner and Peterson, 1982). After the third session, Couples Therapy Alliance Scale (CTAS; Pinsof and Catherall, 1986) was administered by independent research assistant to each spouse separately while the therapist completed the Therapist Alliance Scale (TAS). TAS assessed therapists' view of the alliance conceptualized in terms of Bordin's three dimensions. A week before treatment ended the couple was administered the same four pretherapy measures.

The research findings indicated that pretherapy level of marital adjustment was not related to the quality of therapeutic alliance as viewed by the therapist and the partners. None of the DAS subscales contribute independently to the quality of alliance as viewed by the partner or the therapist. However, a positive relationship was found between therapeutic alliance and therapy outcomes.

The strength of alliance was found to have a differential affect on male and female participants. Men's alliance was more predictive of therapy outcomes. Men's alliance scores account for 7%, 5% and 8% of DAS, MHS and PPCL residualized scores respectively, compared to women, therapeutic alliance as viewed by them accounts for 5% of variance in the residualized post-DAS scores. In case of therapist ratings, 10% and 3% of the variance of the residualized MHS and DAS scores was accounted for by men's alliance scores as compared to women's where there was no significant contribution of the four outcome measures. The conclusion indicated that if men were to benefit from group therapy, it is important for them to feel understood. The tasks and objectives need to be clearly stated and agreed on in the early sessions of intervention program.

Family therapy. There is one study that has investigated the predictive value of therapeutic alliance for outcomes in home-based family therapy by Johnson et al. (2002). The participants in the study (N=81) were members of low socioeconomic status families who had been referred to University clinic for family therapy. The families were seen in cotherapy teams comprised of a family therapist and a case manager. Doctoral students served as therapists and Masters' level MFT students served as case managers.

The families were asked to fill out the demographic information, Outcome Questionnaire (OQ-45.2; Lambert, 1996) and Family Crisis Oriented Personal Evaluation Scales (F-COPES; McCubbin, Oslon and Larsen, 1981) during the initial contact. At the end of the treatment, the families filled out Family Therapy Alliance Scale (FTAS; Pinsof and Catherall, 1986) in addition to OQ-45.2 and F-COPES. The sessions were conducted twice a week for the initial 6 to 8 weeks, after which it was reduced to once a week. The

average number of sessions attended by the families was 19.8 (SD=12.3 sessions) and remained in treatment for 14.3 weeks on an average.

The results indicate that the therapeutic alliance accounts for significant amount of variance in mothers (19%), fathers (55%) and adolescents (39%) change in distress scores. They also found that tasks subscale accounted for more variance in mothers and adolescents symptom distress change whereas the goals subscale accounted for more variance in change of distress scores in fathers.

The relationship between therapeutic alliance and treatment outcomes is well-established in literature. The positive association between therapeutic alliance and outcomes in therapy has been established in the different treatment modalities. Therapeutic alliance has been found to significantly predict the outcomes in treatment.

Most studies have, however, used the scores at termination as the measure of outcomes. The shortcoming in using the scores at termination is that the termination scores do not take into account the scores at intake. A more rigorous measure of the outcome would be a change score. Johnson et al. (2002) have used change in symptom distress as the measure of outcomes of therapy. Therefore there is a need to use change scores to study the outcomes in therapy.

Another commonality across studies is that all studies have used termination scores that covers a wide range of number of sessions to termination. The need to standardize the number of sessions across which change has been measured, thereby measuring the change across the same time period.

Supervision and client outcomes.

There have been some studies in the area of social work and individual psychotherapy that were found to be relevant to the current investigation.

The lack of studies in linking supervision with client outcomes has been exemplified by the study done by Harkness and Poertner (1989) in social work research. They reviewed 26 studies relevant in exploring some aspect of interaction of supervisors with workers to help clients. Interestingly none of the studies were found to address clients. Only five studies were found to address change of some sort, either in the supervisor, worker or the supervisor-worker relationship. The need to reconceptualize supervision into multiple operational definitions was suggested. This would help the organization of variables into protocols of supervisory practice that can be tested. They have emphasized the need for more behavioral observations such that the links of supervisory behavior to improved caseload outcomes. The use of client satisfaction as one of the ways the client outcomes can be measured was also suggested.

Harkness with another colleague Hensley (1991) reconceptualized supervision into multiple operational definitions and conducted a study investigating the effect of focus of supervision on client satisfaction. The supervision conditions included eight week period of mixed focus on administration, training and clinical consultation, followed by eight week period of client focused supervision. The study included two male and two female mental health staff members who were supervised under the two conditions. The client outcomes were measured by generalized contentment and client-satisfaction. They used visual trends to test their hypotheses.

The first hypothesis predicted reduced client depression during client focused supervision. The evidence was mixed, depression decreased in case of two workers and increased in case of the other two workers during client focused supervision. The second hypothesis predicted increased client satisfaction with worker helpfulness during client-focused supervision. The results supported the hypothesis as there was an increased satisfaction was observed with each worker's helpfulness during client-focused supervision.

The third hypothesis was increased client satisfaction with goal attainment during client-focused supervision. There was an increase in satisfaction with attaining goals, observed in clients during client-focused supervision. The fourth hypothesis predicted increased client satisfaction with worker-client partnership during client-focused supervision. There was a decreased satisfaction with workers during mixed-focused supervision in case of three workers; however, there is an increased satisfaction with all workers during client-focused supervision.

The findings suggest that client satisfaction increases during client-focused supervision. In other words, if the supervisor asks questions about client problems and staff interventions in the context of client outcomes, there is an increase in satisfaction experienced by clients. The clients who seem to be more satisfied would work better with the therapist. It would therefore be the foundation for a better working relationship with the therapist that would lead to better outcomes.

Client satisfaction is a form of client outcome that Harkness and Hensley (1991) have studied, in couple therapy relationship satisfaction would be an appropriate outcome

variable to study. To our knowledge, there are no studies in the area of couple therapy that has studied the effect of supervision and outcomes in therapy.

Supervision and therapeutic alliance

There is similarity in the experience of the therapist in supervision and the client in the therapeutic relationship. Patton and Kivlinghan (1997) found that the therapist's rating of supervisory relationship is positively associated with the client's ratings of therapeutic relationship. They used WAI, Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990) and Vanderbilt Therapeutic Strategies Scale (VTSS; Butler et al., 1992). SWAI consists of 19 items in two scales designed to measure aspects of the relationship in counselor supervision. VTSS consists of two scales, Psychodynamic Interviewing Style (12 items) and Time-Limited Dynamic Psychotherapy Specific Strategies (9 items).

Seventy-five volunteer undergraduate students who had a variety of concerns and indicated willingness to discuss them with a beginning counselor. The counseling trainees enrolled in a graduate-level pre-practicum course (n= 75), who were supervised by doctoral students in counseling psychology (n=25). Three judges were seniors enrolled in an honors psychology class. Potential clients attended a group orientation meeting were randomly assigned to counselor trainees. After each of the four counseling sessions, the clients filled out WAI. The counseling trainees had a supervision session after which they completed SWAI. Raters watched the middle 20 minutes of each counseling session and independently filled out the VTTS.

A significant relationship was found between trainees' rating of supervisory working relationship and the clients' rating of counseling working alliance. They also found a positive relationship between trainees' rating of the supervisory working alliance and observers' ratings of the trainees' interviewing skills. The correlation between the trainee's perception of the supervisory working alliance and the client's perception of the counseling working alliance was 0.66. Though not studied by Harkness and Hensley (1991), it is possible that the therapists find client centered supervision as more satisfying and helpful. Patton and Kivlinghan (1997) concluded that the trainees take the knowledge from supervision about building and maintaining relationships and apply it to the relationship with their clients.

This is however not the only way in which the working alliance is affected. The supervision in this study was all case consultation. However, when the supervisor can give immediate feedback in the form of live supervision as compared to feedback on videotaped sessions, the dynamics of the effect of supervision are different.

Kivlinghan with his colleagues (1991) studied the effect of different types of supervision on the ratings of therapeutic alliance by the client. They investigated the effect of live vs. videotaped supervision condition on working alliance and the therapist's intention use and client's evaluation of session effect. The clients met with therapists for four sessions and completed the Working Alliance Inventory (WAI) and Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) after each session. The therapist recorded their intentions using Intentions List (Hill & O'Grady, 1985) for each intervention they used after each session.

The results indicated that the therapists used more of support and relationship intentions when supervised live than did the therapists who received videotaped supervision. The findings suggest that the clients of therapists receiving live supervision rated their alliance as stronger. They however, did not perceive the sessions supervised live to be deeper as compared to the videotaped supervision session.

These studies have been done in controlled settings that are not representative of the more naturalistic setting of supervision. Not all cases are supervised and the time and the quality of supervision on a case is not predetermined. The effect of the quality and quantity of supervision on client outcomes has not been studied in literature. One would assume that more the time spent in supervision and more the intense the supervision, the more it affects the client outcomes. And since supervision would clarify the goals and tasks of supervision, it would interact with the therapeutic alliance to affect the outcomes in therapy. The need for understanding the dynamics of supervision cannot be overemphasized given the importance of supervision in the marriage and family therapy training programs.

III. METHODS

This study attempts to better understand of how the quality and quantity of clinical supervision interacts with the therapeutic alliance to impact client outcomes in couple therapy.

Participants

The data included in the study has been completed by clients who came in for couple therapy between and the AAMFT approved supervisors who have provided supervision to the cases.

Clients. A hundred and twenty-two couples attended therapy at the marriage and family therapy clinic from March 2002 to April 2005. The participants needed to complete at least four therapy sessions and the intake and fourth session paperwork to be included in the current study. Forty-eight couples were eliminated from participation because they did not complete four sessions (39.3%). Of the remaining 74 cases, 14 cases were eliminated because they did not receive any supervision in four sessions (18.9%). Twenty-one females and 25 males of 60 remaining cases did not complete the fourth session paperwork. This is a 65% retention rate for females, and a 58% retention rate for males.

Attrition of Participants

It is important to examine attrition because clients not completing the study could be different from those who do complete the study creating a threat to validity. Chi-square analysis was used to test for a difference between study completers and non-completers compared across the demographic variables of age, education, income and race. The categories had to be collapsed in the variables of income and education to meet the requirements if the Chi-square analyses. None of the analyses yielded significant results.

T-tests were used to test for a difference between participants remaining in the study and those who dropped out on the RDAS and number of supervision hours received within the first session. There was no significant difference between couples who remained in therapy longer than four sessions as compared to those who dropped out before completing four sessions. The t-scores have been reported in Table 1. Therefore there is no attrition bias in the study.

Table 1

Comparing means of drop-outs and four session completers

	Males		Females	
	t-score	*Sig. (2-tailed)*	*t-score*	*Sig. (2-tailed)*
Age	-.89	.38	-.78	.44
Income	-.89	.38	-1.13	.26
Intake Relationship Satisfaction	.40	.69	.49	.63
Session 1 Supervision Time	1.26	.21	1.26	.21
Intake Supervision Level	.69	.49	.69	.49

* $p < .05$; ** $p < .01$; *** $p < .001$

Almost 42% of males and 35% of females did not complete the fourth session paperwork even though they completed four sessions in therapy. Standard t-tests were also conducted to compare the means across the first session paperwork completers vs. non-completers separately for males and females. There was no difference found in males or females on the demographics of age and income; and the intake relationship satisfaction scores for the completers and non-completers. However, the supervision time at session 3 was significantly related to the completion of paperwork in the fourth session for both males ($t = 2.83$, $p < .01$) and females ($t = 2.64$, $p < .01$). The supervisors seem to successfully remind the therapists to get the fourth session paperwork completed in the following session. The t-scores have been reported in Table 2.

The cases that received supervision (81.08%) were compared to the cases that did not receive any supervision in the four sessions (See Table 3). The findings indicate that the cases differed significantly on the male relationship satisfaction score reported at session 1 ($t = 1.96$, $p < .05$) and the male therapeutic alliance score reported at session 4 ($t = 2.24$, $p < .05$). The cases that did not receive any supervision had male partners who reported higher relationship satisfaction at intake ($M = 42.57$, $SD = 9.63$) compared to cases that received supervision ($M = 37.07$, $SD = 9.41$). The cases that did not receive any supervision also had males who reported better therapeutic alliance at session 4 ($M = 242.40$, $SD = 29.78$) as compared to males in cases that received supervision($M = 213.86$, $SD = 36.84$).

Table 2

Comparing means of paperwork completers vs. non-completers for males and females

	Males		Females	
	t-scores	*Sig.(2-tailed)*	*t-scores*	*Sig.(2-tailed)*
Age	.76	.45	.37	.71
Income	1.28	.21	.55	.59
Intake Relationship Satisfaction	-1.44	.15	-1.87	.07
Intake Relationship Satisfaction (Partner's)	-1.30	.20	-1.12	.27
Session 1 Supervision Time	-1.43	.16	-.61	.54
Session 2 Supervision Time	1.05	.30	1.23	.22
Session 3 Supervision Time	2.83	.01**	2.64	.01**
Session 4 Supervision Time	1.08	.29	1.69	.10
Supervision level	-.69	.50	-.44	.66

* p < .05; ** p < .01; *** p < .001

Table 3

Comparing no-supervision and supervision cases

	Males		Females	
	t-scores	*Sig. (2-tailed)*	*t-scores*	*Sig. (2-tailed)*
Age	.71	.48	.09	.93
Income	1.48	.14	-.34	.73
Intake Relationship Satisfaction	1.96	.05*	.55	.58
Session 4 Relationship Satisfaction	1.51	.14	.34	.73
Therapeutic Alliance	2.24	.03*	1.51	.14

* p < .05; ** p < .01; *** p < .001

The age of the individuals included in the study ranged from 19 years to 52 years. Subjects for this study included 33 European American males (86.8%), 31 European American females (81.6%), 5 African American males (13.2%), 5 African American females (13.2%), and 2 Asian females (5.3%).

Reported annual household income for the clients ranged from less than $5,000 to above $40,000. Almost 20% of the subjects earned less than $10,000 per year. Over 30 percent of the subjects earned between $10,001 and $20,000, about 13% subjects earned $20,001 to $30,000 and over 31% of the subjects earned $30,001 to above $40,000 per year.

Education also widely varied from those who completed less than twelfth grade to those with post doctoral work. The clientele reported a wide range of education, with 2.8% of the adults not earning a high school diploma or the equivalent. Almost 37% had attained either a high school diploma or GED, almost 24% had attended some type of higher education classes, and over 34% had obtained either a four year degree or higher.

Table 4

Demographics of Individual Participants

	Males		Females	
Racial/ Ethnic Group	N	Percent	N	Percent
White/Non-Hispanic	33	86.8	31	81.6
African American	05	13.2	05	13.2
Asian			02	5.3
Education Level Completed	N	Percent	N	Percent
Junior High			01	2.8
High School / GED	14	37.8	14	38.9
Tech/ Assoc Degree	07	18.9	06	16.7
Bachelors Degree	09	24.3	07	19.4
Masters Degree	04	10.8	06	16.7
Other	03	8.1	02	5.6
Income	N	Percent	N	Percent
Under $10,000	06	17.2	09	25.0
$10, 001-$20,000	13	37.1	10	27.8
$20,001-$30,000	05	14.3	04	11.2
$30,001-$40,000	04	11.4	06	16.7
Over $40,000	07	20.0	07	19.4
Age	N	Percent	N	Percent
19-29	18	48.6	23	60.5
30-39	12	32.4	11	28.9
40-49	05	13.5	02	5.3
50+	02	5.4	02	5.3

Supervisors and therapists. The supervisors included in the study are the MFT faculty teaching in the Masters' degree program (N=3). They are licensed marriage and family therapists (LMFT) and AAMFT supervisors. They have an average of 16 years of experience as therapists, ranging from 8 to 22 years. Their experience with supervision ranges from 5 to 18 years, with an average being 12 years.

The therapists included in the study are students enrolled in the two-year Masters' program offered in marriage and family therapy, currently in the second year of the Masters' program (N =18). They have different backgrounds in terms of their Bachelors degrees including psychology and human development and family studies. The age of the therapists ranged from 24 to 29, the average age being 26 years.

Procedure

The study has utilized data from an on-campus training facility of a COAMFTE accredited Masters' program offering training in marriage and family therapy. The MFT Center is staffed by student therapists who are currently in the second year of their Masters' program. The data has been collected from the files of adult clients who received couples therapy from March 2002 through April 2005. Information obtained is in the form of self-report questionnaires completed by clients during the intake and the fourth session paperwork. The intake paperwork collected before the first session included Revised Dyadic Adjustment Scale (RDAS); the fourth session paperwork included Couple Therapy Alliance Scales (CTAS) and RDAS.

Therapy is frequently supervised by the MFT faculty in the form of case consultation, live or video supervision. The supervisors complete a Weekly Supervision Record for all cases supervised. Each time the supervisor interacts with a therapist about a particular case, the time and quality of the supervision is logged. Thus, multiple supervision logs can be assigned to one session. Any and all supervision is connected to the most recently completed therapy session. So if a therapist completed the third session and the supervisor watched and provided feedback, the supervision would be connected to the third session. These supervision logs have been tracked from session one through session four.

Measures

Couple Therapy Alliance Scale (See Appendix A). The Couple Therapy Alliance Scale (CTAS) created by Pinsof and Catherall (1986) is a self-report tool. It is comprised of three subscales that contain 29 statements that measure bonds (n = 10 items), tasks (n = 13 items), and goals (n = 6 items). Statements such as "I trust the therapist," and "The therapist does not understand me," can be found in the bonds subscale. The tasks subscale has items such as "The therapist lacks the skills and the ability to help my family," and "The therapist is helping my family". Items in the goals subscale state "The therapist understands my goals," and "The therapist and I are not in agreement about the goals for this therapy." Items are scored on a 7-point Likert type scale. The response ranges from (1) complete disagreement with the item to (7) complete agreement, while (4)

corresponds to a neutral position. Reverse scoring is used on half of the items on each subscale, and then a sum is taken of all the scores in order to obtain a total score.

The authors report test-retest reliability of r = .83. Heatherington and Friedlander (1990) analyzed the internal consistency of the instrument and report a total alpha level of .94 for the scale. The alpha levels for the bonds, tasks, and goals subscales are .81, .90, and .80 respectively. Content validity is the only form of validity that has been established for this scale as reported by Pinsof and Catherall (1986). Internal consistency for this sample was $\alpha = .93$.

Revised Dyadic Adjustment Scale (See Appendix B). The scale was developed by Busby, Crane, Christensen, & Larson (1995). This 14-item scale is a shortened version of the Dyadic Adjustment Scale (Spanier, 1976). RDAS has been reported to have retained the original scales' multidimensionality and the ability to distinguish between distressed and non-distressed individuals and relationships (Crane et al., 2000). The RDAS consists of three subscales: Dyadic Consensus subscale, the Dyadic Satisfaction subscale and the Dyadic Cohesion subscale. Scores range from 0 to 69 with higher scores representing better adjustment.

The internal consistency has been reported to be Cronbach's alpha coefficient of .90 (Busby et al., 1995). The Cronbach's alpha for the subscales has been reported to be .81, .85 and .80 respectively for Dyadic Consensus, Satisfaction and Cohesion subscales (Busby et al., 1995). The Spearman-Brown split-half reliability coefficient has been reported to be .95 (Busby et al., 1995). The reliability coefficients for Dyadic Consensus,

Satisfaction and Cohesion subscales have been reported to be .89, .88 and .80 respectively (Busby et al., 1995). Internal consistency for this sample was $\alpha = .89$.

Weekly Supervision Record (See Appendix C). Every time a case is discussed or watched the supervisor logs in the quality and quantity of supervision into the Weekly Supervision Record.

The supervisor recorded the quality of the supervision and the time spent in supervision on a particular case each time it is discussed. Quality of supervision is rated by three items designated as Limited, Moderate, and Extensive. Intuitively one would assume that quality would be related to time. However, it is only mildly correlated to time ($r=.29$). These categories are qualitative measures of the extent that the supervisor provided feedback on a particular therapy case. The quality of supervision has been averaged over the multiple supervision logs accounted towards each session.

Limited supervision is seen as supervision which focuses on the details of providing services and the therapeutic techniques used in the therapy. Supervisors often check in with therapists concerning decision making. Moderate supervision is characterized by a more in-depth focus on how the therapist is managing the case issues, client relationships, and the flow of therapy. Supervision moves from evaluating therapeutic techniques towards enhancing management skills in therapy concerning session flow, therapeutic ruptures, and case management within session and across sessions. Extensive Supervision focuses not only on the client relationship and functioning, but on how the therapist works with the clients. The supervisor ensures that

the therapy is more process oriented rather than content based. The therapist/client characteristics are evaluated in connection with session flow and case progress.

In an attempt to establish inter-rater reliability the three supervisors provided independent evaluations of the quality of supervision offered on 18 separate cases presented in supervision. These cases were selected as a convenience sample. Two of the supervisors watched the supervision from remote location as one supervisor discussed cases with a student. Each supervisor independently rated the quality of supervision offered while conducting case consultation and video observation. There was complete agreement on nine of the ten cases. The supervisors reviewed their decision processes of the one case with disagreement and came to consensus.

Supervision time has been recorded in increments of 15 minutes except the first category. Supervision has been coded as '1' for less than 5 minutes, '2' for 6-15 minutes, '3' for 16-30 minutes, '4' for 31-45 minutes and so on. The supervision provided on a particular case within a particular week have been accumulated over multiple supervision logs, accounting towards the last session completed.

Hypotheses.

Hypothesis 1: The therapeutic alliance measured at the fourth session will have a positive impact on the change in couple relationship satisfaction for males and females.

Hypothesis 2: The quality and quantity of supervision will moderate the effect that the therapeutic alliance has on change in couple satisfaction for males and females.

IV. RESULTS

This study investigated the effect of quality and quantity of supervision on the relationship between therapeutic alliance and outcomes in couple therapy. The therapeutic alliance was measured using the Couple Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986). The change in scores on Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Christensen & Larson, 1995) from session one to session four was used to measure the outcomes in couple therapy. The quality and quantity of supervision was tracked using Weekly Supervision form.

Research findings

The means and standard deviations of all variables have been reported in Table 5. Standard t-tests were conducted to compare equality of means across males and females on the demographic variables of age and income; and the scores on the measures of therapeutic alliance and relationship satisfaction (See Table 6). The males and females were only significantly different on age with average age of males ($M = 30.89$, $SD = 8.44$) being significantly higher than that of females ($M = 29.14$, $SD = 7.81$), $t = 2.54$, $p < .05$. Commonly, the male partners are older that the female partners. Though the difference may be statistically significant; it does not seem to be practically different. Quality and quantity of supervision were recorded on a per case basis. There are no differences on these measures for males and females.

Table 5:

Sample Descriptive Statistics

	Males		Females	
	Mean	*Std. Dev.*	*Mean*	*Std. Dev.*
Intake Relationship Satisfaction	35.37	9.04	33.89	8.10
Session 4 Relationship Satisfaction	38.71	8.66	38.74	10.72
Therapeutic Alliance	213.86	36.84	217.21	36.43

Table 6

Comparing means of males and females

	t-score	*Sig. (2-tailed)*
Age	2.54	.02*
Income	1.15	.26
Intake Relationship Satisfaction	1.04	.30
Session 4 Relationship Satisfaction	0.06	.95
Therapeutic Alliance	0.23	.82
Change in Relationship Satisfaction	-1.03	.31

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 7

Cases of split alliance

	$\pm$ 1 SD	$\pm$ 2 SD
N	7	3
%	20	8.6

The cases were reviewed to examine the alliances that are split (See Table 7). It was found that 3 cases (8%) have a difference of two or more standard deviations and can thereby said to experience a split alliance. However, using the less conservative approach of one or more standard deviations, 7 cases (20%) were found to experience split alliance.

The data was examined for the type of supervision received by the cases in the study (See Table 8). It was found that over 45% sessions were supervised live by the supervisor. Almost 32% of the first sessions were supervised live, over 47% of the second sessions, over 53% of the third sessions and over 47% of the fourth sessions were supervised live. About 12 cases have been supervised live once (31.6%), 8 cases supervised live twice (21%), 7 cases supervised live three times (18.4%) and 5 cases supervised live four times (13%).

The sessions that have received only case consultation are evenly spread across the first four sessions: 21% in the first session, over 26% the second sessions, over 26% for the third and about 32% for the fourth. There are very few sessions that have been supervised using videotaped sessions at least once: about 10% in the first two sessions, about 8% in the second session and about 16% in the fourth session.

The sessions that have received no supervision decreased from 42% in the first to 21% in the second session. It decreases further to 10.5% and in the fourth session drops to only 5.3% in the fourth session. There is a trend towards therapists seeking more supervision as the number of sessions completed in the case increases.

Table 8

Statistics for the type of supervision received

	Live		Video		Case Consultation		No Supervision	
	N	%	N	%	N	%	N	%
Session 1	12	31.6	2	5.3	8	21.0	16	42.0
Session 2	18	47.4	2	5.3	10	26.3	8	21.0
Session 3	21	55.3	3	7.9	10	26.3	4	10.5
Session 4	18	47.4	6	15.8	12	31.6	2	5.3

The data was examined for outliers. An outlier was defined as any case that is two or more standard deviations from the sample mean. Two outliers were recorded for females (change in relationship satisfaction = -2.07 and -2.66) that were more than two standard deviations from the mean. The single outlier for males (change in relationship satisfaction = 3.76) was almost four standard deviations away from the mean. The data was analyzed including and excluding the outliers to verify if these cases impacted the outcomes of the study. It became obvious that including the outliers altered the findings significantly. The three outliers therefore were excluded from the data analysis.

Each of the two hierarchical multiple regressions were conducted with centered (Aiken & West, 1991) variables to test the hypotheses. The predictor variables (i.e. male/ female therapeutic alliance, supervision quality, supervision quantity) were entered in the first step. In the second step, the two-way interactions of the predictor variables (e.g. male/female therapeutic alliance by supervision quality, male/female therapeutic alliance

by supervision quantity, and supervision quality by supervision quantity) were tested. The third step included the three-way interaction of the predictor variables of therapeutic alliance, quality and quantity of supervision. The regression analyses were conducted separately for males and females.

Hypothesis 1

The therapeutic alliance measured at session four significantly predicted the change in relationship satisfaction scores for males and females. It emerged as the single significant predictor for therapy outcomes in all the stages of regression analyses for males ($t = 2.15$ in step 1, $p < .05$; $t = 2.20$ in step 2, $p < .05$; $t = 2.72$ in step 3, $p < .01$) (see Table 9) and for females ($t = 4.27$, $p < .001$ for step 1; $t = 3.47$, $p < .01$ for step 2; $t = 4.27$, $p < .001$ for step 3) (see Table 10). The beta values for the significant predictor are very similar for males and females. When the clients rate the therapeutic alliance with the therapist high, the increase in relationship satisfaction is greater. This is equally true for both males and females.

Hypothesis 2

Male Change in Relationship Satisfaction

The change in relationship satisfaction in males was the dependent variable in the first regression analysis. None of the stages of the regression analysis significantly explained the variance in the change in relationship satisfaction for men. Although the interactions with supervision quality and quantity were non significant, there are certain trends in the data that need further attention with a larger sample size. The trend seems to

indicate that the three-way interactions, $F(1, 26) = 3.95$, $p = .06$, add more to the explained variance in change scores for males than the two-way interactions.

Female Change in Relationship Satisfaction

The change in relationship satisfaction in females was the dependent variable in the second regression analysis. The Step 1 of the analysis, Adjusted R Squared = .36, $F(3, 33) = 7.64$, $p < .001$ was significant. The trend indicates that the two-way interactions add to the explained variance in the change scores for females as the Adjusted R Squared increases to .42, $F(3, 30) = 2.32$, $p = .06$ in the step 2 of the analysis. The three-way interaction between the predictor variables does not seem to add to the change in relationship satisfaction.

Though non significant, the trend needs further analysis with a larger sample size to more effectively evaluate the two-way interaction model ($t = -1.78$, $p = .08$) and the three-way interaction model ($t = -1.98$, $p = .06$).

Table 9

Regression analysis for males

Variable	R^2 Adjusted	B	SE	β
Male Change Scores				
Step 1	.05			
Male Therapeutic Alliance		.01	.00	.45*
Supervision Time		.02	.03	.19
Supervision Level		-.09	.29	-.05
Step 2	-.01			
Male Therapeutic Alliance		.01	.00	.49*
Supervision Time		.03	.03	.25
Supervision Level		-.24	.39	-.15
Male Therapeutic Alliance X Supervision Time		.00	.00	.02
Male Therapeutic Alliance X Supervision Level		.00	.01	.04
Supervision Time X Supervision Level		-.05	.08	-.17
Step 3	.09†			
Male Therapeutic Alliance		.01	.01	.59*
Supervision Time		.03	.03	.21
Supervision Level		-.72	.44	-.44
Male Therapeutic Alliance X Supervision Time		.001	.001	.182
Male Therapeutic Alliance X Supervision Level		.00	.01	.09
Supervision Time X Supervision Level		-.01	.08	-.03
Male TA X Supervision Time X Supervision Level		.00	.00	-.54†

†p <.10, * p < .05; ** p < .01; *** p < .001

Table 10

Regression analysis for females

Variable	R^2 Adjusted	B	SE	β
Female Change Scores				
Step 1	.36**			
Female Therapeutic Alliance		.01	.00	.58**
Supervision Time		-.03	.02	-.17
Supervision Level		.34	.26	.18
Step 2	.42†			
Female Therapeutic Alliance		.01	.00	.48**
Supervision Time		-.01	.02	-.09
Supervision Level		.25	.28	.14
Female Therapeutic Alliance X Supervision Time		.00	.00	-.11
Female Therapeutic Alliance X Supervision Level		.01	.01	.15
Supervision Time X Supervision Level		-.08	.04	-.29†
Step 3	.42			
Female Therapeutic Alliance		.01	.00	.50**
Supervision Time		-.01	.02	-.06
Supervision Level		.17	.30	.09
Female Therapeutic Alliance X Supervision Time		.00	.00	-.03
Female Therapeutic Alliance X Supervision Level		.01	.01	.22
Supervision Time X Supervision Level		-.09	.04	-.34†
Female Therapeutic Alliance X Supervision Time X Supervision Level		.00	.00	-.21

†p <.10, * p < .05; ** p < .01; *** p < .001

V. DISCUSSION

Hypothesis 1.

The findings support the first hypothesis. The therapeutic alliance has been found to be predictive of the change scores in relationship satisfaction in couple therapy. Therapeutic alliance has been defined by Pinsof and Catherall (1986) as it applies to couple and family therapy as the collaborative bond that exists in therapy between the therapist system and the patient system. The better the perception of the client about the therapeutic alliance, the more are the gains from therapy. This was found to be equally true for both males and females in couple therapy.

It can be understood in terms of the components conceptualized by Bordin (1976). The more the client feels connected with the therapist (bonds component), the more the agreement the client feels about the goals of therapy (goals component), and the more the agreement about the relevance and objective of the tasks of the therapeutic endeavor (tasks component), the better the therapeutic alliance. The higher the agreement about goals and tasks of therapy, the better are the outcomes in therapy.

The findings once again prove the well-established relationship between therapeutic alliance and outcomes in therapy. This relationship has been established with a variety of presenting problems in individual therapy like alcohol abuse or dependence (Connors et al., 1997), avoidant or compulsive personality disorders, chronic depression,

generalized anxiety disorders (Barber et al., 2000); couples in couples therapy (Johnson & Talitman, 1997; Mamodhoussen et al., 2005; Quinn et al., 1997) and couples in group therapy (Bourgeoius et al., 1990; Brown & O'Leary, 2000) and family therapy (Johnson et al., 2002).

Though the relationship is established in literature, the outcomes in therapy have been measured using the scores at termination of therapy without taking into account the level of distress at intake. The present study has studied the relationship satisfaction at the fourth session taking into account the first session scores on the outcomes variable, thus adding to the already available knowledge of the relationship between therapeutic alliance and outcomes in therapy.

The cases in the study were reviewed to examine the alliances that are split. Eight percent of cases differed by two standard deviations. That percentage is lower than the percentage of 13.3% reported by Mamodhoussen at al. (2005). Using a less conservative difference of one or more standard deviations, the current sample has 20% that would be said to have a split alliance. This is also much lower than the percentage of 32% reported by Mamodhoussen at al. (2005). Overall, the couples in the current sample report more agreement than the sample in the study by Mamodhoussen et al. (2005).

Hypothesis 2.

Findings for males.

The suggested model did not explain significant variance in the change in relationship satisfaction scores for males. One should however be cautious in reading too much into the results because of the small sample size. With the current sample size, supervision quality and quantity do not seem to moderate the relationship between therapeutic alliance and change in relationship satisfaction for males.

However as suggested by the preliminary data analysis, the relationship between supervision and male treatment outcomes might be more complex. When the group that received supervision was compared to group that did not receive any supervision, the male partners in cases that received supervision reported significantly lower relationship satisfaction at intake and lower therapeutic alliance at session four as compared to cases that did not receive any supervision.

Though causal inference cannot be drawn from the difference in means of two groups, it intuitively makes sense if one looks at the set-up of supervision. The therapist brings up the cases in supervision that they want feedback and guidance from the supervisor. Therefore, the cases brought to supervision have some characteristics different from those who are not. It fits clinical experience of therapists and supervisors that the cases where the therapist and/or the supervisor sense a poor therapeutic alliance receive more time in supervision. The toughest cases are therefore receiving more supervision, the relationship between therapeutic alliance and quality and quantity of supervision would be negative. The trend towards which can be seen in the data.

This is further complicated if the male experiences a low relationship satisfaction at intake. There is some literature that has found a positive association between relationship satisfaction and therapeutic alliance (Knobloch-Fedders et al., 2004; Mamodhoussen et al., 2005). The therapists would experience these cases as more difficult to work with, thereby spending significantly more time on these cases in supervision. On the contrary, if the male partner has a good relationship satisfaction at intake, the process of establishing a good therapeutic alliance is facilitated and the therapist feels comfortable in handling the case with less feedback from the supervisor.

Another reason for supervision not being predictive of change in relationship satisfaction could be the bleed effect. The bleed effect refers to the carrying over of the supervision from one case to other similar cases without actually receiving any direct supervision on the other case. The cases that might not be receiving any direct supervision may still be benefited from supervision on similar cases. Therefore, bleed effect would make the effect of the interaction of supervision variables on therapy outcomes more difficult to study.

The interesting part is that it is the male partner's therapeutic alliance that plays a more important role in the decision of the therapist to seek supervision. There are different potential reasons for this finding. It can be understood in the light of differential socialization practices for males and females. Females are usually more expressive than males.

Another reason could be that more often it is the female partner who calls to set up initial appointment. The male partners usually come to therapy under threat and are

not sure how therapy would be beneficial. These conditions are not very conducive for male partners to establish a good therapeutic alliance with the therapist. Therefore establishing therapeutic relationship with the male partner in couple therapy would be more challenging for the therapist.

The interaction of supervision variables with therapeutic alliance seems to be more complex in case of male partners than hypothesized. It is supported by the trend in the data. The trend indicates that it is the three-way interaction between therapeutic alliance and supervision variables of quality and quantity that have a potential to explain the outcomes in couple therapy for males better than the two-way interactions.

Historically there has been a concern about therapists hiding their difficult cases from the supervisors. The evaluative nature of the relationship seems to be reason fueling the concern. However, the findings indicate that when male clients have lower relationship satisfaction scores at intake and lower therapeutic alliance scores at session four, the therapist requested more supervision.

Findings for females.

For females, the first model emerged as significant, explaining significant amount of variance in the change in relationship satisfaction scores. The trend indicates that the two-way interaction model adds to the explained variance in the change scores for females. The three-way interaction model does not seem to the change in relationship satisfaction for females.

It seems that since the therapeutic alliance scores for females are not different among cases that do and do not receive supervision, the two-way interaction scores are

more explanatory of change scores. The trends in the data seem to indicate that the interaction between quality and quantity of supervision explains more variance than the quality and quantity of supervision individually. The direction is towards more the quality and quantity of supervision, the greater the increase in relationship satisfaction in females.

When we compare the findings for males and females, it seems that the explained variance for females is much higher than that for males, 36% as compared to 5%. However, since the sample size is small, one needs to look at the more stable measure of beta in the regression analysis. When one looks at the betas for male and female partners, they are similar if not identical.

Though supervision quality and quantity have not emerged as moderating factors in the present study between couple therapy alliance and change in relationship satisfaction in couple therapy, the trends in the data are encouraging. There is a need to replicate the findings with larger sample size.

Limitations

The small sample size is the major limiting factor of the study. The sample includes 34 males and 37 females that include data complete from 33 couples. The small sample size limits the power of the tests creating challenges in finding the significant results that really exist.

The sample has been taken from a University-based clinic in the southeastern region of the country, predominantly ethnic group being Caucasian. It presents challenges

to the applicability of the findings to populations in the other regions and ethnic groups. The attitudes, perceptions and behaviors of the group could be different due to the differences in the cultural, societal and religious influences in the region that may not be applicable in the other parts of the United States.

The data is based entirely on self-report. Self-report data is limited by the respondent's willingness to share. The data may also have a social desirability bias. Socially desirability bias refers to the individual's responses being affected by what they feel is socially acceptable. However, the therapeutic alliance data states that client reports are the most related to outcomes.

Future Research

Despite the number of limitations, the study offers invaluable information about the relationship between supervision, therapy alliance and outcomes in couple therapy. Therapeutic alliance has emerged as the predictor variable of change in couple therapy for males and for females. Though supervision has not been found to be predictive of the change in relationship satisfaction scores, there are some interesting findings. The cases that receive most time in supervision have been found to have male partners with low relationship satisfaction and poor therapeutic alliance. However, the corresponding scores for female partners are not significant.

Future research should include more couples such that the tests will have high power and be able to detect the significant relationships that exist. The interaction effects though not significant for the current sample, had some encouraging trends. The

replication of the results with a larger sample size will be able to see if the trends continue in the same direction.

The couples data provides a glimpse into how the interaction of different dynamics affects the outcomes in couple therapy. About 8 percent of the data had a difference of 2 or more standard deviations from the mean, and over 20% of one or more standard deviation. The future research can also focus on studying the effect of split alliance on the dynamics of supervision and therapy outcomes.

The current study could not focus on the type of supervision and how it interacts with the quantity and the quality of supervision. The impact of different types of supervision and their interaction with the quality and quantity of supervision on client outcomes would also be a research question worthy of consideration in future research.

The further possibilities are endless since the research in supervision is sparse. The emphasis accorded to supervision in marriage and family therapy training programs necessitates further research to establish the relationship between supervision variables and outcomes variables in couple therapy.

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APPENDIX A

Couple Therapy Alliance Scale

Instructions: The following statements refer to your feelings and thoughts about your therapist and your therapy right NOW.
Please work quickly. We are interested in your FIRST impressions. Your ratings are CONFIDENTIAL. They will not be shown to your therapist or other family members and will only be used for research purposes. Although some of the statements appear to be similar or identical, each statement is unique. PLEASE BE SURE TO RATE EACH STATEMENT.

Each statement is followed by a seven-point scale. Please rate the extent to which you agree or disagree with each statement AT THIS TIME. If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in-between to describe variations between the extremes.

Completely Agree 7	Strongly Agree 6	Agree 5	Neutral 4	Disagree 3	Strongly Disagree 2	Completely Disagree 1

1. The therapist cares about me as a person	7	6	5	4	3	2	1
2. The therapist and I are not in agreement about the goals for this therapy.	7	6	5	4	3	2	1
3. The people who are important to me would be willing to help me in this therapy.	7	6	5	4	3	2	1
4. Some of the people who are important to me and I do not feel the same ways about what I want to get out of this therapy.	7	6	5	4	3	2	1
5. I am satisfied with the therapy.	7	6	5	4	3	2	1
6. The therapist lacks the skills and ability to help me with my important relationships.	7	6	5	4	3	2	1
7. I trust the therapist.	7	6	5	4	3	2	1
8. The therapist does not understand some of my important relationships.	7	6	5	4	3	2	1

9. The therapist understands my goals in therapy.	7	6	5	4	3	2	1
10. Some of the people who are important to me would not agree about the about the goals for this therapy.	7	6	5	4	3	2	1
11. The people who are important to me would approve of the way my therapy is being conducted.	7	6	5	4	3	2	1
12. I would feel safe talking with the people who are important to me about this therapy.	7	6	5	4	3	2	1
13. The people who are important to me would understand the goals for this therapy.	7	6	5	4	3	2	1
14. The therapist does not understand me.	7	6	5	4	3	2	1
15. The therapist is helping me with my important relationships.	7	6	5	4	3	2	1
16. The therapist does not understand some of the people who are important to me.	7	6	5	4	3	2	1
17. The therapist cares about my important relationships.	7	6	5	4	3	2	1
18. I do not feel accepted by the therapist.	7	6	5	4	3	2	1
19. The people who are important to me would understand what I am doing in this therapy.	7	6	5	4	3	2	1
20. The people who are important to me would care about and want me to be in this therapy.	7	6	5	4	3	2	1
21. The therapist and I are in agreement about the way the therapy is being conducted.	7	6	5	4	3	2	1
22. Some of the people who are important to me would distrust the therapist.	7	6	5	4	3	2	1
23. The therapist has the skills and ability to help me.	7	6	5	4	3	2	1
24. I do not care about the therapist as a person.	7	6	5	4	3	2	1
25. The people who are important to me and I would be in agreement about my goals for this therapy.	7	6	5	4	3	2	1
26. The therapist is not helping me.	7	6	5	4	3	2	1

27. The people who are important to me and I would be in agreement about my goals for this therapy.	7	6	5	4	3	2	1
28. Some of the people who are important to me and I would not be in agreement about what I need to do in this therapy.	7	6	5	4	3	2	1
29. The therapist understands the goals I have for my important relationships.	7	6	5	4	3	2	1
30. The therapist does not appreciate how important some of my relationships are to me.	7	6	5	4	3	2	1
31. Some of the people who are important to me would not be pleased with what I am doing in this therapy.	7	6	5	4	3	2	1
32. The people who are important to me would feel accepted by the therapist.	7	6	5	4	3	2	1
33. The therapist does not agree with the goals I have for my important relationships.	7	6	5	4	3	2	1
34. Some of the people who are important to me would not trust that this therapy is good for my relationships with them.	7	6	5	4	3	2	1
35. The therapist understands what the people who are important to me would want me to achieve in therapy.	7	6	5	4	3	2	1
36. Some of the people who are important to me would not be accepting of my involvement in this therapy.	7	6	5	4	3	2	1
37. I am comfortable disagreeing with or challenging my therapist.	7	6	5	4	3	2	1
38. I want to share more with my therapist but keep pulling back.	7	6	5	4	3	2	1
39. My therapist wants to know too much about me.	7	6	5	4	3	2	1
40. I feel that I am wasting my therapist's time.	7	6	5	4	3	2	1

APPENDIX B

Revised Dyadic Adjustment Scale

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always agree	Almost Always Agree	Occasionally Agree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters	_____	_____	_____	_____	_____	_____
2. Demonstrations of affection	_____	_____	_____	_____	_____	_____
3. Making major decisions	_____	_____	_____	_____	_____	_____
4. Sex relations	_____	_____	_____	_____	_____	_____
5. Conventionality (correct or proper behavior	_____	_____	_____	_____	_____	_____
6. Career decisions	_____	_____	_____	_____	_____	_____

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	_____	_____	_____	_____	_____	_____
8. How often do you are your partner quarrel?	_____	_____	_____	_____	_____	_____
9. Do you ever regret that you married (or live together)?	_____	_____	_____	_____	_____	_____
10. How often do you and your mate "get of each other's nerves"?	_____	_____	_____	_____	_____	_____

	Every Day	Almost Every Day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	_____	_____	_____	_____	_____

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	_____	_____	_____	_____	_____	_____
13. Work together on a project	_____	_____	_____	_____	_____	_____
14. Calmly discuss something	_____	_____	_____	_____	_____	_____

APPENDIX C

Therapist-in-training Name_____

Weekly Supervision Record

Supervision type: 1. Individual Planned 2. Group In-Class 3. Group Night Live 4. Individual Extra
S# Session Number
Warning Status 1. Suicidal 2. Family Violence 3. Self Mutilation 4. Abuse/Neglect 5. Major Psych Problem 6. Drug Abuse (Please provide explanation on reverse side)

Client Code	Date	SUP	S#	Lim	Mod	Exten	<5	5>15	16>30	31>45	46>60	61>75	Live	Video	Warning
1._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
3._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
4._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
5._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
6._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
7._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
8._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
9._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
10._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
11._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
12._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
13._____	_____	___	___	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____