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Exploration of Counselor Development Using Cotherapy in Postgraduate Training

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College of Counselor Education & Supervision

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Jennifer Calloway Ross

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Walden University
2017

Abstract

Exploration of Counselor Development Using Cotherapy in Postgraduate Training

by

Jennifer Calloway Ross

MA, University of Nevada, Reno, 2009

BA, California State University, Chico, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision – General Program

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December 2017

Abstract

Researchers have supported the use of cotherapy in both training and application for couple and family counseling as a clinical practice. However, there is not enough evidence to determine whether cotherapy can meet the learning needs of counselors-in-training more comprehensively than other forms of live supervision. The purpose of this transcendental phenomenological study was to explore the training experiences of postgraduate couple and family counselors who participated in cotherapy with a clinical supervisor. These experiences were examined using social and experiential learning theories. A modification of the Stevick-Colaizzi-Keen method served as the procedural guide for the analysis. Hand-coded interview data from 7 licensed marriage, couple, and family counselors (MCFC) and MCFC interns revealed that individual factors such as anxiety and expectations, relational factors such as trust and support, and procedural elements of the cotherapy practice contributed to a perception of efficacy in the cotherapy process. Trainees believed these factors positively influenced their self-efficacy and clinical competency. The results of this study can offer insight into how counselor educators might better prepare trainees for specialized work with couples and families by using cotherapy effectively as a systems-congruent approach to their supervision plans. Such information may contribute to improved quality of care to client systems and better protection of consumers.

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Dedication

To Gavin. Love bug, you rock! Never give up. Be fearless, even when something seems too big or too difficult to endure. I know you can do anything you set your mind to in this life, and I am so proud to try to live by example for you.

Acknowledgments

I owe endless gratitude to many, for the last handful of years and beyond. First, to my parents who never gave me a choice not to go to college, and who continually showed their confidence in my ability to keep climbing. Mom and Dad, thank you for believing in me. To Gavin, who was only four when I started this doctoral journey, and who gave up so much time with mommy in service of this dream. Buddy, I hope I make you as proud as you make me. Thank you, David, for being my cheerleader in these final innings; I am so happy to have you by my side. Fiji, here we come! To my friends and colleagues who offered support and encouragement, thank you so much for laughing with me when I needed to laugh, for drinking wine with me when I'd had enough of my computer, and for reading drafts of things you didn't want to read. Dr. Steve Nicholas, cheers. . . "here's to not sucking."

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Chapter 1: Introduction to the Study

Critical incidents in a counselor's development may include moments of self-awareness, pride about successes and acknowledgement of his or her potential, parallel processes and relational dynamics in supervision, the development of conceptualization skills, and increased theoretical orientation (Howard, Inman, & Altman, 2006). On a larger scale, knowledge of how to supervise counselors-in-training may help the profession to maintain integrity, continue its growth and relevance in the mental health disciplines, and improve the quality of care counselors provide to the public.

In this chapter, I provide an overview of my study and include a preliminary background of research on counselor supervision and cotherapy. I follow this background with the problem statement and purpose driving this study and the theoretical and methodological considerations involved in its design.

Background of Supervision in Counselor Education

The profession of counselor education has experienced much advancement over the years, and educators continue to seek the most effective ways to develop counselors who can carry forth the profession with skill and integrity. Council for the Accreditation of Counseling and Related Programs (CACREP; 2015) has helped define this process at the graduate education level, emphasizing ethical and competent practice, the implementation of best practices in clinical work, and counselor professional identity. The American Association of Marriage and Family Therapists (AAMFT; 2004) has adopted standards to direct competent MFT practice beyond the graduate level—throughout internships and careers after obtaining professional licensure—, as has the

American Counseling Association's (ACA) International Association of Marriage and Family Counselors (IAMFC) division in concert with the National Credentialing Academy (NCA). These associations are comprised of professional counselors with a variety of licenses and certifications who specialize in treating the clinical issues of couples and families. Thus, counselor development across the disciplines is significant.

Current approaches to counselor development at the postgraduate internship level extend these educational and professional values through the clinical supervision process, which typically includes both indirect and direct contact with supervisees' clinical work through individual, triadic, or group supervision meetings, and the review of various work samples such as documentation, recorded client sessions, or live observation methods (Bernard & Goodyear, 2009). Due to the complexity of family therapy, which requires therapists to conceptualize on multiple levels, work samples are important in the training process (Berkman & Berkman, 1984).

Document-Based Supervision

Self-report and case note supervision are widely used methods, likely because there is little need for additional equipment other than the intern's presence and, in the case of a chart or case note review, the client record (Bernard & Goodyear, 2009). Self-report supervision can offer a richer description of what occurred in a therapy session that may uncover subjective and countertransference material, although there is risk of biased or incomplete information (Bernard & Goodyear, 2009; Noelle, 2002). The use of case notes can augment the process of self-reporting by giving the supervisee and supervisor a

reference for some of the session content and conceptualization, with self-report or process notes to fill in the subjective pieces (Bernard & Goodyear, 2009).

Observation-Based Supervision

Supervision that involves the direct viewing of a trainee's work, whether live or electronically, answers concerns about inaccurate or skewed recall that are inherent risks in self-report methods (Haggerty & Hilsenroth, 2011). Audio and visual recordings, one-way mirrors, and live video feeds are other possibilities for observation-based supervision techniques.

Technology-assisted observation. Audio and video recorded sessions are typically used in technology-assisted supervision, which the intern and supervisor review for evaluation and processing. Viewing recorded sessions is the more precise tool, giving supervisors an opportunity to evaluate the supervisee's skill level and offer another perspective of what occurred verbally and nonverbally in the session, which can lead to meaningful reflection for the supervisee (Huhra, Yamokoski-Maynhart, & Prieto, 2008).

Live observation. Live observation takes the benefits of technology one step further by allowing a supervisor to have direct, real-time knowledge of what is happening in session and the ability to intervene to provide consultation, education, or direct assistance (Beddoe, Ackroyd, Chinnery, & Appleton, 2011; Bernard & Goodyear, 2009; West, Bubenzer, Pinsoneault, & Holeman, 1993). This intervention is typically done via communication through a bug-in-the-ear (BITE) device, a phone call to the therapist-in-training mid-session via a telephone in the counseling room, or use of a reflecting team.

Live supervision. As an alternative to more indirect observational methods, live supervision incorporates the basic spirit of direct observation while altering it so that the supervisor sits in the same room as the supervisee and client without any participation other than to intervene as needed. Beddoe et al. (2011) has found live supervision to be a valuable training tool that offers opportunities for formative feedback and evaluation, particularly when used in conjunction with clear communication of goals and expectations along with a debriefing process. These elements are part of a comprehensive model of live supervision that begins with preparation for the live session through conceptualization, goal setting, and session planning. Feedback and debriefing occurs immediately following the observation and involves the supervisor and supervisee reflecting on the session and developing a learning plan to enhance skills demonstrated by the supervisee (Beddoe et al., 2011).

Incorporating Cotherapy

Cotherapy, or the provision of psychotherapy services by two therapists in the same therapeutic encounter, has historically been an integral part of the marriage, couple, and family counseling (MCFC) literature. Past researchers have reported cotherapy increases flexibility in how clients are supported and confronted, allows a balance to meet the needs of the client or the dynamic (e.g., with gender or age), provides opportunities to reflect and identify process dynamics and transference issues, and models interactive patterns by the co-therapists for the client system (Bowers & Gauron, 1981; Lantz, 1978; Roller & Nelson, 1991; Whitaker & Garfield, 1987). Those with misgivings about cotherapy cautioned about potential abuses of power, triangulation between co-therapists

and the client system, and changes in the co-therapist relationship that may jeopardize the work being done with clients (Bowers & Gauron, 1981). Without much empirical support for the clinical efficacy of cotherapy (i.e., client outcomes), much of the focus has turned to the utility of the practice for therapeutic process and counselor development (Silverthorn et al., 2009; Tanner, Grey, & Haaga, 2012).

Given the complexity that can occur when therapy includes multiple systems, live supervision approaches may neglect to attend to the multiple levels of relationship that occur between the supervisor and supervisee, between the supervisee and client system, and, more indirectly, between the supervisor and the client system. Thus, a cotherapy relationship could allow supervisors to engage with trainees at a deeper level through the incorporation of experiential and observational learning, direct professional accountability (Siddall & Bosma, 1976), and increased opportunities for exploring transference, content, and process in the supervisor-supervisee-client triad (Braver, Graffan, & Holahan, 1990). Cotherapy allows for the supervisor to adopt a participant-observer stance to offer the most appropriate support for the needs of the supervisee based on the direct experience of the trainee's work (Van Atta, 1969).

There is a fair amount of information about the value of cotherapy as a clinical tool for systemic therapy (Hoffman & Rosman, 2004; Lantz, 1978; Livingston, 2001; Napier, 1999; Napier & Whitaker, 1978), as well as some dated arguments in its favor as a supervision method. However, few publications over the last several of decades have explored the use of cotherapy as a viable means for training counselors who wish to develop their skills in working with couples and families. This study would reintroduce

cotherapy into the supervision literature by providing information from postgraduate interns' perspectives about how they believe cotherapy has impacted their professional developmental process.

Statement of the Problem

Supervision has been a part of the counseling literature since the inception of the profession, although few studies have provided clear evidence of the impact supervision has on trainees and their therapeutic efficacy (Schofield & Grant, 2013). The need for competent and knowledgeable supervisors has been a part of the written standards for developing formalized training programs and guiding institutions such as professional associations and accrediting bodies. For example, the AAMFT (2014a) has developed its own set of guidelines for the qualification and specialization of those who supervise MCFC interns, which augments the best practices in supervision offered by the Association for Counselor Educators and Supervisors (ACES; 2011) with guidelines specific to the incorporation of systemic thought in counselors' work with couples and families. The history of research in the MCFC supervision field honors the complicated nature of the client system and therapeutic work. Live methods have been among the preferred practices for the last several generations of trainees and supervisors because of the direct involvement afforded to the supervisor (Bernard & Goodyear, 2009; Ellis, 2010; Smith, 1993; West, Bubenzer, Pinsoneault, & Holemanm 1993).

Scholars have focused on cotherapy as a clinical practice, but few over the last several decades have examined how this systems-congruent tool might serve in the supervision of future generations of counselors-in-training who work with couples and

families. Despite what exists in the literature to date, the professional community still has little understanding of the mechanisms at work behind the cotherapy process and whether the practice has an identifiable impact on the competence and self-efficacy of trainees. This gap in the literature leaves many questions unanswered regarding supervisory best practices for helping trainees develop skills in the specialized practice of marriage, couple, and family counseling. Without adequate information in this area, counselor educators are ill prepared to help trainees fully develop their skills and competency in systemic therapies. Cotherapy in supervision combines the benefits of direct supervisory observation described by Bernard and Goddyear (2009), Ellis (2010), Lee and Nelson (2013), and many of their colleagues with the theoretical foundations of experiential and social learning that suggest some of the learning mechanisms that might occur through a collaborative session between a supervisor and supervisee; I describe this latter point in more detail in Chapter 2.

Purpose of the Study

While live observation methods have been described as beneficial to counselors-in-training (Beddoe et al., 2011; Bernard & Goodyear, 2009; West et al., 1993), few contemporary researchers have addressed cotherapy as a specific tool for promoting counselor development. However, cotherapy has been in counselor training literature as early as the 1960s (e.g., Van Atta, 1969) and has been deemed a valuable supervision approach to the training process for mental health professionals who specialize in MCFC (Romans, Boswell, Carlozzi, & Ferguson, 1995). Through this transcendental phenomenological study, I sought to explore the experiences of MCFC supervisees who

engaged in cotherapy with their clinical supervisors, with a secondary focus on the interns' perceptions of how cotherapy may have influenced their self-efficacy and clinical competence. Self-efficacy develops because of a person's belief that she or he can perform a given task with a high likelihood of success (Bandura, 1982; 1989), while professional competency is measured by a person's ability to perform the tasks associated with his or her trade in a manner consistent with best practice standards (Falender & Shafranske, 2004). For the MCFC profession, competency is collectively described by AAMFT (2004), CACREP (2009), and the NCA (n.d.). I describe these areas in Chapter 2.

Research Questions

My aim for this study was to examine the experiences of postgraduate counseling interns who participated in cotherapy with their clinical supervisors, and who intended to develop their skills in working with couples and families. The primary research question was: What is the lived experience of being a marriage, couple, and family therapy intern who participates in a cotherapy relationship with his or her clinical supervisor? An additional question was: How do these interns perceive the cotherapy relationship to impact their self-efficacy and clinical competence regarding their therapeutic work with couples and families?

Theoretical Framework

The primary foundation of this study relates to the question of how MCFC trainees learn to excel and how they become confident in new skills. Thus, social and experiential learning theories are relevant. Social learning theory served as the primary

theoretical rationale for my study. According to Bandura (1971), new behaviors are learned through a combination of direct experiences and observation of others. The observation of modeled behavior, such as that which might occur in a cotherapy session with a supervisor (Whitaker & Garfield, 1987), helps to shape the skills or new behavior of the learner and remediate harmful consequences during the developmental process. As new experiences are observed, attempted, and mastered, self-efficacy is increased. Principles of experiential learning also have applicability to my study. Experiential learning is said to involve a process of direct practice, reflective abilities, and conceptualization (Kolb, 1984), all of which have been identified as important components of counselor development (Bernard & Goodyear, 2009; Lee & Nelson, 2014). The phenomenological data of this study may contribute to insights about how these learning mechanisms develop self-efficacy and competency through cotherapy as a component to supervision of MCFC trainees. A more detailed review of these learning theories and related research will be provided in Chapter 2.

Nature of the Study

I used a phenomenological design for this qualitative study. As a research approach, phenomenology is geared toward the collection of participant data to obtain an in-depth understanding of the essence of an experience or phenomenon from the perspective of those who have lived it first-hand (Hays & Wood, 2011; Patton, 2002). As a philosophical construct, phenomenology is the study of subjective, conscious experience and the meaning ascribed to that experience (Giorgi, 2009; Smith, 2008), which is an ideal fit for the topic under investigation. The transcendental phenomenology

of Husserl (1931; 1970) served as the driving force behind this study. I selected this approach because it allows for a balance between a researcher's own experience of a phenomenon with the experiences of others to describe the phenomena under study without undue influence from the researcher's own experience (Moustakas, 1994). This type of phenomenological approach was appropriate for the aim of further understanding the experience of cotherapy with a clinical supervisor and how it contributes to self-efficacy and competency.

Research Design

I used a purposive approach known as criterion-based sampling used to identify participants who have had the necessary clinical training experiences that allow them to provide applicable phenomenological information (Maxwell, 2013; Patton, 2002). I recruited participants through a network of qualified clinical supervisors and licensed counseling interns in a suburban community in a Mountain-West state who were currently using or have recently used cotherapy as part of their supervision process. Each of the participants had obtained a graduate degree in counseling, held a license issued by the state to practice counseling independently or as a postgraduate intern, and had worked with a supervisor who was qualified to oversee their work with couples and families.

Data collection. I invited licensed professionals and postgraduate interns to provide information in a semi-structured interview format, using field notes as a secondary data source to record context and affect. I describe the semi-structured interview in detail in Chapter 3; I designed the questions to address the research questions, with flexibility to allow for elaboration and clarification as needed. I also used

an audio-visual recording device and medical transcription of interviews to increase accuracy in the data analysis process (Maxwell, 2013; Patton, 2002).

Data analysis. Once the interviews and transcriptions were completed, I began looking for themes in the data that related to the research questions using a traditional first- and second-pass hand coding processes. I looked for data in the video footage, transcripts, and field notes that represented the overall lived experience of being an intern in a cotherapy relationship with his or her supervisor, as well as information that spoke to the constructs of self-efficacy and clinical competence. As described by Moustakas (1994), I used a variation of the Stevick-Colaizzi-Keen method as the procedural guide for my data analysis. I provide a detailed description of this process in Chapter 3.

Definition of Terms

Clinical competency: When a professional has the knowledge and skills necessary to practice his or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards (Falender & Shafranske, 2004). For MCFC, competency is collectively defined by professional and credentialing organizations such as AAMFT (2004), CACREP (2009), and NCA (n.d.).

Clinical supervisor: Used interchangeably in this study with *supervisor*. A clinical supervisor is an experienced professional who provides postgraduate training and oversight to counseling interns regarding all aspects of their work with clients, and who serves a professional gatekeeping function (Bernard & Goodyear, 2009; Lee & Nelson, 2014). In my study, the clinical supervisors have received AAMFT designation as an approved supervisor; this is a designation required by state law for counseling interns who wish to develop their

skills in working with couples and families. To receive this designation, supervisors must complete a specialized training process that includes one 30-hour fundamentals of supervision course, 180 hours of supervised supervision of counseling interns, and 36 hours of supervision of supervision with an AAMFT-approved mentor supervisor over an 18-month period (AAMFT, 2014a).

Cotherapy: Psychotherapy provided by two qualified clinicians with the same client or client system during the same therapy session (Christie & Morgan, 2006; Lantz, 1978; McGee & Schuman, 1970; Roller & Nelson, 1971).

Experiential learning: Theory that posits that learning is a dynamic and ongoing process based on the learner's ability to modify what is known and done as new experiences are accumulated that shape a person's understanding of the world. Each new experience builds upon and reconstructs a learner's existing foundation of knowledge and behavior, with this building and reconstructing occurring in an interaction between learners and their environment. The building blocks of learning are theoretically constructed from internal (i.e., affective or cognitive) and external (i.e., hours of practice) experiences, along with reflective processes that engage the two in some meaningful way (Kolb, Kolb, Passarelli, & Sharma, 2014; Kolb, 1984).

Marriage, couple, and family counseling (MCFC): The practice of working with client systems (i.e., couples and families), which may be provided by any licensed mental health professional. Marriage and family therapists, clinical professional counselors, clinical social workers, and psychologists may be among the licensed professionals who specialize in working from a systems perspective (IAMFC, 2014).

Marriage, couple, and family counseling intern: A professional who has completed a postgraduate degree in a mental health field (e.g., counseling, psychology, or social work) and, for professionals in the Mountain-West state in which this study took place, an individual who has received documentation from the State Board of Examiners in the form of an internship license that allows him or her to engage in the supervised practice of counseling with couples and families. States vary on how this process is conducted, and this term is used in specific reference to the state regulations in place for the study participants in their state of licensure.

Phenomenology: The philosophical construct of phenomenology posits that no truth can be known because the perceptions of human beings are filtered through each person's unique psyche. Phenomena occur in the world and are interpreted by the experiencer, a conscious being with reflective abilities that allows him or her to make sense of the surrounding world (Giorgi, 2009). From a methodological standpoint, the philosophical constructs of perception and knowing are built upon to offer a means of empirical exploration that takes the experiential data provided by those who have intimate knowledge of a phenomenon to create a composite description of the essence of that phenomenon and what meaning may be ascribed to it (Giorgi, 2009; Laverty, 2003; Moustakas, 1994).

Self-efficacy: A state in which a person believes in his or her ability to perform a given task with some degree of confidence that success, however that may be defined, is possible (Bandura, 1982; 1989).

Social learning: Theory used to explain that most learning occurs through direct experiences and observation of others in combination with reinforcement and consequences that shape future behaviors. When the reinforcement is positive and the learner has a sense of

success, there is increased motivation to continue some version of the new behavior and more effort is likely to be exerted (Bandura, 1982; 1989).

Assumptions, Delimitations, and Limitations

I took a few assumptions into consideration for this study. I assumed that participants would provide honest information about their training and experience, self-reflections, and observations. Given the license requirements for counseling interns in the state in which this study took place, I also assumed that each participant had a working knowledge of counseling practice and the supervision process, and that each had developed an ability to report on his or her subjective experiences of counseling and supervision.

It is also important to consider the epistemological assumptions in my research approach. At the foundation of phenomenological ideology is the belief that a given phenomenon, as perceived by human consciousness, has scientific value. Descriptive phenomenology includes the additional assumptions that there are essences in phenomena (i.e., common features among varying experiences of a given phenomenon) that can be identified and described, and that description alone (as opposed to interpretation) is sufficient to understanding the phenomena (Natanson, 1973).

Scope and Delimitations

I employed several delimitations to manage the scope of this study. I only included postgraduate licensed counselors and counseling interns who worked with couples and families, and I excluded practicum students, student interns, and other postgraduate mental health professionals such as clinical social workers and

psychologists. I did this to narrow the focus to a particular stage of counselor development within a specific professional identity, particularly given the historically significant use of cotherapy within the MCFC disciplines compared to other mental health professions and individual therapy (Romans et al., 1995). With this delimitation in place, the results relate more directly to the group of professionals who have been deemed most likely to utilize the practice of cotherapy. However, the results of this exploratory study warrant an examination of the use of cotherapy in the training of a broader community of mental health professionals and across additional treatment configurations.

I also excluded MCFC practitioners outside the Mountain-West state in which this study took place. The primary purpose for this delimitation was to capture the essence of cotherapy as experienced by members of a specific therapeutic community operating under a common professional identification. By providing an encapsulating description of a group of professionals from collecting phenomenological data, I have given other groups of professionals results they can apply to their own professional communities. From that point, larger and more diverse groups of practitioners may be included in future studies about cotherapy.

Limitations

The primary limitation in this study is my own positive experience with cotherapy during my clinical internship. I took measures to ignore my past experience to discover the essence of others' experiences of cotherapy. The use of a transcendental

phenomenological approach allowed me to bracket my own experiences to relay a less biased account of the phenomenon (Moustakas, 1994).

Another limitation is the restricted population from which to draw my sample. At the time of this study, there were 300 licensed MFT interns (State Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors [BOE], personal communication, May 28, 2014) working under the supervision of 89 approved supervisors statewide (AAMFT, 2014b); in the Northern counties those numbers were drastically reduced to 27 approved supervisors (AAMFT, 2014b) overseeing an unknown proportion of the statewide number of licensed MFT interns (BOE, personal communication, May 28, 2014). The limited the number of interns who had participated in cotherapy with their supervisors led to an expansion of the participant pool to include licensed professionals who could provide retrospective information about their internship experiences. The small number of supervisors who had employed cotherapy in their supervision practice was also quite limited in that the narratives contained in this study are representative of only two supervisors' work.

Additionally, the Clinical Professional Counselor (CPC) license in the state in which this study took place had recently undergone changes that permitted those holding the license to work with couples and families only if sufficient training and education is in place. The definition of sufficient training and education has not yet been precisely defined by the BOE, meaning there are fewer CPCs in the state who have been approved to do work with couples and families. Because of these changes and the continually evolving definition and culture of counseling practice in this Mountain-West state, CPC

interns who worked with couples and families were not as well represented as MFT interns in this study. The sample is representative of a small therapeutic community with potentially little heterogeneity among the participants; which may limit transferability to other professional communities. However, given the research design and the goal of the study, I did not intend for generalizability. The process of studying this small population in a transitioning professional community may provide an opportunity for the two merging professions to continue their dialogue about how competency is achieved.

Significance

Live supervision methods have historically been discussed as a valuable practice in the development of competent professionals in the helping industries (Beddoe et al., 2011), especially for those working with couples and families (Bubenzer, West, & Gold, 1991; DeRoma, Hickey, & Stanek, 2007; Smith, 1993; Wark, 1995). The value of cotherapy has been emphasized despite concerns that the practice may at times be disruptive to the therapeutic process (Berger & Dammann, 1982), anxiety-provoking for the supervisee under observation (Mauzey, Harris, & Trusty, 2000), and potentially time-consuming for the supervisor (Beddoe et al., 2011; Bubenzer et al., 1991). The use of cotherapy as a systemic, interactive form of live supervision has the potential to combine the benefits of each of the approaches, while counteracting some of the reported inefficiencies of live supervision alone.

From a social change perspective, understanding the experiences of postgraduate MCFC interns who participate in cotherapy as part of their supervision plans, especially as it relates to their confidence and skills as clinicians, may add to supervisors' repertoire

of clinical training tools and help sustain the future growth of the counseling profession. Good supervisors develop good clinicians, and good clinicians are better equipped to carry forth the basic values of the profession.

Summary

In this chapter I introduced the reader to the multitude of supervision modalities that are currently available to supervisors who work with counseling trainees developing skills in MCFC. Supervisors can observe and assess trainees' skills through self-report and case review consultations, audio and visual recordings, and live supervision methods such as reflecting teams. Cotherapy as a clinical practice has been said to help therapists work with client systems more effectively for a variety of reasons (Bowers & Gauron, 1981; Lantz, 1978; Roller & Nelson, 1991; Whitaker & Garfield, 1987), but has seldom entered the supervision dialogue throughout the history of the MCFC profession. Through a phenomenological exploration of the experiences of MCFC interns, the results of this study contribute information to inform supervisors' repertoires of interventions. By using a foundational understanding of learning through the lenses of experiential and social learning theories, I examined the development of self-efficacy and clinical competency as perceived by MCFC interns who engaged in cotherapy with their supervisors. In Chapter 2, I provide a review and analysis of the current body of literature spanning supervision approaches and cotherapy as a clinical practice, as well as considerations for combining the two for the benefit of MCFC development.

Chapter 2: Literature Review

Despite the current information on supervision models and approaches, few studies have provided clear evidence of the overall bearing supervision has on trainees' efficacy (Schofield & Grant, 2013). My purpose for this study was to explore the experiences of counseling supervisees who engaged in cotherapy with their clinical supervisors in their work with couples and families, specifically regarding their respective perceptions about the development of the counselor-in-training's self-efficacy and clinical competence as collectively defined by the AAMFT (2004), the CACREP (2009), and the NCA (n.d.). My aim was to illustrate the role of supervisor-supervisee cotherapy dyads in the counseling training process amidst other established modalities.

Within this literature review, I cover (a) clinical supervision, with an overview of the current climate of supervision in general and in MCFC specialization as well as its definition, purpose, goals, and common practices and their efficacy; (b) the practice of cotherapy, with a description of using cotherapy in clinical practice independent of a supervisory component to include rationale for its use and the associated benefits and challenges; and (c) the introduction of cotherapy into the training milieu, reviewing the current literature on the combination of a cotherapy modality within the supervisory process and the foundational applicability of experiential and social learning theories. This final section holds the groundwork for my examination of how counseling interns and their supervisors perceive cotherapy within the context of the competency and self-efficacy of interns.

I conducted a literature search using Walden's database and the EBSCO search engine. Search terms for the following sections included these primary keywords and combinations of key words: *clinical supervision*, *supervision* AND *competency*, *supervision* AND *self-efficacy*, *supervision methods* OR *approaches*, *supervision* AND *marriage and family therap**, *cotherapy*, *cotherapy* AND *supervision*, *cotherapy* AND *marriage and family therapy*, *social learning theory*, *social learning theory* AND *therap** OR *counsel**, *social learning theory* AND *supervision*, *experiential learning theory*, and *experiential learning* AND *therap** OR *counsel**. Many of the resources used were part of my own library of articles and textbooks. Several of the articles from the EBSCO search were unavailable in full text, so I obtained them through Google Scholar and another university's onsite library. The literature search revealed few recent works addressing cotherapy, particularly as it related to the clinical supervision process. Therefore, I included older studies as part of the foundational description and justification for my study, with more recent related works included to demonstrate the direction of literature about cotherapy to date.

Theoretical Foundations

Researchers have described the benefits of cotherapy as development of skills, expansion of therapeutic techniques, increased awareness of interpersonal dynamics and key therapeutic processes such as transference and isomorphism, and development of a stronger professional identity (McGee & Burton, 1998; Siddal & Bosma, 1976; Tuckman & Finkelstein, 1999; Van Atta, 1969; Yerushalmi & Kron, 2001). Experiential and social

learning theories provide an explanation these outcomes and served as the theoretical bases for the study.

Cotherapy and Experiential Learning

Experiential learning theory is a relevant learning theory in healthcare due to emphasizing the application of theoretical knowledge to applied knowledge (Yardely, Teunissen, & Dornan, 2012). According to Kolb (1984), learning is a dynamic and ongoing process based on a learner's ability to modify knowledge and actions after experiences that shape his or her understanding of the world. Each new experience builds upon and reconstructs a learner's existing foundation of knowledge and behavior through the interaction between learners and their environment. In a cotherapy dynamic, this interaction would include the trainee, the supervisor, and the client family.

Experience, both internal (e.g., affective or cognitive) and tangible (e.g., accumulated hours) represents important pieces of experiential learning, but there must also be a reflective process that allows the learner to interact with new knowledge (Fowler, 2008; Kolb, 1984). Experiential learning occurs when a trainee is both the participant and observer and can engage in a series of four skills: (a) open and unbiased exposure to concrete experience, (b) reflective observation from multiple perspectives, (c) abstract conceptualization in which the new experiences are integrated into the existing knowledge foundation, and (d) active experimentation in which the new knowledge base is used to generate involvement in the next experience (Kolb, 1984). The degree of learning relies heavily on the meaning and quality of the experience and reflective process. A positive correlation exists between the level of involvement the

learner has in the process, the relevance of the experience to the learner, and the degree of learning that takes place (Fowler, 2008).

These principles were recently exemplified in a qualitative study by Moody, Kostohryz, and Vereen (2014) on live supervision's impact as an experiential learning tool on the development of counseling trainees in both mental health counseling (MHC) and MCFC specializations. Trainees believed that live supervision engaged with the material from their textbooks, which they were able to connect to from the emotional component of therapy and being part of a supervision group. The students reported that it was valuable to experiment with being in both the therapist and supervision role (i.e., on both sides of the one-way mirror), and they increased tolerance for giving and receiving feedback on clinical skills. The reflection process was cited by most of the students as the "cement" to the learning process because they were able to learn a skill or theory didactically, experience the learning material first hand, and then engage in reflection that required them to integrate their self-assessment with feedback given by others in the group. The more immediate the feedback (i.e., directly following a session as opposed to hours or days later), the more value students perceived themselves to derive from it (Moody, Kostohryz, & Vereen, 2014).

Experiential learning is a key element in supervision. According to Milne (2008), an experiential approach to supervision can result in the development of counseling trainees who are more aware in their clinical work, who learn to use the reflective process in conceptualization and treatment planning, and who eventually become licensed clinicians who engage in ongoing self-supervision.

Experiential learning has also been shown to develop the reflexive abilities of counseling interns. McCandless and Etough (2012) interviewed a group of supervisors at a counseling clinic about their journey to the MCFC profession in both a clinical and supervisory capacity, as well as their perceptions about their supervisory styles and skills and how those related to the development of reflexive abilities in the trainees they oversaw. They cited creating a sense of safety and confidence in the supervisory relationship as a critical step toward increasing trainees' tolerance for feedback and for priming them to engage in experiential pieces (e.g., performing counseling techniques in front of others or being on the receiving end of a particular technique to experience the client perspective) and perceive their own blind spots (McCandless & Etough, 2012). The results of this small (n = 3) qualitative study offer a glimpse into the incorporation of experiential learning through a supervisory lens but do not contribute to knowledge of the supervisee perspective on aspects of experiential learning. With cotherapy as an experiential learning opportunity in a supervision relationship, this study may contribute to the remaining gaps in this area.

Cotherapy and Social Learning

Social learning theory may serve as another way to understand the underlying processes at work when cotherapy is part of the supervision process. According to Bandura (1971), most learning occurs through direct experiences and observation of others in combination with reinforcement and consequences that shape future behaviors. This reinforcement may come internally in the form of an affective response (e.g., pride or shame), or externally from social cues, situational outcomes, or vicarious experiencing

of the reinforcement or consequences that others face. Contrary to traditional behavioral theories, reinforcement is not a mandatory component of the learning outcomes but rather a facilitative factor (Bandura, 1971). When the reinforcement is positive and the learner has a sense of success, he or she is motivated to continue some version of the new behavior and will likely exert more effort (Bandura, 1982; 1989).

Those using a social learning approach to counselor supervision view the relationship as learning based and provide learning opportunities to address learning gaps for each individual supervisee (Hosford & Barmann, 1983). From this perspective, cotherapy may be an appropriate addition to a supervisor's repertoire of activities to help supervisees in their professional development. In a cotherapy relationship, the supervisor is basis for modeling and additional feedback from the client shapes new clinical skills and behaviors. In a cotherapy session, trainees have opportunities to observe how their supervisors handle a variety of clinical challenges, including those that do not have favorable outcomes; these observations can help supervisees learn to tolerate mistakes and take reasonable risks as they try out new approaches and interventions (Tuckman & Finkelstein, 1999). Additionally, client feedback has been suggested as an often-neglected way to facilitate counselor development by providing trainees with information about how clients perceive the therapeutic relationship, their clinical outcomes, and how accurately the trainee has conceptualized the system. With both supervisor and client feedback, trainees can assess their performance and make alterations as necessary (Sparks, Kisler, Adams, & Blumen, 2011).

Literature Review

The following review of the literature will provide a background of supervision methods such as their delivery and efficacy and associated strengths and challenges. I also review the literature regarding cotherapy in practice and as a supervision modality.

Clinical Supervision

Clinical supervision in the mental health professions has been defined as an active process by which an experienced member of a profession oversees and helps to develop the skills of a novice member of that same profession (Bernard & Goodyear, 2009). Researchers working on a more precise definition have defined it as "the formal provision by senior/qualified health practitioners of an intensive relationship-based education and training that is case-focused and which supports, directs and guides the work of colleagues (supervisees)" (Milne, 2007, p. 439). Using this definition, formal supervision must also include techniques or interventions that target mutually identified training goals as well as ongoing feedback to guide supervisees' professional development. In MCFC, these definitions are expanded to clarify the inclusion of supervisors' focus on relational and systemic models both in the supervisory process and in supervisee skill development (AAMFT, 2014). While the supervisory process is similar across professions, a systemic perspective is unique to MCFC and was thus the primary lens for this study (Becvar, 2010).

Goals and purpose. The overarching purpose of clinical supervision includes the professional development of supervisees in addition to protection of the profession itself and of the clients being treated by those supervisees (Bernard & Goodyear, 2009; Lee &

Nelson, 2014). Professional development may encompass a variety of functions such as skills acquisition and refinement, involvement in the professional community, development of self-care strategies and personal insight to avoid burnout and reduce associated risks, and self-supervision skills that will ultimately work in service of a more autonomous and accountable licensee (Allanach, 2009; Bernard & Goodyear, 2009; Milne, 2007; Schofield & Grant, 2013).

For interns wishing to specialize in MCFC, their goals should include developing an intimate understanding of systems-based theories and their applications with clients, along with a strong ability to self-reflect on their own roles in their families, in client family systems, and in the therapeutic processes. A set of core competencies for MFT practitioners combined these relational and reflective needs with six primary practice-oriented domains that include: (a) admission to treatment, (b) clinical assessment and diagnosis, (c) treatment planning and case management, (d) therapeutic interventions, (e) legal issues, ethics, and standards, and (f) research and program evaluation (AAMFT, 2004; Nelson et al., 2007). Each of these competencies measures the ability of trainees who specialize in MCFC to conceptualize and intervene on both systemic and individual levels and manage multiple perspectives within the same session, which are critical abilities for practitioners who work with couples and families (Berkman & Berkman, 1987). These guidelines appear to be universal to the MCFC specialty, as they have been reflected in the professional competencies defined for graduate students by CACREP (2009), as well as by the NCA (n.d.) in their credentialing requirements for family therapists. The IAMFC, in their *Code of Ethics*, addresses this issue by adopting the

CACREP guidelines as the primary measure of competency for its members. Thus, the AAMFT core competency areas will provide a structure for the following discussion with the understanding that it is one of several professional voices that has helped to define competency for couple and family therapists.

Core competencies as indicators of skills development. focused on core competencies for professional practice for a variety of helping professions, most notably in the medical and mental health care fields. Competencies in a profession provide a valuable orientation in professionals' work when such competencies encompass specific information, abilities, and beliefs unique to the profession and its current climate. When used in this way, trainees learn to think critically about their work and rely on a solid foundation of principles that allows them to work effectively with a variety of clients and situations (Falender & Shafranske, 2004).

In a qualitative study that examined the experiences of family medicine residents who were receiving training and supervision based on an established set of professional competencies, Saucier, Paré, Côtë, and Baillargeon (2012) discovered that the incorporation of core competencies was best made explicit to the supervisee and taught with intentionality by the supervisor. Of the 11 instructors and six residents who participated in the study, many did not realize how core competencies were being incorporated into the training, although all were able to recognize their knowledge of the competencies in reflecting upon their clinical and supervisory work in a focus group setting. Saucier et al. (2012) highlighted the need for instructors to embody the core competencies for their professions and include them in ways that are specific to each

training issue. Additionally, when residents could use the competencies to guide the help they sought from their supervisors, both parties reported positive learning outcomes (Saucier et al., 2012).

As part of its duties to enhance and validate the work of family therapists, the AAMFT (2004) published a guide of core competencies to define the practice of MCFC within the mental health profession and for third-party insurance payers, and to assist educators and supervisors in determining when trainees are ready to practice in accordance with professional values and standards of care (Chenail, 2009; Lee & Nelson, 2014; Miller, 2010; Miller, Todahl, & Platt, 2010; Nelson, et al., 2007). There are currently 128 competencies in six skill areas that describe expectations for members of the organization, each of which becomes absorbed into the supervision process as trainees develop their conceptual, perceptual, executive, evaluative, and professional abilities (Lee & Nelson, 2014). Clinicians who seek licensure or professional specialty in MCFC must demonstrate knowledge, skills, and values in the initial, working, and termination phases of treatment, as well as regarding legal and ethical practice and professional growth (AAMFT, 2004; Nelson, et al., 2007). I will discuss each of the specific competency areas below as they relate to supervision.

Admission to treatment. To work effectively with clients, practitioners must have knowledge of the foundations of the profession, to include theories and techniques specific to systemic therapies and general psychotherapy. They must understand cultural influences in their work, and client factors that would necessitate a different level of care or type of service. With this foundational knowledge in place, interns must know how to

navigate the informed consent process as well as how to enter into and structure a therapeutic relationship with multiple members of a family system (AAMFT, 2004; CACREP, 2009; NCA, n.d.). While all of this information is typically covered in a counseling graduate program, the skills are further developed during internship through instruction, modeling, and supervised practice.

Counselor educators have taught and evaluated this and other domains using a model based on objective structural clinical exercises (OSCE), which allow counseling students to demonstrate their ability to comprehend and apply a given task within a competency domain through demonstrated behavior in a series of role-played scenarios that are reflective of common clinical situations, and that are designed to elicit the skills being measured (Miller, 2010). Miller (2010) posited that the OSCE model offers a reliable and more standardized means of providing formative evaluation of clinical skills that are more difficult to assess through traditional means. One of the limitations to this method is that the pressure on students under observation may be high enough to affect their performance, making the results of the evaluation less representative of their actual abilities. Additionally, the simulated clinical scenarios may not be representative of realistic clients and situations, and require a great deal of faculty planning and supporting staff (e.g., role players). Cotherapy may offer a means to combine the benefits of such live clinical practice with the very real client scenarios that would present in clinical practice for students to practice these important skill areas.

Clinical assessment and diagnosis. To provide effective treatment to clients, MCFC interns must have a working knowledge of human development, gender and

sexuality, pharmacology, and the relational dynamics that occur in couples and families. They must understand psychopathology, to include the etiology, prognosis, and appropriate treatment of psychological and substance use disorders, and how best to assess and diagnose these disorders within the context of the client system, as well as the larger sociocultural systems (AAMFT, 2004; CACREP, 2009; NCA, n.d.).

In preparing students for conducting comprehensive biopsychosocial assessments and diagnostic interviews, training programs must focus on both content and process in order to address the artful balance of interviewing and symptom analysis. One means of accomplishing this may be through the use of a phenomenological interviewing methodology that attends to the therapeutic relationship, the context in which symptomatic phenomena occur, and the meaning ascribed to those phenomena by the counselor and client (Stanghellini, 2004). Practice opportunities that encompass such complexity may be somewhat limited in a traditional didactic setting, and this competency area is one that trainees may be more likely exposed to during their clinical internship and may benefit from doing so with a more advanced member of the profession (i.e., in cotherapy).

Treatment planning and case management. Marriage Couple and Family Counselor interns must be able to synthesize the assessment information into a cohesive conceptualization and, with clients' strengths and resources in mind, develop a comprehensive plan of care to address the identified needs. The treatment plan is a living document that is responsive to changes in status and needs, and is reflective of clinical best practices. Marriage Couple and Family Counselor interns learn through clinical

practice how to work in multidisciplinary teams and within systems of care (both medical and social) in order to advocate for and with clients (AAMFT, 2004). Unique to the field of couple and family therapy is in the inclusion of a systemic lens in the assessment and treatment process. This systemic lens creates a shift in the treatment approach that requires trainees to consider relational patterns and broader systems components when designing a course of treatment with a client or client family, as opposed to other treatment modalities that may only focus on one individual (Celano, Smith, & Kaslow, 2010; Lee & Nelson, 2014).

Therapeutic interventions. With a comprehensive plan in place and all the key participants engaged, MCFC interns must also learn how to select and implement therapeutic interventions that are consistent with best practices and their chosen theoretical orientation. They must attend to both content and process, and be able to navigate through those elements to help clients reach optimum health and functioning (AAMFT, 2004; CACREP, 2009; NCA, n.d.). This competency area addresses knowledge of major systems theories, as well as their translation into practice with clients (Lee & Nelson, 2014).

This blending of conceptual understanding and practical application has particular relevance given recent findings that suggested a significant incongruence between therapists' perception of engaging in specific practices and the actual occurrence of those practices in session (Carroll, Martino, & Rounsaville, 2010). A variety of theories and approaches are associated with systemic therapies, each of which with its own set of therapeutic interventions and rationale based in the theoretical framework. While it is

beyond the scope of this manuscript to describe them all in detail, MCFC supervisors are tasked with guiding trainees to develop competency in recognizing and performing multiple applications of these approaches.

Legal issues, ethics, and professional standards. Throughout their work with clients, from initiation to termination, trainees will be exposed to a variety of legal and ethical quandaries. To do so competently, interns must have the ability to identify situations that warrant consultation and supervision, and the applicable legal and ethical codes to which they must refer (AAMFT, 2004; CACREP, 2009; NCA, n.d.). Working with client systems poses an array of ethical pitfalls that individual counseling may not, and supervisors are responsible for MCFC trainees' understanding of complex issues such as confidentiality, mandated reporting, dual relationships, and boundary-setting within a systemic milieu (Lee & Nelson, 2014).

Research and program evaluation. This competency area refers to the roles of consumer and disseminator of knowledge through continuing education and research, advocacy, and professional development (AAMFT, 2004; CACREP, 2009). This area also pertains to a therapists' ability to assess the efficacy of the therapy they provide and to ascertain which best practices might be appropriately used with a given client system. Supervisors must work with trainees to further develop their critical thinking and analysis skills in order to apply their literary findings toward that end (Lee & Nelson, 2014). A primary modality for counselor development in the area of research and program evaluation is through mentorship with a member of the profession who has been involved with organizations and projects that are relevant or of interest to the trainee, and who can

offer an open window to new growth opportunities and immersion into the professional culture (Allanach, 2009); a supervisor is one such figure.

Counselor self-efficacy. Self-efficacy in counselors has been defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future," and is based largely on Bandura's social learning theory (Daniels & Larson, 1998, p. 180). The more self-efficacy a person has about a given task, the less anxiety he or she tends to experience in the performance of that task and the better she or he is able to self-regulate whatever anxiety is present (Bandura, 1989). Consistent with this finding is that counselors who are confident in their clinical abilities tend to exhibit more competence in their therapeutic practice (Briggs & Miller, 2005; Kozina, Grabovari, De Stefano, & Drapeau, 2010), and the development of confidence represents one of the most fundamental tasks in the early phases of counselor development (Bischoff & Barton, 2002; Kozina, et al., 2010). Thus, the two primary constructs of self-efficacy and clinical competence are highly related and applicable to the ultimate goals of clinical supervision. As does skills competency, self-efficacy builds over time and, perhaps, in somewhat predictable ways that can be used in designing supervision modalities.

Qualitative interviews with 39 interns who had completed a year-long clinical internship as part of their graduate counselor education programs provided indication that confidence develops in three distinct stages during the first year of direct client contact (Bischoff & Barton, 2002). Using a constant comparison analysis, the researchers learned that for the first one to three months of direct client contact, trainees' confidence could be extremely variable and vacillate between very high and very low (or even

lacking) within hours or days. For a period of five to six months following this insecure stage, the student interns transitioned into a state of emerging confidence as their anxiety lessened and they experienced successes in their work with clients and in the supervision process. A final transition marked the passage into a more stable state of confidence as the student interns became more grounded in their theoretical knowledge and application, as well as in their use of self in therapy, in addition to the building of successes in practice and ongoing supervisory guidance (Bischoff & Barton, 2002). Consideration for such trajectories when planning appropriate supervision interventions across modalities may provide a more valuable training experience for supervisees.

Developing self-efficacy in counselors. Given that self-efficacy is something that develops with time and experience, considerable research exists to help explain how this happens. Direct experience with clients (either in session or via role play), viewing of counseling skills modeled by a more advanced professional, and receiving constructive and directive feedback about trainees' own skills have been identified as primary means for supervisors to help trainees increase their self-efficacy. Perceived efficacy also remains highly dependent upon the participant's level of emotional arousal, suggesting that anxiety may be a relevant factor (Barnes, 2004).

In a study that included a qualitative examination of the primary contributing factors to perceived changes in the self-efficacy of 98 supervisees in a graduate-level counseling program, Lent et al. (2009) found several common themes. The most commonly reported source of change in self-efficacy was related to the perceived performance of the trainees; that is, self-efficacy was reported by eighty-six percent of

respondents to increase or decrease as a result of behaviors they believed themselves to demonstrate well or poorly in session. Other common factors that influenced reported self-efficacy included trainees' perceptions about the clients' experience in session (61%), perceptions about the quality of the therapeutic relationship (33%), the affective or physiological states of the trainees (26%), direct feedback received by trainees from their clients (25%), beliefs about session outcomes (17%), and the impact of the supervision process (10%) (Lent et al., 2009). These results are consistent with the philosophy of social learning theory and confirm the complexity involved in developing self-efficacy as a counseling trainee.

Paez (2010) sought to examine how counselor self-efficacy developed in relation to the supervision process in particular. This was done using a Q methodology with a sample of 45 graduate students in practicum and internship courses at a CACREP-accredited university in the mid-western United States. The students participated in the Q sort process by ranking statements about their experiences of supervision and its perceived effect on their self-efficacy on a scale from least helpful (-4) to most helpful (+4); from the data, three factors emerged. A perception of security in the supervisory relationship, which included availability of the supervisor to provide feedback and concrete guidance, was the first and most heavily loaded factor. The second factor, readiness to learn, shared some crossover items with the first factor related to supervisor feedback and guidance; this second factor contained additional items related to specific supervision interventions that were deemed facilitative of self-efficacy such as reviewing counseling tapes and discussion of supervisee self-care. This group valued their

supervisors' encouragement to think more independently and was more tolerant of less direct feedback in favor of guidance to find answers for themselves. The third and final factor encompassed items related to openness to feedback and reflective processes, and related most strongly to basic counseling skills and relational processes (Paez, 2010). Each of these factors may be helpful for supervisors to consider when planning a supervision intervention, and cotherapy could meet a variety of needs when tailored to each individual supervisee.

In the preceding sections, I have provided a review of the constructs of counselor competency and self-efficacy. In the section that follows, I offer information about the modalities through which supervisors' work with supervisees to increase their clinical competency and self-efficacy as marriage and family therapists-in-training.

Traditional Methods of Supervision

Supervision is not a new practice. It has taken many forms over the generations as counselor educators and supervisors devise new ways to meet the needs of both the profession and its trainees. The primary means of supervision in counselor training are best reduced to the categories of verbal and document-based supervision modalities, and observation-based modalities. The variations within these categories are discussed below.

Verbal and document-based supervision. Much of clinical supervision takes place verbally through the presentation of clinical cases (Bernard & Goodyear, 2009). Self-report supervision offers the least amount of observation by the supervisor and is subject to a high level of perceptual or intentional misrepresentations of the clinical work

by the supervisee. This may be because of factors such as inaccurate recall of a session, a distorted or incomplete conceptualization of the case and related details (e.g., as filtered through countertransference), a desire to be highly regarded by the supervisor, trainees' discomfort in describing their own strengths or successes, or anxiety about not performing well, among others (Bernard & Goodyear, 2009; Haggerty & Hilsenroth, 2011; Noelle, 2002). Such factors are likely exacerbated by the evaluative nature of the supervisory relationship and the power differential inherent in the gatekeeping role of the supervisor (Noelle, 2002). However, a benefit to the self-report method is the opportunity to explore the subjective experience of the session through the lens of the supervisee, countertransference and all, and to deconstruct the narrative of the supervisee in a way that extracts some of the meaning conveyed through nonverbal or unconscious mechanisms (Noelle, 2002). As valuable as such information may be to the supervision process, this is not a benefit unique to a self-report method.

Case note supervision takes self-report methods one step further by introducing the clinical record and, if available, the supervisee's process notes. Case note supervision allows supervisors to ensure that trainees have grasped one of the core tasks of legal and ethical practice (i.e., documentation), and uses this information as a basis from which to discuss clinical concerns and conceptualization (Bernard & Goodyear, 2009). Even with this information at hand, many supervisees find it difficult to provide an accurate and thorough account of the core clinical issue, and may require coaching in order to do so. For MCFC trainees, reporting less on content and more on the systemic and relational characteristics of a client family, as well as discussing the structure of the therapy and

therapeutic approach, provide a wider breadth of opportunities for a supervisor to be helpful and for supervisees to make the most out of their training (Maione, 2011). Observation-based and live interventions, particularly cotherapy, provide myriad opportunities to explore such clinical issues with the benefit of additional data about the therapeutic interactions and the family system.

Observation-based supervision. It may be the case with many forms of supervision that there is simply not enough time or resources to review every detail of every client family with which an intern is working. The job of a supervisor is much more difficult in later phases of professional development if a skills deficit is identified than in the earlier phases, making it critical to provide a thorough and representative review of a trainee's work earlier on (Ladany, Friedlander, & Nelson, 2005). With observation-based methods, supervisors have an increased opportunity to see what an intern is doing (or not doing) in sessions, and have additional data from which to develop growing edges and recommendations for practice that may be more generalizable or representative of the trainee's abilities than with self-report alone (Haggerty & Hilsenroth, 2011). Observation-based supervision may be conducted through ex-post facto means such as reviewing audio or videotapes, or through live avenues such as two-way mirrors, real-time audio or video feed, or cotherapy (DeRoma et al., 2007). I discuss the latter in more detail in later sections. Regardless of the specific observational approach used, it is considered best practice in supervisory responsibility to see a supervisee's work first-hand before a supervisor confirms an intern's successful completion of training (O'Donovan, Halford, & Walters, 2011).

Technology-assisted observational supervision. The use of audio recordings in family therapy supervision has been an established part of the training process for generations of counselors, as early as the 1940's, due to the additional data that became available through its use (Bernard & Goodyear, 2009; Protinsky, 2002). Audio and video supervision has been more commonly used in MCFC training compared to other mental health disciplines (Romans et al., 1995), likely because their use offers the advantages of direct supervision of sessions to which the supervisor might not otherwise have access, either due to location, scheduling, or other logistical barriers.

The utility of audiovisual media in supervision is wide, and offers many benefits. Sessions can be viewed multiple times, and all at once or in pieces based on the skill set under review. Taped sessions can be paused, rewound, slowed, or fast-forwarded to augment focus on a particular portion or process (e.g., to more deeply examine body language or facial expressions, or to review parts of the session that did fall within the trainee's awareness in the moment). The taped sessions can provide a documented pattern of growth and highlight areas for further development; when viewed and processed in a group format, vicarious learning becomes possible for the other trainees in the group (Huhra et al., 2008; Lee & Nelson, 2014; Protinsky, 2002).

The benefits of audiovisual technology have been extended beyond client session data alone; recording the supervision process for later review and reflection has been an additional area of exploration in the literature. North (2013) interviewed 15 counseling trainees in the United Kingdom about their experiences of reviewing taped supervision sessions with their clinical supervisors. The findings were indicative of a valuable shift

from participant to observer, which allowed trainees to tune in to processes of which they had not been aware during the recorded supervision meetings. Participants cited that nuances in their supervisory dialogues such as changes in voice intonation, behaviors, and response patterns provided them insights into their own strengths and growing edges, as well as their relationships with supervisors and clients. Additionally, reviewing the recorded sessions provided opportunities to observe the supervisors' styles and draw from their use of the core conditions of counseling, application of theoretical foundations, and conceptual abilities (North, 2013).

However, there may be a few limitations to the use of audio or visual recordings. Clients and supervisees may demonstrate a period of discomfort about being recorded through changes in interactional patterns, responses, and behaviors that are not reflective of their typical presentation in session, which may skew the observational data (Huhra et al., 2008). Additionally, a major piece that is missing from ex-post-facto supervision is the option for the supervisor to intervene in the moment for the purposes of demonstration for the trainee or protection of the client. Audiovisual recording may be an approach worth applying to a cotherapy session with a supervisor so that supervisees can glean benefits from both the live observation in the counseling process and the pre- and post-session discussions, with the added benefits of having the tape to view again for later reflection.

Live supervision. Live supervision may take an observational or an active approach, depending on the resources available to trainees and supervisors, as well as the needs of the trainees and their clients. Live observation is a form of supervision often

conducted from behind a two-way mirror, through a live video feed, or in the therapy room with the supervisee and client. In a live observation approach, the supervisor does not intervene at any point in the session but will use the session data for supervision material following the close of the trainee and client's session together (Bernard & Goodyear, 2009; Lee & Nelson, 2014). Live observation, particularly when used in conjunction with clear communication of goals and expectations, along with a planning and debriefing process, has been found to be a valuable training tool that offers opportunities for formative feedback and evaluation; these elements were proposed by Beddoe, et al. (2011) as part of a comprehensive model of live supervision via observation that begins with preparation for the live session through conceptualization, goal setting, and session planning. Feedback and debriefing occurs immediately following the observation and involves supervisor and supervisee reflection of what occurred in session and the development of future learning or skills goals based on what was demonstrated by the supervisee (Beddoe et al., 2011).

In contrast, live supervision utilizes a variety of intervention methods during the therapy session, as opposed to after the fact. This type of immediate supervision may take place via a phone call into the therapy room, a bug-in-the-ear (BITE) device, or in the room with the supervisor as a guide or model (Bernard & Goodyear, 2009; Lee & Nelson, 2014; Mauzey et al., 2000). In an examination of live supervision outcomes, Silverthorn, Bartle-Haring, Meyer, and Toviessi (2009) assessed the perceived status of cases following zero to three live supervision sessions from both the therapist and client perspectives. Therapist trainees with live supervision rated a significant improvement in

client outcomes, which was progressively higher for those who had the maximum number of live supervision sessions. With live supervision as a time-varying covariate and charted in comparison to cases with no live supervision, the slope representing perceived progress was calculated to be .52. The coefficient for the live supervision condition was statistically significant at alpha .05. The overall perception of progress from clients' perspectives was not statistically significant between the live supervision and no live supervision groups. The root and function of the therapists' perception of progress is not made clear by these results.

Esposito and Getz (2005) explored supervisees' perception of the live supervision process through written questionnaires. While all of the supervisees received in-room supervision from their supervisors, some of the supervision was done via silent observation and post-session processing while some supervisors provided in-the-moment feedback and redirection during the sessions. Overall, supervisees reported perceiving a higher level of support and increased confidence in trying new therapeutic interventions with the supervisor present to assist as necessary, while others perceived an undesirable shift in the relational dynamic with the client or felt more nervous and distracted in the presence of their supervisors. Some respondents, both supervisors and supervisees, reported discomfort or anxiety associated with role confusion. Thus, these would be factors to consider in preparing for an effective cotherapy session. These findings are consistent with previous qualitative studies that explored the perceptions of supervisees and supervisors of a live supervision format (Wark, 1995).

Anxiety in particular has been one aspect of live supervision examined based on prior research that indicated varying levels of anxiety can be expected during live supervision, which may also be influenced by the developmental level of the supervisee (i.e., more novice trainees tend to report higher levels of anxiety when their work is directly observed as compared to reading or talking about their counseling skills) (Bowman, Roberts, & Gieson, 1978; Costa, 1994). In an examination of both anxiety and anger experienced during a combination of delayed, BITE, and phone-in interventions, Mauzey et al. (2000) recruited 70 students in a graduate-level counselor education program and administered the State-Trait Anxiety Inventory (STAI) and the State-Trait Anger Expression Inventory (STAXI) across three points in time representing trait anxiety and anger (one week prior to the supervised session), and state anxiety and anger (pre- and post-session). Contrary to historical reports that live supervision may lead to increase state anxiety in counseling trainees, the results of this study indicated no overall difference in state anxiety or anger among the three live supervision methods tested, although there were fluctuations noted across the three points of measurement. Trainees' reported anxiety increased slightly between the trait and initial state measures and then decreased pre- and post-session measures; state anger decreased between the pre- and post-session measures for the phone-in and delayed methods, and increased for respondents who received BITE supervision. None of these changes in state anxiety and state anger were statistically significant, although there was a significant main effect for time ($p = < .03$) (Mauzey et al., 2000). While the baseline trait anxiety and anger scores for the sample were reported to be lower than the established norms and may have thus

lead to less generalizable results, this study nonetheless offers reason not to rule out the use of live supervision methods due to the risk of trainee discomfort alone.

Team supervision. The reflecting team model serves the function of incorporating multiple clinical viewpoints in the supervision process, as well as for offering client families an opportunity to experience the inner workings of the therapeutic process, thus making it more transparent (Andersen, 1987; Bernard & Goodyear, 2009; Paré, 1999). In a reflecting team, a group of clinicians view a counseling session from behind a one-way mirror in much the same manner as other live supervision methods. The difference in a reflecting team approach is that the client and treating clinician then can listen in as the observing team discusses the therapeutic process and their impressions of the issue at hand, usually through a reversal of lighting in the one-way mirror that allowed the family to peer into the observation room, or through a live audio feed. The treating clinician and client then return to their work together with this new information provided by the observing team. One of the primary benefits to this approach has been cited to be a redistribution of responsibility from the trainee by himself or herself, to one of shared responsibility with the team who becomes a more direct participant in the therapy process, all the while allowing the clinician to remain a more cohesive part of the therapy system by remaining in the room with the client rather than consulting in private with the supervisor mid-session (Young et al., 1989). However, a reflecting team is most effective when implemented in a manner consistent with its original design and structure; deviations from the method, insufficient guidance from the supervisor, or incomplete preparation for the reflecting process (e.g., a team that is unfamiliar with the client

system and presenting issues) have led to perceptions of poor outcomes and dissatisfaction from participants in the process (Reichelt & Skjerve, 2013).

Nonetheless, several authors have explored variations on a reflecting team approach. In what is deemed an "open live supervision" approach, Ron (1996) used a reflecting team that consulted with the treating clinician in the same room as the client rather than from behind a one-way mirror. This approach allowed for more transparency and for a deeper level of involvement from the reflecting team in therapeutic interventions (e.g., psychodramatic enactments or structural experiments). Additionally, Lowe, Hunt, and Simmons (2008) suggested the use of a multilayered live supervision approach that enlists two separate teams to attend to multiple aspects of the session. One team is positioned in a traditional live supervision setting behind a one-way mirror to directly observe the treatment itself, and with direct access to the clinician in the room with the client; the other team is further removed from the process by observing the session from a video feed and does not have access to the primary clinician during the session. Each team is assigned a different area of focus, with the more distant observation team tasked with broader conceptualization and the reflecting team working with the clinician to address the more immediate therapeutic process and treatment approach. With careful planning and appropriate debriefing, such an approach can offer valuable perspectives to trainees to which they may not otherwise have access.

In utilizing any of the supervision techniques, particularly those in which additional parties (i.e., a supervisor and one or more other trainees) become part of the therapy session through direct intervention and observation, unique ethical quandaries

arise. Pertinent questions must be addressed in order to clearly delineate the roles and responsibilities of each professional involved and any potential risks to the therapeutic process that might occur through clients' responses or changes in behavior due to having an audience, or increased risk-taking by the clinical team as a result of the social impacts of working in a group (Gottlieb, 1995). When a crisis occurs in session that requires the trainee to respond to threats to the health and welfare of clients or other mandated reporting scenarios, live supervision may require a supervisor to intervene in a much different manner than would occur in a post-hoc review of the events (Charlés, Ticheli-Kallikas, Tyner, & Barber-Stephens, 2005). Cotherapy in supervision may address several of these challenges; this will be addressed in the discussion of the strengths and benefits of the approach.

The Practice of Cotherapy

Family therapy is predicated on systems and has its roots in cybernetics. Families, much like other types of systems that have working parts that interact with one another in a circular fashion, are subject to the influence of each of those parts and subsystems within the whole and will naturally work to maintain a state of homeostasis (Hoffman, 1981; Minuchin & Fishman 1981; Napier & Whitaker, 1978; Palazzoli, Boscolo, Cecchin, & Prata, 1978). From this foundation, practitioners from various schools of thought have offered insight into why and how families function the way they do, and about the origins of dysfunction in family systems. A complete discussion of these paradigms is beyond the scope of this manuscript. However, it is necessary to

acknowledge the influence the foundations have had on the development of cotherapy as a common therapeutic modality with families.

A very basic definition of cotherapy describes the provision of psychotherapeutic treatment by a dyad of therapists, as opposed to the traditional approach with one therapist working alone with a client. Cotherapy has been used in the treatment of couples (Hoffman & Rosman, 2004; Livingston, 2001), families (Lantz, 1978; Napier, 1999; Napier & Whitaker, 1978), psychotherapy groups (Harwood, 2003; Yalom & Leszcz, 2005), and children (Eppler & Latty, 2001; Levinger, 1994), all within a broad range of presenting issues and diagnoses. There are both benefits and challenges to enlisting a co-therapist, and the body of literature is rich with examples of cotherapy in clinical practice. Of note, however, is the relative dearth of such literature within the last decade of research publications.

Support for the use of cotherapy. Several benefits to the use of cotherapy in couple and family therapy have been suggested. At its most practical level, working in a cotherapy dyad offers a means of support for each of the therapists involved and continuity of care for clients should one of the therapists fall ill or become otherwise unavailable, both of which help reduce risk to clients. Additionally, co-therapists who work well together can enhance one another's awareness and creativity in session, as well as develop a broader perspective about the interactions and processes occurring within and between the therapists and clients in session (Berkman & Berkman, 1987; Bowers & Gauron, 1981; Kosch & Reiner, 1984; Roller & Nelson, 1991; Yalom & Leszcz, 2005).

From a systemic perspective, the advantages of including a therapy partner are augmentative to these fundamental benefits.

To address a presenting issue effectively, co-therapists may opt to take on specific roles with a couple or client family. One therapist may take on a supportive role by providing validation and accurate empathy for one or more clients in the room, while the other takes on a more provocative or confrontative role, perhaps even through forming an intentional coalition with one more parts of the system. In so doing, the therapists may increase the client's tolerance for being pushed in a different way than might be achieved in session with a solo counselor, and their awareness of the dynamics that occur between them. Such an approach can work to create tension or unbalance a system, thereby disrupting homeostasis and creating a pathway for change (Lantz, 1978; Yalom & Leszcz, 2005).

One or both therapists may also find themselves taking on a transference role within the client system and drawing from the parallel process to explore the difficulties that are occurring (Livingston, 2001; Yalom & Leszcz, 2005). Modeling of healthy interactions, including healthy conflict, can occur throughout each of the processes and roles described above (Berkman & Berkman, 1987; Lantz, 1978; Yalom & Leszcz, 2005) and provide a unique and important benefit to the treatment of couples and families as opposed to working with individual clients. As Satir (1991) stated,

> How the co-therapists behave with one another, how they use each other, how they manage their differences – these are all models for health in relation to the

> individuals and families under treatment. Therefore, cotherapy is not a technique but a way of modeling being human (p. 211)

This modeling can occur in many different ways and highlight many valuable skills. Of note is the idea of congruence and the potential impact on self-esteem that comes from accepting all the parts of oneself in such a way that those parts are honored and expressed with trusted others. Co-therapists can create this safety for one another and pave the way for clients to do so as well (Satir, 1991).

Challenges of using cotherapy. Of the several challenges that exist to using cotherapy, those that address the complicating factors in the therapeutic relationship are at the forefront (Yalom & Leszcz, 2005). Critics of cotherapy have discussed the potential difficulties posed by the increased level of intimacy that may occur between co-therapists and the varying layers of relationship management that must occur between the client-therapist-therapist triad and the co-therapist dyad. If the latter becomes strained or crosses professional boundaries (i.e., if co-therapists engage in a romantic or sexual relationship), there is an increased risk that the focus of sessions will shift from the client process to that of the co-therapists' interpersonal dynamics (Bowers & Gauron, 1981; McGee & Schuman, 1970; Storm, York, & Sheehy, 1990). Others have discussed the potential conflict that may arise when one of the co-therapists is perceived to be favored over the other by the client. The resulting hurt or envy may give rise to a competitive dynamic between co-therapists, posing yet another shift in focus that would be a potential detriment to the therapeutic process (Berger, 2002; Dugo & Beck, 1997); Livingston, 2001; Yalom & Leszcz, 2005).

Roller and Nelson (1991) have summarized these concerns as "the five C's of cotherapy dilemmas," which they named competition, countertransference, confusion and lack of communication, lack of congruence, and co-dependency (p. 100). Each of these challenges describe the difficulties that arise when co-therapists engage in battles for dominance or recognition (competition), re-enact their own family-of-origin issues within the client and cotherapy systems (countertransference), neglect the processing and planning aspects of the cotherapy relationship and clinical work (confusion and lack of communication), disagree about the presenting issue or course of treatment (lack of congruence) or forget how to function as an individual therapist in the absence of the co-therapist or otherwise lose their identity as individuals (co-dependency). Co-therapists must attend to each of these issues to achieve a successful working relationship.

Considerations for making cotherapy work. Despite the very real challenges that exist and which must be attended, the benefits seem to outweigh the risks. This is particularly true due to the many ways in which the risk can be moderated through careful planning and preparation as well as ongoing maintenance of the various relationships in the therapy system.

Compatibility and co-therapist characteristics. Compatibility between co-therapists is of great importance. In a qualitative inquiry of the perceptions of 24 pairs of co-therapists who primarily represented psychiatric residents and psychology interns who conducted outpatient therapy groups in assigned dyads, Bernard, Drob, and Lifshutz (1987) found that co-therapists base their assessment of compatibility on several factors relating to perceived similarity to one another. Of note, co-therapists who self-described

very similarly about their use of self-disclosures in their work were more likely to assess their partnership as compatible, regardless of how frequently self-disclosure was used (r = -.33, p < .05). A similar correlation was found to exist for co-therapists who rated themselves similarly on a scale of how directive they are with clients (r = -.29, p < .10). While these two factors carried the most significance, the researchers discovered an overall correlation between similarities in self-reported characteristics of each co-therapist and their respective ratings of compatibility (r = -.39, p < .05).

A more recent study offered additional insight into the compatibility of co-therapists based on personality characteristics, theoretical orientation, and leadership styles (Bridboard & DeLucia-Waak, 2011). Fifty-four pairs of group therapists working together in cotherapy teams who represented a broad variety of gender, ethnicity, and clinical experience within and between cotherapy teams completed a research packet independent of their partner, which was returned to the researchers through the mail. Findings in this study indicated that, while all of the pairs reported to be satisfied in their partnerships, pairs in which both clinicians reported a high level of experience (n = 33) were more satisfied with the partnership than those who were both inexperienced (n = 5), $t(36) = 2.36$, p = .023, or those paired with a clinician of a different experience level (n = 16), $t(47) = 3.34$, p = .002. Co-therapists who worked together voluntarily also reported to be more satisfied than those who were assigned to their partner, $F(1, 52) = 12.18$, p = .001. Neither age nor gender was found to be a significant factor affecting satisfaction. Personality factors as measured by the *NEO-Five-Factor Inventory* (NEO-FFI) also did not seem to have a significant impact on participants' satisfaction in their cotherapy

relationships. There were no significant effects on *Cotherapy Inventory* (CI) scores when analyzed against difference scores on the Neuroticism (r = .028, p = .843), Agreeableness (r = -.218, p = .117), Openness to Experience (r = -.106, p = .452), Extraversion (r = .070, p = .616), or Conscientiousness (r = .031, p = .823) scales of the NEO-FFI, indicating the personality differences alone did not predict level of satisfaction. However, higher CI scores were positively correlated with higher scores on the Openness to Experience (r = .302, p = .028) and Extraversion (r = .359, p = .008) subscales of the NEO-FFI while Neuroticism (r = -.248, p = .074), Agreeableness (r = .051, p = .718), and Conscientiousness (r = .121, p = .389) had no significant correlation with CI scores. Finally, compatibility between theoretical orientation (r = .641, p < .001) and similarity in leadership style with regard to confrontation (r = -.376, p = .005) were both found to be of significant importance to the cotherapy teams in this study (Bridboard & DeLucia-Waak, 2011).

This information offers valuable insight into the selection of cotherapy teams in a training milieu to enhance the possibilities of a successful partnership. However, as the authors noted, satisfactions with a cotherapy partner does not necessarily correlate with therapeutic efficacy. Additionally, the cotherapy teams in this study were facilitating various types of therapy groups as opposed to individual, couple, or family sessions. Data that emerged from this study indicated that a perception of compatibility between the experienced/inexperienced cotherapy dyad with couple and family systems was an important part of the perceived efficacy of the cotherapy experience, which adds to Bridboard and DeLucia-Waak's (2011) quantitative findings.

Compatibility does not mean similarity in all cases, as might be presumed based on the suggestion that co-therapists often take on different, and possibly opposing, roles during a therapy session (Lantz, 1978; Reese-Dukes & Reese-Dukes, 1983; Yalom & Leszcz, 2005). The idea of complementarity is one that suggests co-therapists can be different in their core selves and still work together in ways that enhance one another's strengths through those differences (Yalom & Yesczc, 2005). Consistency in how co-therapists work together was more highly associated with better clinical outcomes based on clients' reported outcomes, even more so than the perceived level of effort by the client during therapy (Piper, Doan, Edwards, & Jones, 1979), suggesting the importance of collaboration to achieve complementarity. Ultimately, knowing his or her partner well and taking care of the relationship along the way are of the utmost importance for therapists working in cotherapy.

Tending to the cotherapy relationship. Co-therapists must be aware in their relationship with one another, just as they would be in their relationship with a client family. Dugo and Beck (1991, 1997) have suggested that a cotherapy relationship is a dynamic entity that develops through a series of nine stages and can best be understood systemically. The beginning phases of development encompass the processes of getting to know one another's styles, philosophies about change, goals, and expectations; establishing a structure and working through any issues regarding power, conflicting views, and roles; and transitioning into a process of learning from and trusting each other. As the relationship continues to the middle phases, the co-therapists become closer and must address any interpersonal issues or attractions that arise, manage boundaries, and

continue to work within each other's strengths and limitations; within this increased comfort and professional intimacy, opportunities exist for new and perhaps more innovative therapeutic interventions to help move clients along in their journey. Finally, the cotherapy relationship develops into a safe place for the partners to explore their individual growth, provide and accept feedback to promote that growth, and make decisions about whether their relationship has run its course or will continue on as a new entity that has developed from each partner's own advancements.

While several earlier theories attempted to explain co-therapist relationship development, Dugo and Beck's (1991) original theory encompasses most of the stages discussed by those prior theorists. A comparison of the available theories highlights the consistency among them about the critical nature of the beginning phases of the cotherapy relationship in order to achieve a solid and effective working relationship with the client system (Dugo & Beck, 1997; Wheelan, 1997). The ability of each member of the cotherapy team to communicate and receive feedback about any difficulties that arise within each of the phases is an important part of successfully navigating them (Roller & Nelson, 1991).

Attending to the multiple processes at work. The following considerations are very much in line with the developmental process originally described by Dugo and Beck (1991, 1997) and further supported by Wheelan (1997). Their importance warrants a separate section to highlight the ways in which co-therapists can take preventative or corrective action to ensure continued efficacy. Ongoing check-ins, typically through pre- and post- session meetings to review goals, progress, observations about transference or

countertransference, and any other potential issues that arise has been widely recommended (Berger, 2002; Berkman & Berkman, 1987; Bowers & Gauron, 1981; McGee & Schuman, 1970; Roller & Nelson, 1991; Yalom & Leszcz, 2005). Of particular importance is the co-therapists' ability to maintain awareness of their own and each other's roles within the group dynamic to ensure intentionality and fluidity and to avoid joining into the system in a way that is not intentional or helpful (Roller & Nelson, 1991; Yalom & Leszcz, 2005). Outside consultation or supervision of the cotherapy may also be of value (Berkman & Berkman, 1987; Storm et al., 1990).

Introducing Cotherapy into the Supervision Milieu

Each of the supervision approaches I discussed in earlier sections of this chapter allow supervisors to meet many of the best practice standards of supervision outlined by the Association for Counselor Educators and Supervisors (ACES, 2011). Cotherapy as a supervisory practice meets many of these best practice standards and covers more standards compared to other modalities used independently. Specifically, cotherapy offers an opportunity for supervisors to give feedback on an ongoing basis in close temporal proximity to the session and based on direct observation of trainees' work (standards 3.a.iii and 3.a.v.). Cotherapy also allows supervisors to employ a variety of supervision interventions with multiple learning foci responsive to the developmental needs of each individual supervisee (standards 4.c.i-iv). Through this practice, both formative and summative evaluations can be provided based on supervisors' direct work with supervisees (standards 9.a.i. and 9.a.iv.) and used toward the ultimate supervisory function as gatekeeper (standard 11.b.vi).

Rationale. In considering the offerings of cotherapy to the supervision of interns who are developing skills in MCFC, it is important to note that "the relationship [is] multilayered and contextual. The supervisor and supervisee, as part of the clinical family, bring to the session the mythologies, prejudices coalitions, triangles, rules, expectations, loyalties, and histories of the family of origin" (Allanach, 2009, p. 41). The richness of this experience for the supervision team and the client family may offer benefits to the training process that have been historically touted yet not recently examined.

The benefits and challenges of using cotherapy as a training tool for MCFC interns are connected in many ways to the fundamental goals of the training process; that is, to develop the core competencies needed to be an effective systemic therapist with regard to foundational knowledge of systemic constructs, conceptual ability within those constructs, and skillfulness in designing and implementing sound and ethical treatment. Many of the constructs prevalent in family therapy theory and practice may become more apparent within the isomorphic nature of a cotherapy approach due to the multiple systems involved in the treatment process (i.e., the cotherapy team as colleagues and as supervisor and supervisee, the client family, and the combined triad as a working system in the therapy room), and transference phenomena may be more readily identified and processed (Liddle, 1988; Tuckman & Finkelstein, 1999; Van Atta, 1969).

Cotherapy, when used as a form of live observation, also allows a developmental process to occur in which trainees are exposed to both an observer and active therapist role, giving them a much more hands-on experience with those core competencies being

developed. For example, Yerushalmi and Kron (2001) described a participant-observer model of clinical supervision in which cotherapy provided by a supervisor and supervisee team was said to yield three main points of learning for the supervisee. First, the development of complex skills and awareness of interpersonal dynamics not easily attained through indirect instruction became more easily facilitated through the process of experiencing them first-hand as both an observer and as the primary interventionist. This may be a particularly helpful aspect when the client family represents a diagnosis or presenting issue that is outside the trainee's current scope of competence and requires closer monitoring to ensure the best outcome for both client and trainee (Van Atta, 1969).

The second benefit, according to Yerushalmi and Kron's (2001) experiences, is that cotherapy promoted a deeper identification with the supervisor and thus a stronger sense of professional identity in the supervisees. Finally, the breadth and depth of knowledge that can emerge from the cotherapy process may exceed those of other forms of supervision that do not occur in real time. This knowledge expands beyond facts and techniques to a more personal and, perhaps, meaningful level as:

> supervisor and supervisee work together on a shared experience which is equally visible to both of them. The mutuality of this experience reduces the asymmetry of [traditional supervision] ... The supervisory process becomes more meaningful, as a result, and facilitates aspects of professional development which are related to identification and internalization (Yerushalmi & Kron, 2001, p. 104).

Each of these points of learning has been reflected in very similar terms elsewhere in the literature (e.g., Grunebaum & Hoffman, 2005; Latham, 1982; Siddall & Bosma (1976); Tuckman & Finkelstein, 1999; Van Atta, 1969; Whitaker & Garfield, 1982; Yalom & Leszcz, 2005). According to an earlier account of cotherapy written from the perspective of the supervisor and supervisee as co-therapists working with several different couples, supervisors themselves also have much to gain from a cotherapy relationship with a supervisee. The opportunity for direct observation of the trainee's work may help the supervisor develop a deeper trust in the trainee's clinical judgment, skills, and growing edges to streamline the training process and diminish liability concerns. The relationship may also offer contributions to the supervisor's professional identity and challenge him or her to maintain a higher level of competence as both a clinician and supervisor (Siddall & Bosma, 1976).

In a mixed methods investigation of counselor trainees' and clients' perceptions of cotherapy outcomes, Hendrix, Fournier, and Briggs (2001) found supporting evidence for these earlier assertions. The researchers assigned 402 clients to therapy teams classified as "low experience" (both therapists were in the beginning phases of training), "mixed experience" (one trainee was low experienced, and the other high experienced), and "high experience" (both therapists were in the latter phases of training). No statistical differences in client outcomes, as measured by completion rates, were found among these cotherapy groups ($p < .19$). A similar examination of client and supervisee outcomes in a cotherapy training milieu revealed that client retention and symptom alleviation were no different for the cotherapy teams versus individual therapists, and that

a significant portion of the clients who received treatment across each configuration experienced some level of perceived improvement over time (Tanner et al., 2012).

The qualitative portion of the study conducted by Hendrix et al. (2001) revealed a variety of perceived benefits and challenges for the trainees in particular. Perceived benefits included increased confidence to try new interventions regardless of the experience level of the therapy team, exposure to different conceptualizations and insights into the relational processes of therapy, and access to the knowledge and resources offered by the co-therapist. Trainees also gained a deeper awareness of the need to attend to power and conflict in the cotherapy relationship and the multiple layers of relational dynamics occurring between and within each system in the room. Benefits and costs to clients were reported to include the modeling of healthy relational behavior by the co-therapists and the richness of insights offered by more than one therapist about a given issue, with a need to attend carefully to the potential risks of a cotherapy team that is not compatible and thus not modeling healthy interactional patterns. From the supervisors' standpoint, strategic matching of cotherapy teams allowed for support, growth, and enhanced systemic awareness (Hendrix et al., 2001). Of note is that none of the pairings in this study included a supervisor and supervisee, as each pair consisted of peers with differing levels of experience. The results of this study add to the information provided by the Hendrix et al. (2001) study by attending, in part, to the power differential that exists in a supervisor-supervisee dyad in the context of a training milieu.

The potential impact on supervisee skill development has been a driving reason to utilize cotherapy and was the original function of its development, despite an alarming

dearth in empirical support for its efficacy (Fall & Menendez, 2002). Tanner (2011) conducted a post-hoc review of counseling records in a graduate training clinic that spanned 10 years. Of the records used for the study, 206 reflected the work of solo counselors who were supervised by one of three supervisors and 30 represented the work of trainees who had conducted cotherapy with one of three supervisors. Results indicated no significant difference among any of the groups regarding client progress (a measure of treatment efficacy based on pre-and post-treatment responses on a treatment outcome questionnaire) or trainee efficacy (based on a comparison of client outcomes between groups of trainees who had received cotherapy supervision to varying degrees and across varying points of their training at the time of treatment). Results of Tanner's (2011) study did not support the use of cotherapy as a supervision tool. However, several limitations exist that give cause for further exploration. The quantitative study was conducted in a CBT clinic in which each of the trainees, regardless of supervision received, was providing a manual-driven treatment under a counseling approach that is not traditionally as relationally focused as other theories. Tanner (2011) cited this condition as being a potential "equalizer" among the groups, thus potentially skewing the results toward insignificant. Additionally, the client-based self-report questionnaire that served as the basis for measuring treatment outcomes and trainee efficacy may have neglected other measures of those constructs that might have been discovered through additional means such as supervisory evaluations and trainee perspectives.

Potential challenges. Each of the concerns that exist for the provision of cotherapy in in a clinical setting still applies to the practice when the dyad includes an

element of supervision, with a few additional considerations that attend to various aspects of the relationships involved. The construct of parallel process is one that describes a phenomenon that occurs when a supervisee unknowingly presents with the supervisor in ways that reflect how the client has presented to the supervisee; this process can reverse directions when the supervisee then engages with the client in the same manner the supervisor has engaged with the supervisee. It is rooted in the psychoanalytic construct of transference and countertransference and represents the intrapsychic experiences of the client and supervisee (Bernard & Goodyear, 2009; Playle & Mullarky, 1998; Tracey, Glidden-Tracey, & Bludworth, 2011, 2012). Critics have argued that, perhaps, the proverbial cigar really is just a cigar. For instance, as Watkins (2012) questioned, when might a parallel process sometimes be two similar processes occurring in parallel to one another, without having an implication of additional meaning about the client and/or supervisee? Tracey et al. (2012) argued in response that, regardless of the level of motivation behind the process (unconscious or otherwise), it remains of importance and should at a minimum be a point of awareness and curiosity in the supervision process. And because the process is assumed to be generally unknown to the supervisee, the burden falls on the supervisor to help the supervisee notice the parallel and bring whatever might underlie the process to the surface for examination and remediation (Koltz, Odegard, Feit, Provost, & Smith, 2012).

A related construct is that of isomorphism, which describes parallel process through a more systemic lens. In contrast to parallel process, isomorphism is more about relationships between people and systems rather than between individuals' internal

processes (i.e., transference) (Bernard & Goodyear, 2009). Isomorphism can be mimetic, normative, or coercive. In the coercive and normative varieties, the isomorphic properties of the interactions are driven by larger systems such as government institutions and professional associations or accrediting bodies (Weir, 2009). The use of the AAMFT core competencies as a structural guide in this current research project can be considered an example of normative isomorphism.

Mimetic isomorphism is slightly different than the others because it is primarily driven from a place of doubt or insecurity. Supervisees are more likely to mimic the work of their supervisors rather than explore their own theoretical preferences and therapeutic style if their anxiety is high or they are unsure how to respond in a difficult situation (Weir, 2009). Given the hierarchical nature of a typical supervision relationship, the potential for increased anxiety for supervisees in a collaborate live supervision milieu, and the ample opportunities a supervisee would have to fall back on the modeled behaviors of the supervisor in session, mimetic isomorphism seems to be of greatest risk in a cotherapy relationship.

If the therapeutic relationship can be considered an isomorph or replication of the supervision system, complete with structures, roles, and hierarchies, then the supervisor's responsibility for awareness and modeling becomes more complicated with their own involvement in the system – particularly in a cotherapy triad in which the supervisor is a part of multiple systems. Koltz et al. (2012) designed a paradigm to assist supervisors in navigating such difficulties, which they have termed the Iso-Para/Para-Iso (IPPI) model. The IPPI model can be used to determine whether the phenomena occurring is parallel

process or isomorphism and is an aid to supervisors in designing an intervention that is appropriate to the process. This decision is based on a four-step system in which a supervisor considers (a) the need for an intervention, (b) whether the intervention should target a parallel or an isomorphic process (or both), (c) the direction and target of the intervention (i.e., just the supervisee or the client, or the therapeutic system as a whole), and (d) the most appropriate supervision role to adopt to most effectively enact the intervention (e.g., counselor, consultant, or teacher). The supervisor's awareness of an effective intervention in parallel or isomorphic processes can aid in the trainee's growth as well as help the pair in their cotherapy relationship.

A related challenge in the supervision relationship, which may be more complicated by the addition of a cotherapy component, is collusion. Collusion occurs when a supervisor and trainee engage together in "safety behaviors" toward the avoidance of some part of the supervision process that one or more parties find difficult or threatening. Rather than address the issue(s), the supervisor and supervisee collude to maintain a sense of safety and place the needs of the threatened party over the needs of the overarching supervision process (Milne, Leck, & Choudhri, 2009). When such interactions bleed into the cotherapy relationship, both the supervisory and therapeutic processes can be compromised because the supervision and family systems might withhold feedback that could otherwise create movement toward growth (Roller & Nelson, 1991). This collusive process may be particularly problematic if the threat to safety is the supervisee's fear of completion and subsequent independent practice; in a cotherapy relationship this risk may be even greater (McGee & Burton, 1998). To

effectively deal with collusion, supervisors must be able to engage in a self-reflective practice that helps them identify and confront the collusive dynamic, provide the supervisee with feedback representative of both strengths and growing edges and be prepared to intervene and challenge the supervisee at an appropriate level (Milne et al., 2009).

An examination of the various relational and intrapsychic forces at work highlights the need to pay specific attention to power in a cotherapy supervisory relationship. When a supervisor is also a co-therapist, the relationship is collaborative at times and hierarchical at others. The supervisor must step in and out of the cotherapy partnership to be able to embrace the evaluative functions of the supervision role, although that power differential lingers even when supervisor and trainee are acting as collaborative peers in a cotherapy session. Transparency about this imbalance of power in the form of regular check-ins is advisable and should include a very clear delineation by the supervisor about his or her expectations of the supervisee in the co-therapist and trainee roles, and philosophy of and approach to cotherapy and supervision (Tuckman & Finkelstein, 1999).

In considering how a supervisor might best approach this idea of transparency in discussing power and expectations, the research of Green and Dekkers (2010) has particular relevance. They surveyed 42 supervisees and 22 supervisors to explore each side's perspective on the supervisors' use of practices consistent with a feminist approach, which has at its core a focus on power, collaboration, and cultural competence. Their results indicated that supervisors reported their attending to these basic principles in

their work with supervisees at a significantly higher rate than supervisees reported them to have done, $t(62) = 5.86$, $p < .001$, indicating that the supervisors believed themselves to be more transparent and explicit about their espousal of these principles than supervisees observed them to be. The supervisors' use of feminist practices, specifically the use of a collaborative approach versus one of hierarchy in combination with direct attendance to power dynamics in the relationship, were strongly correlated with supervisees' reported satisfaction with the supervision they received, $R^2 = .668$, $F = 9.759$, $p < .001$, and their perception of having met their established learning goals, $R^2 = .633$, $F = 8.372$, $p < .001$. These findings suggest that when supervisors can effectively and adequately address the inherent power differential and navigate power in the supervisory relationship at a level that is obvious to the supervisee, supervision and its outcomes are more likely to be perceived positively. These quantitative results were augmented by the qualitative data that emerged from the proposed study.

Summary

To date, the supervision literature has offered a plethora of information about how to structure and conduct effective supervision such that the developmental needs of supervisees are met, along with providing ample safeguards for clients and the profession at large. Self-report and document-based methods remain widely used, despite some risks associated with reliance on trainee's memory and interpretation of session material (Bernard & Goodyear, 2009; Haggerty & Hilsenroth, 2011; Noelle, 2002). Observational methods, including both live and audio- or audiovisual-recorded methods, have been increasingly prominent for trainees who are learning how to work effectively with

couples and families (Romans et al., 1995) due to the reflective opportunities they present (North, 2013) as well as the direct information about a trainee's clinical skill they offer (Bernard & Goodyear, 2009). Live observation, and live supervision in particular, allows for the same benefits as recorded sessions, with the added safeguard and learning opportunities associated with the ability for the supervisor to intervene in the moment when support or guidance is needed and opportunities for ex post facto supervision immediately after the session occurs (Bernard & Goodyear, 2009; Lee & Nelson, 2014). Cotherapy is an approach discussed primarily by systemic therapists as being useful in their work with couples (Hoffman & Rosman, 2004; Livingston, 2001), families (Lantz, 1978; Napier, 1998; Napier & Whitaker, 1978), and psychotherapy groups (Harwood, 2003; Yalom & Leszcz, 2005). This approach has translated into the supervision realm because cotherapy with a supervisor is thought to offer opportunities for the processing of transference phenomena (Liddle, 1988; Tuckman & Finkelstein, 1999; Van Atta, 1969), as well as the development of more complex skills and awareness of interpersonal dynamics (Yerushalmi & Kron, 2001). Cotherapy as a supervision practice is an area that warrants additional exploration due to these purported benefits.

Despite the vastness of the counseling supervision literature, very little has been written exploring the specific growth processes associated with the practice of cotherapy conducted by a supervisor-intern dyad. Through this study, I provide insights into the use of cotherapy as part of the training process for counselors who specialize in working with couples and families by investigating the lived experiences of interns who participate in

such dyads in their work with couples and families. In the chapter to follow, I delineate the methodological process of gathering this phenomenological data.

Chapter 3: Research Method

I examined the essence of working in a cotherapy dyad within a clinical supervision context in relation trainees' perceptions of clinical competence and self-efficacy. Researchers have explored various methods of providing supervision to counseling trainees who work with couples and families, yet few have looked at cotherapy despite its benefits. In this chapter, I provide an overview of the research methodology I used, beginning with a review of phenomenological thoughts and its application as a research method. I also review in information regarding the selection of coresearchers, data collection and analysis, and safeguards pertaining to ethics and trustworthiness.

Research Design and Rationale

My purpose for this study was to examine the experiences of postgraduate counseling interns who participated in cotherapy with their clinical supervisors as part of their training in working with couples and families. The primary research question was: What is the lived experience of being a marriage, couple, and family counselor intern who participates in a cotherapy relationship with his or her clinical supervisor? An additional question was: How do these interns perceive the cotherapy relationship to impact their self-efficacy and clinical competence regarding their therapeutic work with couples and families?

Definition of Central Concepts

Several primary constructs are pertinent to this study, which I have described in Chapter 2. As the primary phenomenon under study, cotherapy is broadly defined as the

provision of psychotherapy by two qualified clinicians with the same client or client system during the same therapy session (Lantz, 1978; McGee & Schuman, 1970; Roller & Nelson, 1971). In the context of supervision, this therapeutic dyad would consist of one trainee and one supervisor, with the assumption that the cotherapy session would serve a dual function of treating the client and providing opportunities for the trainee to further develop skills and competencies (Sidall & Bosma, 1976; Yalom & Leszcz, 2005). I used the latter definition for participant selection. Each counselor or counseling intern that agreed to participate as has engaged in ongoing cotherapy sessions with a supervisor in service of one or more client systems, which served as the basis for their phenomenological accounts.

Clinical competency has been identified as another central construct in this study and represents one of the fundamental goals of supervision (Bernard & Goodyear, 2009). For a licensed mental health professional, competency is demonstrated by possessing the knowledge and skills necessary to practice in a manner consistent with legal and ethical codes and closely in line with best practice standards (Falender & Shafranske, 2004). For MCFC trainees and licensed professionals, competency has been measured using the criteria set forth by the (AAMFT; 2004) and its stakeholders (Nelson et al., 2007), as well as by the CACREP (2009), and the NCA. In exploring interns' experience of cotherapy, I was interested in knowing what, if any, of these competency areas surfaced in their accounts.

Self-efficacy was the final phenomenon I investigated through this research project. Self-efficacy is a state in which a person believes in his or her ability to perform

a given task with some degree of confidence that success, however that may be defined, is possible (Bandura, 1982; 1989). For this study, I explored the self-efficacy of the supervisees in cotherapy dyads in terms of their experienced level of confidence in their ability to carry out what they believe to be the essential functions of their role as an MCFC.

Philosophical and Methodological Design and Rationale

In selecting a research approach to answer the research questions, I excluded quantitative methodologies because I sought experiential information, which is not readily quantifiable or measurable. Additionally, because many quantitative studies have demonstrated limitations in defining and measuring efficacy in cotherapy, the exploratory nature of this qualitative study may provide direction on how future researchers might quantitatively examine whatever specific constructs emerge from the data. I determined that a phenomenological approach would be appropriate to address the research question and the goal of capturing the descriptive data of participants' experiences to understand what it means to be an MCFC intern in a cotherapy dyad with their clinical supervisors and how these experiences relate to competency and self-efficacy.

Phenomenology, as a philosophy, posits that no real truth can be known because the perceptions of human beings are filtered through each person's psyche. Phenomena occur in the world and are interpreted by the experiencer, a conscious being with reflective abilities that allows him or her to make sense of the surrounding world (Giorgi, 2009). From a methodological standpoint, the philosophical constructs of perception and knowing are built upon to offer a means of empirical exploration that takes the

experiential data provided by those who have intimate knowledge of a phenomenon to create a composite description of the essence of that phenomenon and what meaning may be ascribed to it (Giorgi, 2009; Laverty, 2003; Moustakas, 1994). As Van Manen (2007) has posited, if phenomenological understanding informs the decisions people make and their participation in the world, then the insights from this study could offer valuable data that can be used to inform how supervisors work with supervisees who are developing their skills in working with couples and families.

To narrow the methodological approach of this study, I had to consider which of the phenomenological methods would be most appropriate. The hermeneutic phenomenological method, driven by the phenomenological teachings of Heidegger, is most concerned with discovering the meaning humans make of their experiences based on their own historical and social contexts. An emphasis is placed on interpretation, especially as it relates to language, and the role of the researcher's own history (Laverty, 2003). In contrast, the transcendental phenomenological perspective, with its roots in the philosophy of Husserl, seeks to reduce interpretation or assumption and get to the essence of a phenomenon. Husserl argued this can be done through a process of bracketing (*epoche*) that allows the person seeking an understanding to set aside what he or she believes to be known and be open to how others may view the phenomenon with their knowledge (Giorgi, 2009; Laverty, 2003; Moustakas, 1994).

While the transcendental and hermeneutic phenomenological methodologies share many of the procedural aspects of their research designs (e.g., self-reflection, the collection and analysis of rich descriptive data), the intent behind them and the role of the

researcher is different (e.g., to bracket versus embed; to describe versus interpret) (Laverty, 2003; McConnell-Henry, Chapman, & Francis, 2009). Because of my own experience as a former MFT intern who participated in cotherapy as part of my training process, I am aware of potential bias. A transcendental phenomenological approach was appropriate because I wanted to discover what the experiences of others have been and ignore my own experience. The goal was to discover and describe other interns' experiences of doing cotherapy with their supervisors and to consider how that information can be used in designing counselor development and supervision methods in the MCFC specialty.

Role of the Researcher

My own experience with cotherapy during my training places me in a participant-observer role. Given this history and the necessity of bracketing in the research process (Giorgi, 2009; Moustakas, 1994), as well as standards of rigor in qualitative research (Shenton, 2004), I chose a transcendental approach over a hermeneutic one to reduce bias. Cotherapy cannot be determined as an effective supervision tool from only my experience.

Another consideration as the researcher was the relationships that may exist between me and the coresearchers. Local demographics and the small size of the professional community contributed to the likelihood that I would know some of my coresearchers. I did not interview my own supervisees or students, removing risk of exploitation and reducing filtered responses. If conflicts arose in participant selection, I would offer the coresearchers the option to terminate their participation at any point in

time; however, no such instances occurred. Given the hierarchical nature of many supervision relationships, I also took measures to ensure that responses were kept anonymous so that any negative perceptions of the cotherapy process could be openly reported without threat of retaliation; this will be outlined in greater detail in a later section.

Methodology

This section contains information that outlines the methodological procedures in the proposed study. I describe the selection of the participants, instrumentation, and data collection and analysis.

Participant Selection

I used a criterion sampling to identify MCFC interns and licensed professionals who participated in cotherapy with a supervisor and who were willing to share their experiences for this study. Because there are no prescribed formulas for determining how many participants will be sufficient in qualitative research (Englander, 2012; Patton, 2002), I sought a minimum of eight participants based on general estimates of appropriate sample sizes for phenomenological studies (Creswell, 2007), with the expectation that more respondents may have been needed to achieve saturation. Saturation is used to describe the point at which most or all the information about a given phenomenon has been collected, and there is little chance that further interviews will yield new information to the data (Brod, Tesler, & Christensen, 2009; Patton, 2002). Saturation for this study was reached after seven interviews, at which point each of the respondents had reflected in nearly identical ways about their experiences in cotherapy.

The population from which I recruited the coresearchers included people who (a) currently held a State-issued license to practice counseling or who were postgraduate interns under the supervision of a clinical supervisor who was qualified as defined by state statute to oversee their work with couples and families, and (b) who participated during their internship in an ongoing cotherapy relationship with one or more clinical supervisors to include work with one or more client systems over a period of at least 3 months. Use of these criteria ensured that participants had all met a minimum standard for practice (i.e., completion of a postgraduate degree in counseling) and had sufficient exposure to the cotherapy process to be able to describe their experience. Coresearchers all held licensure as MFTs and MFT-interns, although letters of invitations were also distributed to clinical professional counselors (CPC) and CPC-interns who also met the criteria. In the location of the study, those with a CPC license could only work with couples and families when approved by the BOE based on sufficient education and training, but the criteria for this judgement was still in development, meaning CPC interns who had received approval form the BOE were fewer in number than MFT interns.

The recruitment process began with the development of an informational letter of invitation, which described the intent of the study and the inclusion criteria for participants (Appendix A). Specifically, I included information about my role as a clinician, counselor educator, and supervisor in the local professional community and my intent to contribute to the professional dialogue about effective methods in counselor development. I also included information regarding the potential contribution

prospective coresearchers' participation may offer to the advancement of the counseling profession through the acquisition of additional knowledge of clinical training methods.

I distributed this letter to professionals who are qualified to work with couples and families under the MFT and CPC licenses and who received supervision within the major metropolitan area of the northern region of the state in which the study was conducted. I collected the names via the published lists made available by AAMFT and the BOE.

Due to the limited number of supervisors in the northern part of the state, it was possible that too few participants who met the identified criteria would be available and that too few supervisors may have been offering cotherapy opportunities to their interns to comprise a large enough participant group to achieve saturation. Should that have occurred, I planned to expand my search to southern regions using the statewide directory as a guide. However, saturation was accomplished before this option became a necessity.

Instrumentation

To conduct the interviews with flexibility for further exploration and clarification, I developed a semi-structured interview protocol (Appendix B). Use of a semi-structured approach is ideal for collecting descriptive information about a phenomenon because it allows a researcher to have some direction about the type of information being gathered (i.e., information specific to the identified phenomenon), while avoiding the restrictions imposed by a rigid interview format that does not allow for further exploration responsive to the descriptions being provided and open to the discovery of new insights or meaning about the phenomenon (Englander, 2012; Giorgi, 2009; Moustakas, 1994).

I first asked those who elected to participate in the interview to describe their experience of cotherapy with their supervisor, to include aspects of the supervisory relationship and the cotherapy supervision process. The core competencies as collectively defined by AAMFT (2004), CACREP (2009), and NCA (n.d.) served as a guideline for asking respondents to reflect on and describe their perceived level of competence and self-efficacy in admission to treatment, clinical assessment, treatment planning, therapeutic interventions, and legal and ethical issues as well as research and program evaluation across the subdomains of conceptual, perceptual, executive, evaluative, and professional abilities. I limited the structured part of the interview to a few open-ended questions that directed coresearchers to the specific phenomenological themes as defined by the research questions (Englander, 2012).

Data Collection

I conducted interviews on an individual basis with each of the participants, scheduling them for a maximum of 90 minutes. The ultimate length of each interview was guided by the flow of information and the tolerance of the coresearcher, which averaged out to approximately 45 minutes; my goal was to gather as much information about the participants' experience as possible without exhausting or inconveniencing them in a way that negatively influenced the data (Giorgi, 2009). Because my office is in a centralized location and offered a location free from distractions, I provided it as an option to participants as an interview location. However, each participant had an opportunity to suggest a time and location that was convenient for her or him, and

accommodations for these preferences were made (i.e., several interviews were conducted in the private offices of several interviewees).

I began the process with a brief pre-interview contact to establish preliminary rapport, acquaint participants with the research questions and purpose, obtain permission to provide more comprehensive information regarding the research and consent process, and schedule the full face-to-face interview. I intended this preliminary step to help participants be more comfortable in the face-to-face interview, and to give them time for reflection about their experience of cotherapy and of their self-efficacy and clinical competence that may enhance the richness of the descriptions provided (Englander, 2012).

I began the face-to-face interviews with informed consent, which I provided in both verbal and written format with time allotted for any questions participants had about the process. I recorded the interviews using a small audiovisual recording device, and I also recorded field notes during the interview to capture context and affect during the interview. I sent the audiovisual data to a medical transcription service, and later layered this with the visual data (i.e., non-verbal communications such as body language, as well as shifts in speech patterns that enhance the meaning of the verbal message) (Creswell, 2007) through a simultaneous review of the tapes and transcriptions. At this time, I also corrected several errors in transcriptions. Additionally, I collected demographic information at the beginning of each interview to gather information about characteristics such as age, gender, and length of time in both internship and cotherapy, as well as contact information to facilitate follow-up if needed.

Data management. I backed up all of the interview data on a password protected hard-drive, with a hard copy of transcriptions stored in a locked, secured file cabinet my office. I have kept the identity of each coresearcher in a separate location from the data, with code names used to protect the identity of interviewees. I used first- and second-pass hand coding procedures consistent with best practices in qualitative data analysis used to identify relevant and recurrent themes in the data (Patton, 2002).

Data Analysis

I used a variation of the Stevick-Colaizzi-Keen method, as described by Moustakas (1994), as the procedural guide for this data analysis. My goal in this process was to obtain rich textural and structural descriptions that could then form the basis for a complete phenomenological understanding of the lived experiences of the counselors in cotherapy with their clinical supervisors. The textural description is representative of *what* participants experienced (i.e., their narrative account of the phenomena), while the structural description layers the content with information about *how* participants experienced the phenomena (e.g., contextual factors such as the setting or conditions under which the cotherapy occurred or the quality of the relationship between co-therapists) (Moustakas, 1994).

My first step in this process involved the bracketing of any preconceived notions I had regarding cotherapy and its influence on the self-efficacy and clinical competence of counseling interns. In so doing, I could more closely approach a state of neutrality in which data gathered from coresearchers could be seen through an unbiased lens (Moustakas, 1994). To approximate this state of near objectivity, I set aside reflective

time to review my own experience of cotherapy, including the thoughts, feelings, and behaviors that arose from those experiences and which related in some way to my sense of competence and self-efficacy. Next, I processed that information in the same manner I analyzed the descriptions given by the coresearchers. This systematic approach included:

- Consideration for how each statement in the narrative related to the phenomenon and contributed to the definition of its essence. For this study, such statements related to the overall experience or process of cotherapy to include thoughts, feelings, and behaviors that occurred before, during and after each session or the entire relationship; perceptions about the professionals' clinical competence before, during, and after each session or the entire relationship; and beliefs, feelings, and behaviors associated with professionals' self-efficacy before, during, and after each session or the entire relationship. Toward this end, I read each written narrative, along with reviewing the audio-visual recording, to ensure accuracy and to be able to include non-verbal data into the data set by making notes about shifts in movement, gaze, voice intonation (Maxwell, 2013). Through these means I sought to achieve a reduction of the data to its purest, most objective form (Moustakas, 1994; Patton, 2002).
- I then organized relevant statements into meaning-confirming units that spoke to various aspects of the experience that ultimately described the essence. In this part of the process, I treated all of the meaning units equally, with none carrying more significance than the others (horizonalization); it is simply a process of

sorting through what has been offered and beginning to make sense of what is there (Giorgi, 2009; Moustakas, 1994; Patton, 2002).

- I then engaged in the analysis of the meaning units as they informed larger themes that described the essence, with the development of a textural description highlighting the richness and complexity of the narrative accounts (i.e., *what* the participants experienced in their cotherapy sessions or about their perceptions of self-efficacy and clinical competency).
- Next, I incorporated a structural understanding of the textural descriptions that added depth regarding the context, situation, or conditions under which the phenomena were experienced (i.e., *how* the participants experienced the phenomena).
- Then I created a composite description which encompassed each of the individual accounts on both a textural and structural level. The ultimate goal of creating this textural-structural description is the essence of the transcendental phenomenological approach; the outcome of this description provided insight into how the participants as a group experienced cotherapy as it related to the professionals' clinical competence and self-efficacy and offered a basis for deeper understanding of the specific phenomena and directions for further exploration.
- The final step in this process included my invitation for a follow-up interview with participants to verify the accuracy of the analytic outcome and to elicit any additional or clarifying information from the coresearchers. I discuss this in more detail in the section to follow.

Trustworthiness

In the absence of mathematical formulas and objective, invariable procedures, qualitative researchers must find rigor through other means to establish a level of trustworthiness commensurate with quantitative methods. This need is representative of the shift from the positivist views of the quantitative research paradigms to the post-positivist, constructivist and postmodern views espoused by the qualitative traditions (Williams & Morrow, 2009). Trustworthiness, as an overarching goal in achieving high levels of reliability and validity in qualitative research, has been summarized to encompass the four main principles of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Morrow, 2005; Rolfe, 2006; Shenton, 2004). While there is some controversy about whether these positivist-driven principles can be accurately applied to research not positivist in nature (Morrow, 2005; Rolfe, 2006; Williams & Morrow, 2009), they hold value due to their current reign as the primary indicators historically used to determine rigor in the qualitative realm. I strived to employ numerous strategies throughout the research process to increase the trustworthiness of my study by ensuring credibility, transferability, dependability, and confirmability. I describe each of these principles in the sections to follow as they relate specifically to the methodology that I stated in the preceding section.

Credibility

Credibility encompasses the positivist idea of internal validity, or the extent to which a study is measuring that which it was designed to measure. For a phenomenological study, internal validity in the form of credibility speaks to the

accuracy with which the results of the study describe the phenomenon being explored (Shenton, 2004). A variety of ways exist to increase the credibility of a qualitative research project, several of which were built into the design of the proposed study.

In order to gather rich, descriptive data of the experience of cotherapy with a supervisor as it relates to clinical competence and self-efficacy, it was important that I used a commonly understood language about those phenomena. Thus, in my introductory paperwork and during the interview itself, I used operational definitions of these phenomena that are consistent with language used in the profession to ensure that my coresearchers and I were speaking about the same concepts (Shenton, 2004). I drew the operational definitions of cotherapy, clinical competency, and self-efficacy used in this study from widely known resources in the MCFC profession, and they were readily available for reference.

The idea of "prolonged engagement" is another factor that lends to increased credibility (Lincoln & Guba, 1985; Shenton, 2004). While I may not have had prolonged exposure with the coresearchers themselves, as a licensed MFT and AAMFT-approved supervisor, I have been immersed in the academic and professional fields with my colleagues for nearly a decade. This membership allowed for a level of trust and understanding not otherwise afforded, while my lack of direct involvement with the coresearchers (i.e., that I was simply a colleague rather than an instructor, supervisor, or other authority figure in a position of power) may have lent to more honest and thorough responses to the interview prompts (Shenton, 2004).

Triangulation is another important piece of credibility. With triangulation, additional sources of data are used to increase the strength of the findings by providing additional perspective on the phenomena that may support, expand upon, or challenge the researcher's interpretation of the data (Lincoln & Guba, 1985; Patton, 2002; Shenton, 2004). In this study, I triangulated with multiple analysts to help reduce bias in my own presentation of the findings; other analysts included trusted peers in the profession, and dissertation committee members who reviewed the findings, as well as participant coresearchers who were invited to review the findings and provide feedback about the accuracy with which their experiences were represented (Patton, 2002; Shenton, 2004).

This latter form of triangulation using participant review is closely related to the practice of member checking, in which the information gathered is reiterated back to and confirmed by each coresearcher following the interview, with opportunities to add or clarify as necessary (Lincoln & Guba, 1985; Shenton, 2004; Williams & Morrow, 2009). I employed member checking with participants who agreed to a follow-up meeting (I extended invitations following the initial interviews via phone call), and I employed participant analyst triangulation at the close of the study. At both points, I invited coresearchers to participate in a voluntary follow-up interview to address any identified points of conflict or inaccuracy. These processes focused more on confirming the precision and truthfulness with which I have represented the coresearchers' experiential accounts rather than an attempt to replicate the original account. Because of the subjectivity inherent in each person's experience of the phenomena and of their

experience of sharing the phenomena, accuracy is a more realistic and philosophically consistent goal than replication and conformity (Rolfe, 2006).

Finally, I kept a reflective research journal in order to track the research process and to create a working account of all of the steps I took along the way, as well as to hold myself accountable for any sources of bias and maintain as clear a distinction as possible between which pieces of data or interpretation were mine versus those of the participants. I discuss the former in more detail in the context of dependability; the latter is a product of the bracketing process. Such reflexivity, or self-awareness, can help to mitigate the effects of bias and increase the overall trustworthiness of qualitative research (Williams & Morrow, 2009).

Transferability

Transferability is most often compared with the quality indicator of external validity, or the measure of how applicable the results of a study are to populations outside the participant group. The goal of qualitative research is to generate enough descriptive information that can be extrapolated in the form of informed hypotheses regarding the pertinence of the findings in comparable supervisory situations (Patton, 2002). Information gleaned from this study may contribute to supervisors' consideration for whether cotherapy might be an appropriate addition to their supervision plans. For supervisors already employing cotherapy in their work with interns, results of this study may provide valuable information to direct the manner in which they conduct their cotherapy in supervision.

In this study, I employed several methods to increase the transferability of the results. First, a I provided a thorough description of the context in which the data were collected, which allows readers to determine to what extent, if any, the results have applicability to their own work with supervisors or supervisees. Information that clearly describes the researcher, the participants, the community in which they live and work, their relationship to one another, and the processes by which the data were accumulated all provide a basis for this decision (Morrow, 2005).

Dependability

Dependability can be compared to the quality indicator of reliability, which determines if there is sufficient detail about the manner in which I conducted the research to allow for replication of methods. Dependability relies heavily on the steps taken to ensure credibility (Lincoln & Guba, 1985; Shenton, 2004). The primary means for establishing dependability is through an audit trail, which delineates very clearly and specifically the methodology used and its implementation (Morrow, 2005; Shenton, 2004), as well as the data analysis procedures (Williams & Morrow, 2009). Throughout this research project I made use of an ongoing audit trail inclusive of a step-by-step methodological journal and ongoing documentation of the analytical process as themes and categories developed.

Confirmability

Confirmability in qualitative research indicates the degree to which the findings of a given study are representative of the data collected from the sources themselves (in this case, the interns who volunteered their time and experiences to inform this research

question), as opposed to those of the researcher (Morrow, 2005; Shenton, 2004). Reflexivity came into practice again here through my use of a reflective journal and a comprehensive audit trail; transparency in the research process, inclusive of the reflective journal and thorough disclosure of the researcher's own experiences (bracketing), was an important element to insure greater confirmability (Shenton, 2004). Additionally, the direct reporting of data without any interpretations or alterations (i.e., the inclusion of direct quotes from the coresearchers to demonstrate their experiences in the purest form) provides readers with an opportunity to determine their own impressions of the accuracy of the overall findings (Morrow, 2005).

Ethical Procedures

I considered a multitude of factors in an effort to conduct the most ethically sound research possible. I included the following safeguards in the design for the protection of the coresearchers, and were derived from the standards set forth by the American Counseling Association (ACA, 2014) for responsible practice in research endeavors.

Informed Consent

I provided all participants with a comprehensive informed consent form prior to the formal interview and I reviewed it with them at the start of the interview to address any questions or concerns and to obtain their signature of consent. I maintained the original signed consent with the demographic record, separate from the content data, and gave a copy to each participant for their records. I designed the consent form to comply with all of the criteria designated in part 45 of the Federal Code of Regulations (CFR), as outlined by the Office for Human Research Protection (OHRP, 2009), to include: a clear

delineation of the purpose of the research, the methodology being used and the participatory requirements of each coresearcher (e.g., time commitments and data collection procedures), potential risks and benefits of participation, potential conflicts of interests held by the researcher, and contact information should participants need to contact the researcher or Institutional Review Board (IRB). The consent form clearly reiterated the voluntary nature of coresearchers' participation and the absence of any compensatory exchange. Finally, I explained confidentiality and data management safeguards and procedures. I explain this in more detail in the section to follow.

Confidentiality and Data Management

I collected data for my study via face-to-face interviews individually with each participant. I recorded these interviews using an audiovisual device. I advised coresearchers of the recording device and gave each the option to decline its use. In such cases that a participant did not consent to the use of the recording device, I would have taken notes during the interview and would have checked the accuracy of those notes at the close of the discussion; this option, however, was not used as all participants consented to use of the device. I then sent the recorded interviews to a transcriber, whose services I retained ahead of time with a signed confidentiality agreement in place.

As an additional safeguard, I kept the identities of each coresearcher in a separate location from their transcribed interview data and interview notes, with demographic information maintained only for the purpose of follow-up should clarification be necessary. I used a coding system to link the interview data with the participants' identifying information and to maintain anonymity of the data. I assigned pseudonyms to

each participant and used those in the final write-up to protect the identity of each respondent.

Due to the stated recording procedures, data exists in both written and electronic formats. I password-protected the electronic data and it does not contain the real names or contact information of any of the coresearchers; following the receipt of interview transcripts and the final review of the taped material, I destroyed the electronic data. I will keep the written data for a period of five years in a secured location in my professional office, which will only be accessible to me in a locked filing cabinet; after such time, I will shred all written data.

Additional Protections

One or more instances may have presented that would require additional protection of coresearchers, or of the clients with whom they were working in the context of cotherapy dyads described during the interview process. Such instances were most likely to involve potential dual relationships or conflicts of interest, psychological distress, and mandated reporting of abuse or neglect, or of professional misconduct. I thorough described each of these issues in the informed consent process and, ultimately, no such instances occurred.

Dual relationships and conflicts of interest. One of the primary risks to participants existed in the inherent power differential of the supervisory relationship and the potential impact on those relationships that providing process feedback in the interviews might have. For example, if one of the interns experienced their working relationship in the cotherapy dyad to be unhelpful or otherwise negative, he or she may

have been hesitant to speak about that in a fully transparent way due to the fear of how the supervisor may interpret and then respond to that information. Considering this, I took additional steps to de-identify each coresearcher when reporting direct data in the results/analysis narrative. Depending on the content of direct data (i.e., quotes from coresearchers that exemplify certain themes), I was faced with the need to exclude certain details about the clinical sessions or clients being seen that would reveal the identity of the coresearcher to his or her cotherapy partner without changing or detracting from the parts of the data that spoke to the research questions and results being reported. I also used gender neutral language when referring to the supervisors to further de-identify the participants. The member checking portion of the research process allowed coresearchers to review these modifications in the results section and request changes or deletions if they believed they had not been adequately de-identified.

Additionally, my own membership in the clinical community and status as a counselor educator and supervisor had the potential to create some dual relationships of which I needed to make coresearchers aware. Given the closeness of the clinical community from which the sample was drawn, it was very likely that coresearchers who agreed to participate in this study knew me in some way, either as a colleague or former instructor. As such, it was necessary for me to clearly review the nature of confidentiality in much the same manner I would do with a client and provide coresearchers the opportunity to remove themselves from the study at any time should they become uncomfortable or if a conflict presented. For each of these issues, however, risk was considered relatively low because the training counselors receive in their

graduate programs includes information pertaining to research practices; thus, each participant entered into the study with some foundational knowledge that enhanced informed consent.

Psychological distress. Although the psychological risks to coresearchers were thought to be relatively low, this remained a consideration nonetheless. It was possible that coresearchers may have experienced psychological distress during the interview process, and I made resources in the form of referrals as needed. Of note is that distress management is a natural part of the supervisory process, and counselors are specifically trained to attend to their own psychological needs. Based on the professional training each coresearcher was presumed to have undergone, I assumed them capable of self-assessing if they were experiencing distress and whether their distress would best be addressed via a supervisory consultation (e.g., an intern who is struggling with a skills issue or a challenging client), or a therapeutic referral (e.g., a professional who reveals personal challenges that interfere with his or her work with clients). Through the interview process and subsequent follow-up with coresearchers, no such instances became evident.

Mandated reporting. Finally, a situation may have arisen in which a coresearcher reports an instance of professional misconduct or a client scenario in which mandated reporting regulations applied. Action in response to reports of professional misconduct would be driven by principle 1.6 of the AAMFT ethical code (2012) and principle 71 of the National Board for Certified Counselors (NBCC) ethical code, which refers reports of misconduct to applicable state laws, and subsequently to applicable state

code (NAC 641A.243), which mandates the reporting of any "unlicensed, unauthorized, unqualified, or unethical practice of marriage and family therapy" (as stated in item 8 and further defined by NAC 641A.256) to the State Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors. Guiding codes of ethics for reporting procedures were selected based on applicable state laws governing the standards of practice and professional affiliations of MFTs and CPC in the state in which the study took place. Non-egregious offenses (i.e., those with no clear legal violation as defined by state law or with no clear detrimental impact to clients or supervisees) would be handled in accordance with professional best practices, to include a thorough consideration of the factors involved in the suspected misconduct, reference to applicable codes of ethics, professional consultation, and/or a direct conversation with the professional with whom the misconduct is suspected to have occurred (Bush, Connell, & Denney, 2006).

Action in response to mandating reporting requirements would be determined based on whether the suspected violation had already been reported to the necessary authorities or otherwise addressed within the context of the professional relationship. Examples of mandated reporting issues include risk of harm to self or others, as well as suspected cases of child or elder abuse or neglect. If such information had arisen during the interviews, I would have asked coresearchers to confirm whether necessary courses of action had been taken and whether the primary clinical supervisor had been made aware of the issue. If the coresearcher answered in the negative (i.e., no report has been made in cases where a report is necessary), I would have referred them immediately to their

clinical supervisor for follow-up. The likelihood of such occurrences was low because the participants, as counselors, were already held to these standards and were expected to be aware of mandated reporting procedures; hence, no such instances occurred.

Summary

In the preceding chapter, I outlined the methodological steps and ethical considerations for this qualitative transcendental phenomenological study exploring the experiences of counselors and postgraduate counseling interns who participated in cotherapy dyads as part of their clinical training, in particular as it applies to the interns' self-efficacy and clinical competency in couple and family therapy. Following a process of conducting individual semi-structured interviews with the interns, I used a modified version of the Stevick-Colaizzi-Keen method, as described by Moustakas (1994), to create a composite description of the essence of the phenomenon under examination. In the following chapter, I present the results of this analysis in detail.

Chapter 4: Results

My aim for this study was to examine the experiences of MCFC supervisees who have participated in cotherapy with one or more clinical supervisors as part of their professional training. I was interested in how these professionals viewed their experiences of cotherapy in relation to self-efficacy and clinical competency in their postgraduate work with couples and family systems. The primary research question was: What is the lived experience of being a marriage, couple, and family therapy intern who participates in a cotherapy relationship with his or her clinical supervisor? An additional question was: How do these interns perceive the cotherapy relationship to impact their self-efficacy and clinical competence about their therapeutic work with couples and families?

In this chapter, I provide a summary of the participant demographics and the applied research process, followed by a description of the major themes that emerged from the analysis. The themes I identified developed into a directional flow from contributing factors to the perceived success of cotherapy, and to the participants' belief in their development of self-efficacy and clinical competency.

Setting

At the time the interviews took place, five of the seven participants were working in private practice settings (three of them in the same practice as their supervisor), one in a community mental health agency, and one in a combination of school and private practice settings. Each coresearcher selected the date, time, and location of his or her interview based on availability and preferences. I conducted six interviews in

interviewees' private offices at their places of employment, and one interview took place in my private office. There were no known factors or conditions present that would have influenced the interview processes or the interpretation of study results.

Demographics

I identified seven professionals during the purposive, criterion-based sampling procedure who volunteered to offer their phenomenological perspectives for this study. Criteria for this study required that participants (a) currently held a state-issued license to practice counseling or who were postgraduate interns under the supervision of a clinical supervisor who was qualified as defined by state statute to oversee their work with couples and families, and who (b) participated during their internship in an ongoing cotherapy relationship with one or more clinical supervisors to include work with one or more client systems over a period of at least 3 months. Use of these criteria ensured that participants had met a minimum standard for practice and had sufficient exposure to the cotherapy process to be able to describe their experience and reflect on their own progress during that time. Due to the limitation of the conditional practice stipulations of CPC in the state in which this study took place and my role as a professional in the community, several potential respondents were turned away due to either their lack of experience with couples and families or due to a conflict of interest with me as the researcher.

Of the 12 professionals who expressed interest in participating, seven met the inclusion criteria. Five identified as female and two as male. They ranged in age from 31 to 58 years ($M = 27$), and had been practicing marriage, couple, and family counseling

for between 2 and 9 years ($M = 5.7$). Five of the seven were fully licensed as MFTs with less than 5 years of experience after the completion of their internships; the other two were licensed as MFT postgraduate interns at the time the interviews were conducted. Six of the participants graduated from a local university with CACREP accreditation, and the seventh graduated from another West coast university that was pending CACREP accreditation at the time of degree conferment. The recruitment process revealed a shortage of clinical supervisors in the selected area who were employing cotherapy practices with their supervisees. Therefore, the accounts are limited to experiences with only two clinical supervisors in the professional community. A brief introduction to each of the coresearchers is included in the section to follow.

Belle

At the time of the interview, Belle held a license as an MFT and had been in practice for approximately 6 years; 2 and a half of those years were in internship. Her primary work setting was in a part-time private practice. Belle and her supervisor participated in cotherapy with one couple for a period of 6 months, with sessions occurring on a bi-weekly basis. She was invited to cotherapy by her supervisor and, despite some initial anxiety, accepted the invitation as a challenge and "an honor." Belle's primary clinical supervisor was her only cotherapy partner.

Chantelle

Chantelle was designated as a postgraduate MFT intern at the time of the interview and was working full-time in an agency setting that provided services

primarily to youth and their families. She had been in practice just under 2 years, which signified the half-way point of her internship. Chantelle had been invited to do cotherapy with her primary supervisor and had worked with two couples, each on a weekly basis, for an estimated 12 to 15 sessions. One couple was seeking help to reconcile their relationship while the other was struggling to blend their family. Chantelle's primary clinical supervisor was her only cotherapy partner.

Darcy

Darcy was a fully licensed MFT who had been practicing for approximately 7 years, 3 of which were in internship and the remainder in private practice. She was invited to participate in cotherapy with her primary clinical supervisor and estimated that over a period of 3 years had seen three to six client systems to include both couples and families. Darcy's primary clinical supervisor was her only cotherapy partner.

Grace

As a fully licensed MFT of nearly 10 years, Grace was working full time in private practice. Her internship was estimated to have spanned a 5-year period, during which she participated in cotherapy with both her primary and secondary supervisors for about 24 sessions. Grace recalled that it was a mutual decision to enter into a cotherapy relationship in both instances and that the majority of her sessions were with her primary supervisor and a small handful with her secondary supervisor. Sessions varied from weekly to monthly schedules with six different client systems that included couples experiencing relational stressors and families struggling with issues such as substance use, adolescent defiance, and mood disruptions.

Jane

Jane had been licensed as an MFT for approximately 3 years at the time of the interview, with about 2 years of internship preceding; she was working full time in private practice. Jane volunteered for cotherapy when the invitation was presented to a supervision group. Jane participated in cotherapy with both her primary and secondary supervisors, seeing two client systems with one and three with the other. While not all concurrently, sessions occurred on a weekly basis for a span of 1 year. She also cofacilitated therapy groups with non-supervising peers, although those experiences were not included in her interview data.

Matthew

At the time of the interview, Matthew had been an MFT intern for approximately 3 years and was nearing the completion of his required hours. His primary work setting was in a school, working with young adolescents and their families. He was invited into a cotherapy relationship with his primary supervisor, and they had been working with a couple for almost 2 years. Sessions occurred weekly to start, and tapered in frequency over time and with fluctuation of acuity. Matthew's primary supervisor was his only cotherapy partner.

Roger

Roger had been a practicing MFT in private practice for over 6 years, with 2 and a half years of internship prior to licensure. He described the invitation to cotherapy as having been "mutually discussed" between him and his primary supervisor and as completely voluntary in nature. Roger and his supervisor worked with two separate

client systems, one blended family and one couple, from the initial visit through to successful termination of care; sessions occurred weekly or bi-weekly, depending on need. Roger's primary supervisor was his only cotherapy partner.

Review of Data Collection

I conducted seven interviews with professionals who volunteered to participate in this study. Each coresearcher participated in the full semi-structured interview process, as detailed below.

Interview Structure and Data Management

I conducted each interview face to face with the participants at a location of their choosing. I traveled to the offices of six of the interviewees at their request for the duration of the 45 to 60-minute primary interviews; the seventh interview was conducted in my office. I began the semi-structured interview with a review of the informed consent document and provided participants with an opportunity to ask questions or state concerns regarding the research and interview process; I followed this with the collection of brief demographic data. The interview itself consisted of a series of questions regarding each participant's experience of cotherapy, including overall impressions of the process as well as the structure of their cotherapy sessions (e.g., what a cotherapy encounter would typically involve from start to finish. I provided the participants with working definitions for the constructs of self-efficacy and clinical competency (Appendix C), and asked them to provide reflections about how cotherapy may have developed these skills and attributes.

I used a small audio-visual recording device to capture the conversations, which I then uploaded to a computer file for transfer to a medical transcriptionist using a secure website. Transcripts were returned via e-mail within a 48-hour window. I stored the hard-copy data files in a Health Insurance Portability and Accountability Act (HIPAA) compliant filing system at my professional office. I de-identified sources of data through a numerical coding system to match each participant's interview with their consent paperwork and transcript, and pseudonyms were assigned to each for use in the narrative. Given the limited representation of supervisors being discussed by respondents, I also removed any identifying information that might indicate the supervisors' identities or association with clients or interns (i.e., names and gender). I made no deviations to the plan detailed in Chapter 3, and no unusual circumstances interfered with the data collection process.

Review of Data Analysis

I began the data analysis with a simultaneous review of each written transcription with the recorded interview, both to correct any transcription errors that may have changed the meaning of a statement and to layer the transcripts with relevant nonverbal data such as the insertion of emphasis or use of gesture to convey meaning. Using a modified Stevick-Colaizzi-Keen analysis method as outlined by Moustakas (1994), I identified descriptive statements that addressed participants' experiences, beliefs, thoughts, and feelings regarding their cotherapy and professional development. As I reviewed each transcript and created lists and groupings of related material, I noticed

common components that created opportunities for what participants considered successful cotherapy; these opportunities are represented as subthemes.

I identified the subthemes of individual factors, supervisory relationship, and process and structure of cotherapy as appropriate descriptors of participants' data on conditions that contributed to effective cotherapy. These conditions contributed to how participants relayed their experiences with cotherapy, indicating how participants believed they grew professionally in self-efficacy and clinical competency. I expand on each of these areas in full in the results section below, following a description of measures used to ensure trustworthiness of the study.

Evidence of Trustworthiness

Trustworthiness in qualitative research is measured by several indicators that examine the rigor and relevance of a study. In the next section I provide a brief definition of each and the steps taken to incorporate appropriate measures into the research design and process.

Credibility. Credibility is an indicator of the extent to which a study is measuring that which it was designed to measure. For a phenomenological study, internal validity, in the form of credibility, speaks to the accuracy with which the results of the study describe the phenomenon being explored (Shenton, 2004). To ensure credibility in this study using the methods outlined by Shenton (2004), I first developed and provided operational definitions of the key phenomena so that the coresearchers and I would be speaking the same professional language. Prior to each interview during the informed consent process, as well as during each interview, I defined cotherapy, self-

efficacy, and clinical competency. A variety of widely known resources in the MCFC profession were used to confirm that I was providing an accurate account of each construct.

Additionally, I considered the idea of "prolonged engagement." Lincoln and Guba (1985) addressed the usefulness of a researcher's ability to obtain an intimate understanding of the culture or phenomena under investigation. While I did not actively engage with the coresearchers for the study at hand, I possess a background as a practicing MCFC who has provided academic instruction and clinical supervision in the region in which each of them practices. Therefore, I was familiar with the climate and culture in which each of them is working and of the colleagues we share.

Finally, I used triangulation to ensure I captured participants' experiences while avoiding my own projections. Triangulation is a process by which additional sources of data are used to increase the strength of the findings by providing varied perspectives on the phenomena that may support, expand upon, or challenge the researcher's interpretation of the data (Lincoln & Guba, 1985; Patton, 2002; Shenton, 2004). I routinely consulted with trusted peers during the data analysis and sought feedback about themes I may have missed or overrepresented. Dissertation committee members were also involved in the review process and provided feedback about the reporting of themes and overall analysis.

Transferability. Transferability is often compared with the quality indicator of external validity in quantitative research, or the measure of how applicable the results of a study are to populations outside the participant group. The goal of this qualitative

research was to generate descriptive information that can be extrapolated into informed hypotheses regarding the applicability of the findings to other supervisory situations (Patton, 2002). I ensured transferability through accurate reporting of the settings and people involved. By providing information about each of the coresearchers' personal, professional, and academic characteristics, as well as the current professional climate in which they are practicing, I allowed readers to make decisions about the applicability of the information based on their own work and professional communities. I provided this information in Chapter 3 as well as in the Participant Demographics section above.

Dependability. Dependability is a criterion that relies heavily on steps taken to ensure credibility and is parallel to the quality indicator of reliability in quantitative research (Lincoln & Guba, 1985; Shenton, 2004). I established dependability through ongoing record-keeping of steps taken throughout the progression of this project to delineate, step by step, the methodology and data analysis process.

Confirmability. Confirmability in qualitative research indicates the degree to which the findings of a given study are representative of the data collected from the sources themselves (in this case, the interns who volunteered their time and experiences to inform this research question), as opposed to those of the researcher (Morrow, 2005; Shenton, 2004). Within a transcendental phenomenological research design, confirmability seems to have relevance due to the assumed potential for researcher bias. I utilized both a reflective journal and the *epoche* procedure to help me me clearly illuminate my own experiences and hold them in a separate space from the accounts provided by the participants. As described in Chapter 3, *epoche* is a reflective process

that allows a researcher to set aside what he or she believes to be known and embrace an openness to what may be learned through the eyes of others, as if the phenomenon had never before been observed (Giorgi, 2009; Laverty, 2003; Moustakas, 1994). To achieve this in a manner consistent with Husserl's philosophy of transcendental phenomenology, I set aside time to reflect on my own experiences as a MCFC trainee and cotherapy partner in as clear and specific detail as possible; this provided an awareness of bias potential and the ability to take conscious action to remediate bias when it surfaced in the analysis (Moustakes, 1994; Sheehan, 2014). Additionally, drawing from and including direct quotes from the participants' accounts of their lived experiences provided a pure source of data that is not influenced in any way by interpretive bias (Morrow, 2005).

Results

I identified several themes in the data that highlighted commonalities in how the participants viewed their experiences with cotherapy during supervision (See Appendix D for raw transcripts). An essential theme emerged that represented several conditions that existed prior to the commencement of cotherapy. Interviewees described these conditions to have provided growth opportunities that contributed to a perception that cotherapy was an effective or successful supervisory experience. A second essential theme emerged representing several factors that occurred during transformation, which contributed to the development of the participants' perceived self-efficacy and clinical competency in their work as MCFCs, and the overall value they derived from their supervisory experience as a whole (Fig. 1).

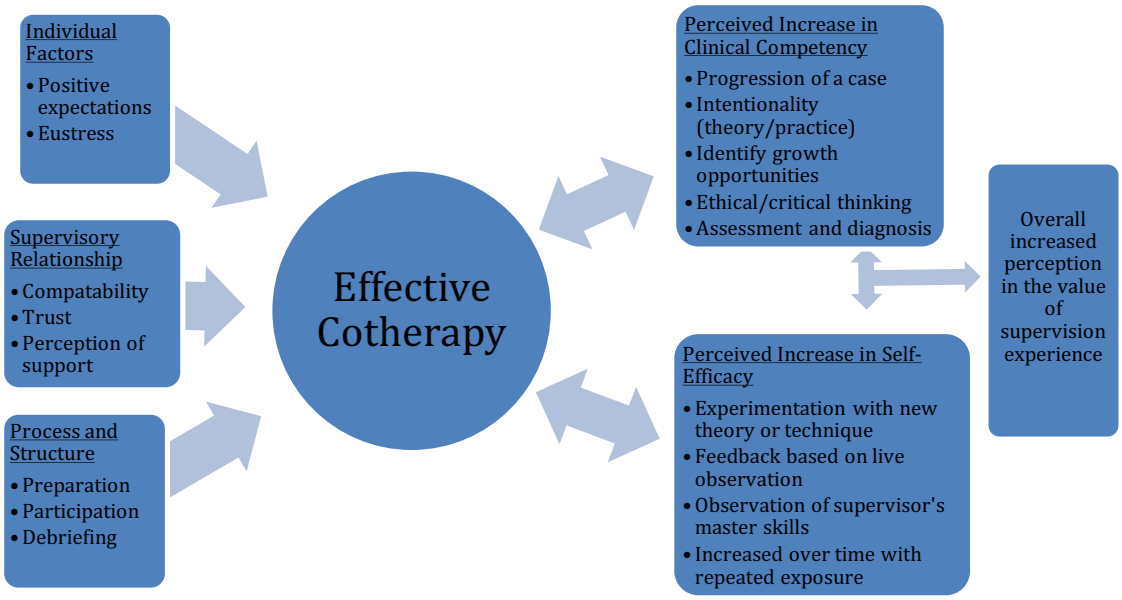

Figure 1. Conditions for effective cotherapy in supervision.

Conditions Present for Growth Opportunities

Participants in this study described several conditions that had an impact on their experience of cotherapy with their supervisors, and in particular toward a positive perception of the experience as a growth opportunity. Each of these informed the first essential theme of Conditions Present for Growth Opportunities, and represent factors at the individual, relational, and structural levels.

Individual attributes and expectations. Individual attributes described by participants fell into two subthemes that related to their expectations of what the experience of cotherapy with their supervisor was going to be like, and the level of anxiety or fear they had going into the experience, and how that fear was ultimately managed. I explain each of these elements in the subheadings below.

Positive Expectations. Most of the participants stated that they were looking forward to or had positive expectations of what they were going to gain from doing cotherapy with their supervisor, despite any trepidations they reported. Statements such as "I knew that I would learn a lot" and "it was mutually agreed upon… that we would do that and it would be helpful" characterized the overall message conveyed in this area. One coresearcher, Darcy, told me:

> I intentionally did that [cotherapy] because I wanted to be better at what I did, and I knew I could be better at what I did. And so I wanted to be in situations where I would be watched and I would get better feedback . . . And so, I would say that, that ultimately kind of putting myself in that place to learn more, kind of an edge where it would be maybe more challenging or scarier that, that I would be a better therapist as a result of that, and that was true. That was definitely true.

Chantelle provided another account of positive expectations when she reflected:

> That's what helps me building confidence, is to sort of take the risk of jumping in. And saying, "yeah, I will do cotherapy with somebody I completely respect and admire and who's been doing this a really long time." And jumping in and saying, "okay, I'm not going to be like them. I can be as good as. . . [my supervisor] is." And I want to learn. I want to get to that place.

The consensus among the coresearchers was that they voluntarily agreed to participate in cotherapy because they expected it to be a valuable learning experience, regardless of the degree of anxiety they had going into the process in the beginning.

Eustress versus distress. Most of the participants described their fear or anxiety as part of the growth process. For them, it was something that motivated them to do well and which did not pose a permanent barrier to growth. Eustress, as opposed to distress, is just such a phenomenon. Eustress, or positive stress, is said to create an environment conducive to improved performance in comparison to distress, which poses a barrier to performance (Hargrove, Becker, & Hargrove, 2015). As one participant stated, "It scared me to death [laughter] but then, um, it was probably one of the more special parts of my internship." Several of the professionals who provided data for this project noted that they agreed to participate in cotherapy as a way to challenge their anxiety and, without using the exact language, to create an opportunity to grow from eustress. This was evident in several of the quotes about expectations, and was reiterated by Jane when she reflected that "there were challenges and it was hard and scary and uncomfortable, and I think that created change, but I don't think it ever hindered me in any way."

For some coresearchers, this anxiety manifested out of a perceived lack of competence in the early phases of their young careers. As Roger recalled, "the majority of my time as an intern, I questioned myself regularly. I questioned if I was knowledgeable, if I was skilled." Grace expressed a similar sentiment with her recollection of experiencing "anxiety as a new intern and, 'am I doing it correctly, am I not doing it correctly?' And the desire to want to do it correctly." She later added,

> in the beginning I wasn't really comfortable speaking. Just as an introvert I was shy and not really sure what to say or when it was my place to jump in. . . . looking back now I can see that it was really just about fear. Fear of taking a risk,

> fear of being outside of what I already knew, um, and what I already knew how to do well, um, and being in a session and feeling like I don't know what to say or I don't know how to be.

The common feature in these responses is that each of these professionals expressed a strong desire to be competent clinicians, and initial uncertainties about how to either engage in the cotherapy relationship itself or with their supervisor as a different type of consultant. For example, Darcy articulated that her supervisor often led the session debriefing "especially at the beginning, um, because I probably didn't have enough confidence to bring something up. Or really know what to ask. It was really new and [my supervisor], I was really nervous around [them]."

Participants' anxiety, at times, also overlapped with the relational factor of respect. Darcy said of her supervisor that "[They're] really good at what [they do] and, uh, [they're] really smart so I kind of took a cautious path. . . because I had so much admiration for my supervisor, I was more nervous and I was more timid." Similarly, Matthew spoke of a fear of judgment and a desire for his supervisor's approval:

> I valued [their] opinion, right? And I wanted to make, you know, to be a good therapist was really important. Or a good enough therapist was really important to me, you know? So I was always aware of that. Certainly we create our own response to things and our anxiety. . . and I was always aware of that.

This anxiety, however, was described as manageable and temporary by each of the coresearchers. As I discuss in Chapter 5, under different circumstances and styles of managing that anxiety, the professionals may have expressed a much different

experience. As a discrepant case in the experience of anxiety, however, Matthew elaborated:

> I think, at least in the beginning, what was really a barrier for me is um, my worry about how I'm being perceived by my supervisor and being judged and I think that really held me back. . . In the beginning, there was actually a fair amount of discomfort, to be honest, because of that fear of judgment and to try to manage that I was, um, I was really wanting [my supervisor] to um, really explicitly say the things that I was doing well. . . I don't think [my supervisor] was doing that to an amount that I would be able to manage my anxiety, so I kind of wished that [they] had.

Ultimately, Matthew described being able to seek that feedback specifically from his supervisor, which allowed for a turning point in the relationship that reinforced his motivation and desire for continued cotherapy, even though it took him some time in working up to that conversation as the relationship grew and his anxiety decreased. The fruitfulness of this growth opportunity between Matthew and his supervisor relied heavily on the supervisory relationship, which surfaced as another condition of great influence on the experience described by the participants in this study.

Perceived quality of the supervisory relationship. One thing was evident during my conversations with the coresearchers in this project: each conveyed a tremendous amount of respect and gratitude for their clinical supervisors, a condition which cannot be ignored in this analysis. This respect and gratitude filtered into three subthemes of compatibility, trust, and a perception of support.

Compatibility. This theme was described by several of the participants as being almost an unspoken phenomenon that just *was*, as opposed to something that needed to be discussed and developed. Belle recalled of her experience that "It's almost like we had a kind of body language where [my supervisor] could tell that I had a question or something." She added:

> And that's always been a personal challenge, like 'who do I need to be to do this,' and always trying to be authentic, and like going, 'okay, you don't really have to be anybody but you.' And that's, that is what it [cotherapy] gave me. And even more so doing cotherapy with [my supervisor], um, to sit there and watch [them] and be an equal partner in the process in working with this couple that had some really important stuff going on. . . We were together providing the best setting, the best holding place for this couple to figure out what was going on.

Grace similarly described her perception of the fluidity of the cotherapy relationship and the balance of their mutual participation. She noted that

> I have a feel for [my supervisor's] supervision style, and I think [they] had a feel for some of my clinical styles. But I had a feel for who [they were] as a person and I think [they] likewise had a feel for who I am, um, which I think allowed us to probably have more of a fluid relationship in those sessions.

Roger relayed a similar experience when he stated,

> I think our roles kind of, you know, there was a cohesion in our roles and we – the interplay of the therapist with how we aligned and joined the client systems really took, you know. Formed well and performed well.

Trust. While compatibility seemed to come naturally for most of the coresearchers without much intentional effort, trust was something that was built over time and with experiences in group, individual, and cotherapy settings. Given that each intern had interviewed and selected their primary supervisors prior to initiating a supervision relationship, compatibility was presumably established early. Trust, especially within the novel cotherapy relationship, was not assumed to exist prior to the interns' exposure to their supervisors in a co-therapist role. As Belle admitted, she initially struggled with her supervisor's style of giving feedback. This supervisor "could be a little rough," which often resulted in Belle feeling hurt or embarrassed because of her deep desire to gain her supervisor's respect and approval. Her assessment that "he worked real hard to understand my depth of respect and admiration. . . he was very good about giving me positive and negative feedback" added to the trust that was established in the relationship and her ability to more clearly hear the supervisor's feedback in order to make the changes necessary for her professional growth.

One primary ingredient to the development of trust was the supervisors' ability to create safety in the relationship and in the therapy room. This idea was exemplified by comments such as "knowing that it was a safe place to try my wings," "I knew that [they] wouldn't set me up to fail," and "it was. . . reassuring in that point that I had a supervisor who stood up for me." Grace expanded on her appreciation of being "stood up" for when she described a situation in which a client family was dismissive of her participation:

> Um, because if he had handled that in some way that made me feel less than or perhaps he didn't draw some of those lines, you know, I wonder how that would

> have gone differently. But he was very, um, supportive of the cotherapy and he was very supportive of, you know, if he's going to draw this line of 'these are joint sessions' and he's not going to have me left out at the last minute. . . So, he was very, very considerate of, you know, what that was and establishing those boundaries with clients.

As Grace emphasized, and which was reflected by her cohort in this project, safety in the supervisory relationship was typically developed through a series of meaningful situations or interactions in which the supervisor demonstrated respect for the intern and a desire to provide a layer of protection. As Matthew stated, "when things go south, they're going to be there."

Once trust was established for these professionals and their supervisors, the level of comfort grew to allow for growth opportunities that related directly to self-efficacy and clinical competence. Jane spoke of having "a safety net of knowing that I could take risks therapeutically with clients and that no harm would really be done because I was, there was a safeguard there." Roger expressed similar appreciation when he stated, "If I didn't trust my supervisor, if there was a hierarchical difference and there was too much of a, a threatening distance, then my growth couldn't happen. But it did."

Support. Respondents consistently discussed support in the context of how it helped to build trust between the supervisees and their supervisors to the degree that it warranted its own sub-theme within the relational factors. Coresearchers in this project had countless recollections of the ways in which they perceived support from their

supervisors. "The support was incredible" is a quote that appeared in many variations throughout the interviews and within many antidotes about shared sessions.

Belle recounted a difficult client couple, in response to which her supervisor "reiterated to me that I was able to pull that [talent of working with "repellant" people] up and be respectful and non-judgmental, but real and authentic." This encouragement helped her to transcend her countertransference and resume a therapeutic presence for this client system. She elaborated on "watching someone who's an expert." For Belle,

> seeing [my supervisor] put into practice what [they were] teaching us in theory. . . and in [their] skillful way guiding us to do with the questions [they] asked and, um, the way [they] would kind of set us up to do things and push us a little bit… watching [them] do that it made it alive.

Her final thoughts included the sentiment that "I felt like there was so much generosity in [my supervisor's] spirit to share that kind of stuff with us and I never felt like [they were] blowing smoke up your skirt."

Chantelle believed that her supervisor "was very interested in my perspective, um, what I thought was happening." She reflected on their debriefing time and how she was supported to discuss her thoughts about the session and the clients they had seen together. Her supervisor often invited her to begin their sessions with clients, and "seeing the process of having someone believe in me and know they believed that I could do it and then figuring out that I could – that I believe in myself, too."

Darcy expressed appreciation for her supervisor's ability to recognize her process and provide support to work through challenges she faced. She recalls a time in which

her supervisor noticed that she was struggling and said to her, "You're having trouble with the male of the couple," and that "[my supervisor] didn't over interpret that. . . there was a lot of opportunity for me to talk about what I thought that was, and then sort of leading into how that might shift how I worked with him." She spoke of her belief that "the level of intimacy in the room is just so profound and I think I would have eventually learned to do that, but not as fast as I did." This intimacy described not only the therapeutic process, but of the level of familiarity and openness between she and her supervisor. She recalled the gentle prodding her supervisor provided when, in her own personal struggle outside the therapy room, she began to take "a back seat" during the cotherapy. She was invited back into the process in a way that created safety and encouragement. In a similar vein, Matthew described that in instances in which his insecurities came to the forefront of his cotherapy work and caused him to become quiet, 'his supervisor often offered "this little head nod that, like, 'Go ahead, jump in any time.'" This nonverbal feedback gave him a chance to reflect on his participation and challenge himself to contribute more to the session.

Jane's perception of support related most to her perception that her supervisors really believed in her ability to do good therapeutic work. In her words,

> any time I questioned my ability or my competency, I could always fall back on, 'well, they believe in me enough to know that I can do this work. Otherwise they wouldn't have invited me to be a part of this. They wouldn't have subjected these clients to my – to me.' I could always fall back on that, and I think that was really important.

The interns' recognition of their supervisors' ability in all of these instances to offer confidence in their work was a common occurrence. Matthew embodied the collective thoughts of the supervisees when he said, "It was never a threatening relationship or a threatening environment. And while there was always hierarchy in the supervisor and supervisor role, that power differential was minimized for the benefit of the client system." He later added, "Again, it comes down to safety, and the supervisor really prioritizing that level of comfort. Had the supervisor not known that, I imagine I would have had a different taste in my mouth."

The structure and process of cotherapy. The final condition present for growth opportunities related to how the supervisors structured the cotherapy sessions, and the investment of time that each of them made to help supervisees prepare for and debrief from each session.

Preparation. One common occurrence in most of the accounts of the cotherapy process was time set aside prior to the session to discuss relevant information such as a recap of the prior session, conceptualization of the couple or family, and any plans or tasks for the upcoming sessions. This time ranged from just a few minutes and up to a half an hour. These meetings ranged in their degree of formality, with both Roger and Matthew recalling a more structured format to their preparation time. Matthew recalled that his preparatory time with his supervisor would be spent

> to review kind of the – what we had seen in the previous session, talk about maybe goals for the session and, um, really strategize on how we wanted to structure the session, things we wanted to bring up. And I would, I would

> actually verbalize maybe personal goals that I would have, like maybe there would be times where I didn't think I was, you know, um, participating enough or talking enough and I would take that time to kind of process, you know, what was going on for me in terms of, you know, thoughts and feelings during sessions.

Similarly, Roger described his time as "a training opportunity." He elaborated that

> we would meet prior to the sessions to review the treatment goals, the systemic opportunities. We tried to understand the clients. We used, uh, genograms. We talked about systemic patterns. We also shot the elephant in the room that it was an intern with a supervisor in the room, so we addressed and identified all of those regularly. Prior to every one of those sessions we would, um, really examine the therapist's sense of self, but it was different, because the therapist was a dyad.

Others in the interview cohort described a similar, yet slightly less formal or structured format to their pre-session preparation meetings. Chantelle and Darcy both described that their supervisors would check in with them to see how they thought the treatment was progressing and what ideas they had about important themes or tasks for the upcoming session. For Chantelle, this occurred through a gradual shifting of power in the conversation which eventually led to the supervisor asking her, "'What do you want? How do you want this to go? What do you think should happen?' And [my supervisor} was really guiding me to think about my – the intention of the session and what I wanted the intention to be." Darcy stated that, while the agenda and task-setting were "held pretty loosely," that ultimately "We always had an agreement that we would go into the session with something but, of course, if something emerged from the family or the

couple that was more urgent we would switch." In this way, there was flexibility in the planning that allowed for some clinical responsiveness and the development of creativity.

Sometimes, however, this time was simply used as a check in for the cotherapy intern, which for some was just as valuable as the clinical preparation. To Roger's point of exploring the self of the therapist, others in the internship position were asked casually how they were feeling on a given day, if they had any thoughts or concerns about the session to come or the client system with whom they were preparing to meet. In this way, these professionals expressed a sense of being cared for and of having importance in the relationship.

Of note, there was one outlying response from Jane. In her experience, there was no formal meeting before her sessions. However, the preparation was built into a part of the larger supervision group of which she was a member with her supervisor and a co-supervisor as the facilitators. In presenting the client system to the supervision group, she and her supervisor achieved the tasks of "preparing for and discussing how we were going to move through the next session, and then during the session I think that really evolved and changed." Jane's comment reflects again on the flexibility and creative responsiveness that naturally became part of the training process as client systems brought their own goals and conflicts to the sessions.

Participation. In discussing the structure of the actual client sessions, all of the participants described an equality that developed in their roles as co-therapists. Darcy expressed this gradual shift from observer to participant when she reminisced that she

> let [my supervisor] sort of lead. . . I watched him introduce people to the space and, uh, kind of lead the assessment process. And then I would chime in here and there, and as we developed a better cotherapy relationship and I got more skilled, then it was more collaborative and egalitarian.

As Grace developed in her relationship with her supervisor, she recalled that "there was no 'this is when I talk and this is when you talk' kind of scenario. . . from the get go we were a therapist team and that was the clients' understanding. . . Then every time they came in it was mutual effort." Belle's recollection of her relationship with her supervisor was similar in terms of having and being "an equal partner," with the added appreciation for having developed "confidence that, um, we were together providing the best setting, the best holding place for this couple to figure out what was going on."

Another recurring element in the session structure was a felt experience of being encouraged to push beyond the current skill or comfort level. In Belle's eyes, this was viewed as a "generosity of spirit," that her supervisor gave her support to participate "as much or as little, um, although actually pushed a lot more for much instead of little!" Chantelle remembered a similar invitation, and a process through which she was able to observe her supervisor begin the sessions before she was ultimately encouraged to take on the role. Each of the respondents expressed their recognition of having been provided opportunities to increase their comfort and level of participation as they grew in their cotherapy relationships. Matthew's relationship grew to a point at which he and his supervisor were able to support and play off one another during sessions:

> the structure of it, it was kind of back and forth. There would be time that my supervisor would maybe see things that um, she wanted to address right away and I wasn't necessarily catching on to it or I was kind of going in another direction, and um, or we would just kind of pass things off and kind of include the other therapist, like, 'What do you think about that?' or 'I know you've had experience with that kind of thing. What might you be able to add?'

Debriefing. In reviewing all of the descriptions the coresearchers provided with regard to the preparation for, participation in, and debriefing from their cotherapy sessions, it seems that the most significant aspects of the developmental progress occurred in this latter process. While the debriefing meetings ranged from just a few minutes to upwards of an hour and a half, the focus was very similar. All of the interns reported being asked to describe their impressions of the session that had just occurred in terms of how they perceived their own performance to have been, what the therapy dyad accomplished, and what new pieces they may have gleaned to enrich the overall case conceptualization and create next steps in the therapeutic process. In all the cases, the supervisors elicited the interns' thoughts about these things, and would contribute their own. Darcy expressed additional gratitude and surprise at her supervisor's "ability to elicit my feedback of [supervisor's] work."

In addition to providing a place to explore reflections on the sessions, the debriefing also offered an opportunity to address specific areas of professional development. Chantelle recalled that "sometimes we talked about theory. Sometimes we talked about personality structure and how that played into the couples and what was

going on with them. Sometimes [my supervisor] would give recommendations for reading or, you know, resources." Grace's supervisor would often take time to create a progress note of the session together, which she found to be of value because it provided "more knowledge than I had coming out of school. Kind of, you know, watching somebody create their clinical interpretation onto a progress note." Jane's supervisor used their debriefings to help further her diagnostic skills. "Having the experiential part of the session and then being able to have a face and move through the criteria of the DSM with supervisors was extremely valuable to me." The diagnosis, then, was also said to inform their shared conceptualization of the treatment goals and assessing progress and regression.

As opposed to the preparatory meetings, the debriefings seemed to offer a different type of value to these professionals in having the actual, first-hand, clinical data as a shared reference for these conversations. Grace, for example, stated that these debriefings were, for her, the most valuable part of the cotherapy experience because "I was able to check my clinical skills in the session and get either guidance to do things differently or reassurance that I was doing things, um, clinically appropriate. . . And that probably facilitated not only my competencies, but my efficacy." In one way or another, each of the professionals providing information for this study described an element of their debriefing meetings in which they were able to seek specific feedback, express their doubts, and receive affirmation of their skills based on what their supervisors had directly observed of them.

The Lived Experience of Cotherapy

The overall lived experience of cotherapy can be encapsulated in several words expressed by the professionals who shared their memories; "special," "priceless," "immensely valuable" and "grateful" are among these words. At multiple points in each of the interviews, these professionals spoke of the value of the presence and involvement of their supervisors before, during, and after the sessions, indicating that the essence of cotherapy is contained in the process by which it occurs and the way in which both the supervisor and supervisee make use of the opportunities contained within that process. Feedback, encouragement, conceptualizations, developing skills and knowledge, and the supervisory relationship itself were all supported and nurtured by this level of contact with the clinical supervisor. In Jane's words, cotherapy "had the most impact on me throughout my whole internship and in my whole supervision experience."

In Belle's perspective, "It's one thing to sit and report something kind of flat and two dimensional like a case. No matter how you do it, it's people on a piece of paper and you're doing second-hand reporting and this was, for lack of a better word, more intimate." For Darcy, the "felt experience of being in the room" taught her how to create "an intimate and private and deep and personal" healing environment, which under less involved supervision methods would be "so hard to teach." Matthew supported these thoughts when he commented about the challenges that existed when he was trying to fully comprehend all the layers of relationships and interactions when working with systems:

> I think cotherapy in general just allows those complexities to, um, be more deeply understood. . . I don't think, if you don't have cotherapy I don't think you're going to get that with a couple. I don't think you'll even get it with a family. I mean that, that adds so much more complexity when you're having four or five, even more people in the room.

Roger offered additional support for this idea in his assertion that,

> I am of the notion cotherapy, especially cotherapy with two professionals who aren't necessarily equals, so two therapists where one is more seasoned and experienced than the other, I think that's an ideal therapeutic modality. You have multiple brains, but competent brains in the room at the same time. So, if there is a cooperative, uh, a tandem approach of two therapists, I believe that they will be able to recognize, treat, triage a client system better than an individual therapist would. . . I sure wish it was a modality that was promoted more. . . I believe that the educational opportunities are indescribable and open-ended. A solo therapist, especially somebody in an internship or young in their career, they don't know what they don't know.

While the majority of reflections were of a positive nature, there were two outlying perceptions with regard to the type of support respondents wished they had received, despite their overall appreciation for having participated in cotherapy. In elaboration of Matthew's comments about his anxiety during the early stages of his internship and the cotherapy relationship (see *Eustress vs. Distress*), he described being very aware of his desire for positive, encouraging feedback. In his words,

> I was really wanting [my supervisor] to, um, really explicitly say the things that I was doing well. I'm not sure [my supervisor] – I don't believe [my supervisor] was doing that to an amount that I would be able to manage my anxiety, so I kind of wished [my supervisor] had, um – that might have been purposeful on her behalf, but – and I actually remember in group supervision I really, that came to a head and I had to – I really wanted [my supervisor] to give me that feedback. So I wasn't forthcoming and actually, in the moment, letting [my supervisor] know that that's what I needed – and actually wanted – so we never really had that conversation. So, uh, certainly a lot of discomfort and anxiety in the beginning about that.

As someone who placed a high value on affirmative feedback from his supervisor, Matthew's perception of "not enough" led to a conflict in the supervisory relationship that ultimately the dyad was able to repair because of their established trust and rapport. Once Matthew expressed his desire to his supervisor, they were able to process the conflict in the context of their mutual developmental goals for the supervisee.

A second outlying perception came from Grace, who wanted a more structured approach at times when it came to the procedural aspects of practicing therapy. As she recalled, her supervisor "was not huge into paperwork." She added,

> I think that coming into it I think there was a discrepancy just in terms of, like, when [my supervisor] came into doing this work and . . . as younger folks are coming into doing this work there's a different belief system maybe on what needs to be there in terms of paperwork.

Grace's comments indicated the presence of a generational gap in the profession that, while not considered by her to be a barrier, did pose what she termed "a challenge."

Jane offered insight on another perceived challenge that, while not a negative influence on her own cotherapy experience, may have potential to interrupt someone else's development due to the differences in what supervisors might expect from their interns. Unlike the other professionals who allowed me to interview them, Jane was able to do cotherapy with two different supervisors during the same period of time. She stated:

> it certainly was a challenge to balance different ways of doing [therapy] because I think early on I had a tendency to, to want to know the right way to do therapy, um, so it was a challenge for me to have two really completely different people, different mentors, different supervisors doing therapy in a different way, um, so balancing that. And I think it the end it just helped to show there's not a right way to do therapy. . . So I don't know that it was a hindrance as much as it was a benefit, but it was a challenge for me trying to figure out what's right and how do I do this right, and [one supervisor] does it this way and [the other supervisor] does it this way.

Jane was able to work with both supervisors to develop her own style and identity that integrated lessons learned from both co-therapists, rather than becoming more confused and stunted in her growth.

Hypothetical reflections: What would have changed my experience? The more common response to my inquiries about the experience of doing cotherapy, and in

particular to my exploration of challenges or barriers perceived by the coresearchers, was framed in hypothetical terms. That is, the majority of respondents stated that they had not directly encountered anything in the cotherapy process or relationship which they believed to pose a hindrance, yet some were able to identify things that likely would have been problematic had they occurred.

Chantelle, for example, was aware that her supervisor's ability to navigate the roles of supervisor and co-therapist was an essential skill that, if lacking, would have made the process difficult for her.

> I imagine if a supervisor just said 'good luck' and or, or not let – if it was extreme in one way or another. Rather than a little balance, uh, just, 'here's the intern'. . . 'They're here to give you therapy and I'm just watching.' And, or vice versa. You know, I don't know if it would have been horrible had I just been watching but I think I was very, um, it was – I really liked being able to participate. . . Because there's an expert in the room and a novice in the room, it's really easy for the novice to just kind of follow.

In this reflection, Chantelle is highlighting a perception of the difference for her between direct observation and cotherapy as supervisory modalities, with cotherapy being a more valuable approach for her.

Similarly, Roger commented on how his supervisor's ability to manage the power differential in an effective way was of great value toward the success of his experience:

> I didn't have any negative experiences. However, if I look back at my – with my first couple of sessions with my supervisor, and I really try to concentrate on the

> fact that I was nervous, intimidated. If my supervisor didn't have – was not effective at minimizing that and transitioning that into comfort and productivity, if that hadn't happened, I envision that cotherapy could be disastrous. Ultimately for the client, and secondarily, uh, it would have a negative impact on the intern's growth. It could stifle their growth. That did not happen with me.

Transformation and Professional Development

Through the relational, personal, and procedural aspects of cotherapy as a supervision modality, a professional transformation seemed to occur for the participants in this study. Each of these elements, and many in overlapping ways, were believed to have contributed to the development of the necessary skills to become competent and effective counselors. By asking each coresearcher about their perceptions of their own clinical competency and self-efficacy, and how they saw those constructs in the context of their cotherapy experience, I could understand how they believed these factors to have been critical.

Clinical competency. Competency is generally defined as being demonstrated when a professional has the knowledge and skills necessary to practice his or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards (Falender & Shafranske, 2004). For those who practice MCFC, competency is collectively defined by professional and credentialing organizations such as AAMFT (2004), CACREP (2009), and NCA (n.d.). For the purposes of this study, I used the AAMFT guidelines as a reference point as they are the primary standards used for supervision in the state in which this study took place by AAMFT-Approved Supervisors

for the ultimate evaluation of interns' performance during internship. There are currently 128 competencies in six skills areas that describe expectations for MCFC, each of which translates to a professional's conceptual, perceptual, executive, evaluative, and professional abilities (Lee & Nelson, 2014). These skill areas include admission to treatment assessment and diagnosis, treatment planning and case management, therapeutic interventions, legal and ethical issues, and research and program evaluation. Several categories emerged that represent overlapping skills in these areas; each will be described in the sections to follow.

Understanding the progression of a case. The "Admission to treatment" section of the AAMFT clinical competencies speaks to many of the procedural components to working with couples and families from intake to termination, including documentation, informed consent, session structure, and rapport-building (among many other elements). Accounts provided by the coresearchers encompassed many of the ways in which the supervisors were able to model these to their intern co-therapists. For example, Matthew's supervisor requested that he keep his own case notes to practice documentation. Belle recalled that her supervisor "had kind of the same way that [supervisor] would check in with the couple" and that she became comfortable with kicking off their sessions (and her own) after observing this process several times. Chantelle's supervisor also modeled elements of a therapeutic encounter:

> The cotherapy experience showed me where I want to be. It showed me, um. . . I mean, I knew that that was the case with my supervisor – that [supervisor] was, you know, advanced and at the highest level. . . But to see it in action, to see

> [supervisor] interact with clients, to have such intention every time. And not just with one session, but from the very first phone call, to have sort of this intention case formulation and then, to the very last conversation with the clients. It was masterful.

Jane spoke about the value in learning the business and mechanics of therapy from her co-therapist supervisor that she did not thoroughly learn in her graduate program and which initially was a source of great discomfort. In her words:

> even just learning how to accept money from clients, and how to talk about, 'okay, your co-pay for your insurance is this much' or, um, you know, 'we end at this time,' or how to deal with silence or how to deal with seating arrangements or how. . . All of those small things that created anxiety for me in the beginning, I didn't even have to ask questions. I just was. . . it was just like osmosis being in the experience of it and being able to have somebody else guide me and, I think, really that helped form the way that I structure a session, the way I do therapy.

Darcy reflected many of Jane's ideas, with the added reflection that her supervisor taught her about "what to do in the room and how to do it well, and timing and pacing. . . . [My supervisor] went slower than anybody I had worked with. . . just letting people talk, listening, and pulling up the feelings. . . and then more seems to happen in the end."

Assessment and diagnosis. This competency area encompasses all of the elements of assessing and conceptualizing a client system, and making a clinical diagnosis if appropriate. Each of the professionals I interviewed mentioned their diagnostic skillset evolving through the course of cotherapy. Darcy spoke of the value of

observing "somebody that talented and effective," while Grace was appreciative of being able to work as a team, "coming up with the diagnosis together, reviewing symptoms that we picked up on that may have been slightly different than the other person [saw]." Jane also spoke of the collaborative diagnostic process, with particular focus on "the experiential part of the session and then being able to have a face and move through the criteria in the DSM with supervisors."

Their cohorts in this study had other ideas about what they learned in this area regarding the nuances of systemic therapies and diagnosing with multiple people in the room. Darcy noted that,

> in general, my assessment process and diagnosis process improved. Even being able to pick up little things like, uh, traits of personality disorders which are much more. . . subtle, and certainly when other people don't have, you know, full blown personality disorders that would be recognizable in the room and then how to pick up on those little subtle things because that's not necessarily something you can get from a client report.

In his recollection of diagnosing and making case conceptualizations, Matthew asserted:

> Couples counseling, as you know, can be really complex and I think cotherapy really allowed the complexity to be more deeply understood because you have another set of eyes and for both our parts, for both of our perspectives that happened a lot, you know? As my supervisor would be talking with one of the members I could watch the other member and when I saw a need to call out, you know, how they're being affected by what the other two are doing and what the

> partner is saying. . . I could call that out and it's a little more difficult when you're alone.

Intentionality in use of theory and technique. Another common and important subtheme falls under the competency areas of Treatment Planning and Therapeutic Interventions; the comments provided by the respondents in this study seemed to fall under the categories of intentionality within the sessions, and the translation of theory into practice. There is some overlap with intentionality and the coresearcher's descriptions of their preparation meetings. For most of them, that time was used to discuss their plan for the coming session based on what the client system had brought to the previous session, while at the same time allowing for some flexibility for new issues or topics that emerged as more pressing. Roger described this occurring through conversations in which he and his supervisor

> discussed some of the core competencies to focus on, because my supervisor and I started peeling apart the systemic lens, and the client systems. We therefore had intentionality during a session based on the coaching that took place prior to the session . . . So I think that is the difference maker. We essentially set the table with our ideas prior to the session, and that carried into the session . . . Because you had two therapeutic brains who are pretty well trained, who are now combining and coming up with different ideas so there's a more comprehensive approach to treatment.

The other piece of this intentionality related heavily to these professionals' views on how they incorporated theory into their therapeutic practice, and their supervisors'

contributions to how that was able to happen for them. Jane stated this succinctly when she said, "Some [theoretical knowledge] I might have developed . . . in my Master's program, but I think the application of all of them certainly was from cotherapy." Darcy recalled her ability to deepen her application of theory and technique:

> Like I could learn [theory-specific] techniques and, and my supervisor was good about knowing that was something I did and wanted to do more of and so [my supervisor] would frame feedback in that way and help me continue to grow and develop those skills. Phenomenally useful. But even things I didn't know I was doing, [my supervisor] would point out.

Matthew expressed a similar experience in that his cotherapy work was "theory and technique driven." In addition to feedback that focused on those particular elements, he found value in

> watching a master therapist and really the nuts and bolts, the technique, the language used, um, you know, the process. And that was just a wealth of information because all of those things are really important to me and it allowed me to even further advance those.

Ethical and critical thinking. A counselor's ability to appropriately address legal and ethical issues in a timely manner is of the utmost importance; so much so that an MCFC in the state in which this study took place must acquire annual continuing education in this area as part of their license renewal. The professionals who reflected on their cotherapy experiences for this study recalled a variety of moments in which learning from their supervisor how to respond to challenging situations helped them become more

confident in doing so on their own later. Some of the client systems described presented with members who displayed "sexually predatory" behavior, verbal aggression, or who indicated that a child was being abused or neglected. They could process countertransference and assess for risk, address behaviors in the moment and ensure the safety of the therapeutic team and other members of the system, and make necessary referrals to Child Protective Services, respectively.

Beyond some of the more clear-cut challenges described above, Darcy was also met with a specific opportunity to consider the multicultural elements of a client system, which was an important part of developing critical thinking and responding appropriately:

> She [a member of the client system] was raised in the U.S., but her dad was from [another country] . . . She experienced a lot of discrimination just in her work and just being who she was in the world at this time, and in the U.S. So noticing how [my supervisor] handled that and how fluid he was and how we sort of, I don't know, maybe more sensitivity in certain interventions to ensure that there wasn't a power dynamic or we weren't being condescending, or not taking into account her race and the difficulties that created for her in work and life.

A final aspect of critical thinking that came up for both Darcy and Chantelle related to their supervisors' willingness to evoke their thoughts about the supervisors' performance, and to provide feedback about the session. Darcy expressed appreciation for her supervisor's "ability to elicit my feedback of his work . . . Somewhere along the way [my supervisor] started asking me about that and then [my supervisor] would ask me

even more, and then sometimes [my supervisor would] be like, 'that might not have been the best thing to do' [in reference to his own work]." Per Chantelle, her supervisor "was very interested in my perspective, um, what I thought was happening." This was reported to have helped them gain confidence in both their work and in the supervisory relationships.

Identification of growth opportunities. While not related to a specific competency, it is of note that coresearchers made several comments about how their work in cotherapy and the specific feedback provided by their supervisors based on their observations helped them to identify areas in need of development. Grace recalled that the convenience of having debriefing time allowed for immediate opportunities to seek clarification or direction. "If I had questions about documentation or questions about, um, how to handle…vulnerable populations, confidentiality around minors. . . things that would just come up naturally in the midst of learning how to do the job and meeting new clients." According to Roger, "I didn't know what I didn't know until I had a very talented supervisor – and I did – who would sit down with me and review the core competencies. And several of them specifically as we would prepare for a session together."

Self-efficacy. Self-efficacy is a state in which a person believes in his or her ability to perform a given task with some degree of confidence that success, however that may be defined, is possible (Bandura, 1982; 1989). As new experiences are observed, attempted, and mastered, self-efficacy is said to increase (Bandura, 1971). In Roger's words,

> Cotherapy with my supervisor without a doubt improved my self-efficacy. Because I admired and saw my supervisor as very competent and talented. And when I recognized that I could hang with him, and we could be productive together, I had to accept that I was also competent and efficacious as a therapist because I was doing the work with the person that I saw as competent and efficacious.

When asked to describe their perception of self-efficacy, interviewees spoke of a gradual development of this construct over time that had specific impact on several areas of their work because of two distinct features of cotherapy and the inherent building blocks of Social Learning Theory – the were able to see, do, receive feedback, and do again, ad infinitum throughout the course of the therapeutic and supervisory relationships.

Observation of supervisor's mastered skills. One of the important parts of cotherapy identified by the coresearchers was being able to observe the work of their supervisors, whom they believed to be masters of the trade. Statements such as "I don't know that there's another way to teach [the nuances of therapy] except for invite somebody into the room and say, 'watch this, and then try to do it with me'" were a common theme throughout the interviews.

Belle shared that, for her, the most facilitative part of cotherapy was to observe her supervisor, "an expert." She recalled that "Seeing [my supervisor] put into practice what [my supervisor] was teaching us in theory. . . watching [my supervisor] do that made it alive." Mathew echoed this sentiment with his reflection that seeing his supervisor's choice of language, body language, vocal tone and pace, and the client

processes and data his supervisor responded to was "really, really helpful." Along the same vein, Darcy stated,

> All of [the cotherapy] certainly contributed, but there's still this piece for me about being in the room with somebody who's a master of this. Like just being able to be part of that dynamic that [my supervisor] established in the room and I could just, sometimes witness and sometimes have a felt experience of it and sometimes join in it, and then of course, more and more being able to create that sort of environment myself. That is so difficult to teach somebody because it's not a technique.

She later added, "I think that the level of intimacy in the room is just so profound and I think I would have eventually learned to do that, but not as fast as I did."

Experimentation with new theory or technique. Many of the thoughts participants shared about the observational process overlapped with the contributing professionals' willingness and confidence to try on alternative theories, and to test out skills and techniques that were foreign to them. Belle referred to the cotherapy relationship as one in which "it was a safe place to try my wings." Analogously, Jane expressed that cotherapy with her supervisor provided a "safety net of knowing that I could take risks therapeutically with clients and that no harm would really be done because I was – there was a safeguard there." As an extension of having a "safeguard" to protect the client and supervisee in the cotherapy session, many of the respondents spoke of their experience having observed their supervisors attempt an intervention that fell flat

and the value in seeing how they recovered from it without damaging rapport. Chantelle revealed that she learned a lot about recovering from her co-therapist supervisor.

> I could throw something out that I was thinking and if it didn't – if it didn't go well or if it wasn't received really well, we could work it out. And that's something I really learned and I really loved about being part of the cotherapy relationship because we could help each other kind of recover if we needed to.

Jane expressed a similar experience about observing her supervisor take therapeutic risks, and learning vicariously from the modeling of those risks. She said,

> because I have relationships with each of [my supervisors], knowing that they weren't comfortable yet trying something new, maybe trying a different technique or working from a different theory or establishing a different dynamic in the relationship . . . Watching them work through that discomfort or uncertainty or anxiety about it – watching them model that I think was really helpful, showing me that I could do that and showing me that even though they weren't perfect at whatever they were demonstrating, it still had a pretty positive impact on a client. It didn't have to be perfect.

Matthew summarized this phenomenon well with his remark that, "when things go south, they're going to be there. I think that's a really key component."

Feedback based on live observation. Each of the coresearchers expressed a deep appreciation for the feedback they received from their supervisors throughout their internships, yet the feedback gained from their supervisors' direct observations and felt experiences of their work were reported to have been the most impactful. This impact

was related to the immediacy and accuracy of the feedback, and a greater sense of trust in the feedback due to the supervisors' exposure to their work. As Jane indicated, "It just allowed me to trust my own observations of what was happening in a session because I could compare and contrast with what my supervisors were observing."

Darcy shared her perspective on the value of having her supervisor in the therapy room in receiving useful feedback:

> I got a lot more feedback about my sort of particular, um, I can't think of the word. We'll go with 'quirks' (laughs). Like my personality, right? And like, you know, like the delay in responding, or things that I might say that weren't carefully worded, or could have been worded more carefully and better thought out, as well as things I did well that I would not have thought of, um, got pointed out. So, to me that helped me grow as a therapist, probably more than any other supervision I had, really, because it was son personal and we were in the same room with the same people. And it's even different, I think, than watching a tape of my therapy work, so I would say hands down it was the most growthful."

Grace endorsed this view with her experience that, "the whole dynamic function is different and maybe even some of the feedback might be slightly different" with regard to doing group supervision "reviewing your tape and trying to present exactly what was going on," versus cotherapy with individual debriefing.

In addition to receiving this immediate and accurate feedback, some of the professionals were challenged to accept their own skill levels in ways they had not previously done. Matthew expressed gratitude for the positive input he received:

> When [my supervisor] would maybe point out things that [supervisor] appreciated about what I had done, it was pretty golden. . . and I realized I'm kind of good at this and I'm on the right track and that helped me. . . gain confidence to take more risks.

Roger found himself challenged in this way as he grew to accept that he was, indeed, an effective therapist:

> And it absolutely helped, uh, performing cotherapy with my supervisor. Just again because I think of my supervisor as very talented - very, very good at the art of therapy. And if my supervisor recognized those qualities in me, my self-esteem and self-concept as a therapist rose . . . If I can conceptualize that [my supervisor] knows what he is talking about.

Increased over time with repeated exposure. Self-efficacy was described to be a fluid construct that developed as the professionals matured through their cotherapy relationships and gained in experience working with a variety of client systems alongside their supervisors. A common pattern began with interns tentatively entering sessions, allowing their supervisors to take the lead and waiting to be drawn into the session. Chantelle remembered being "very hesitant to jump in" with a particularly dynamic, "rapid-fire" couple. She went on to say,

> And then I have a supervisor who I really respect and I'm like, you know, 'go ahead and handle this' (laughs). And, uh, so I was very timid at first to – it took quite a while for me to know that the confidence in myself and the self-efficacy,

> as you point out – that I could jump in and I have really valid statements and thoughts to contribute and reflections to make . . . Seeing the process of having somebody believe in me and know that they believed I could do it and then figuring out that I could. . . That I believe in myself, too.

Grace alluded to her unfamiliarity with cotherapy as part of her initial anxieties about participating. "It wasn't something that we did in school, and so the idea of having somebody right there who has a lot of expertise can be intimidating at first." As her relationships with her supervisor and the client systems grew, so did her comfort with the cotherapy process and her overall level of participation.

Personality was also cited by some as being a contributing factor to initial anxieties. Jane referred to herself as "an introvert" who, at the outset, was "shy and not really sure what to say or when it was my place to jump in." Over time, she became "more vocal as each of those relationships developed." She stated that she is now able to stand behind the work that she does with pride. "I have made a lot of reflection about how I've evolved in that way. I certainly wasn't efficacious in the beginning, um, but I do have a certain level of confidence now in the work that I do."

Summary

In summary, the coresearchers provided many insights into their lived experiences as MCFC interns participating in cotherapy with their clinical supervisors. Their detailed accounts revealed that individual influences such as trainee expectations and manageable anxiety, along with the presence of trust, respect, and support in the supervisory relationship as they flowed through a structured cotherapy process created opportunities

for successful cotherapy experiences. Through these experiences, the contributing professionals believed they were able to grow in several aspects of their clinical competency and perceived self-efficacy; the research cohort described experiences of increased confidence in demonstrating theory and technique through the direct observation of their supervisors' abilities in combination with feedback gleaned from supervisors' observations of them, as well as a sense of competence in core areas such as assessment and diagnosis, clinical intentionality, ethical practice, and the ability to progress through a case from initiation to termination.

Information gleaned from these professionals' experiences may offer guidance for supervisors who are interested in incorporating cotherapy into their repertoires, as well as directions for future research about the varying aspects of the practice. In the next and final chapter, I discuss the ways in which these findings confirm much of the historical research about the benefits of cotherapy in supervision. I also provide a review of this study's limitations and offer recommendations on how these findings may serve to guide the effective use of this practice by contemporary supervisors toward the development of trainees' clinical competence in the areas specified by professional organizations, as well as their self-efficacy as independent practitioners. Finally, I discuss implications of the findings and their potential impact on positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

My purpose for this study was to explore the experiences of MCFC trainees who had the opportunity to participate in cotherapy with one or more clinical supervisors over the course of their postgraduate internship. My aim was to understand how these trainees viewed their experiences in cotherapy and how they believed their experiences contributed to their clinical competency and self-efficacy. What I learned from my coresearchers may be useful to MCFC supervisors who wish to utilize cotherapy with trainees to facilitate professional growth on a broader level. I also confirmed prior research findings by demonstrating that trainee expectations and manageable anxiety, along with the presence of trust, respect, and support in the supervisory relationship throughout cotherapy led to successful cotherapy experiences. Through these experiences, the contributing professionals believed they were able to grow in several aspects of their clinical competency and perceived self-efficacy. I explore these ideas further in this chapter and will inform recommendations for their application and further research.

Overview and Interpretation of Findings

The results of my study indicated that there were a variety of elements related to trainees' expectations and anxiety about cotherapy, their perceptions of the quality of the supervisory relationship, and the way in which they believed the structure of cotherapy influenced their growth in clinical competency and self-efficacy. These elements were reflective of conditions present for growth and do not represent a comprehensive model for the implementation of cotherapy in clinical supervision. However, these themes offer

insight into what this group of MCFC trainees found to be instrumental in their successful professional development, which is consistent with current research on counselor development at the postgraduate practicum level. For example, in a small Internet survey of MCFC graduate students and recent graduates, Piercy et al. (2016) found that participants routinely identified experiential training modalities as one of the most impactful experiences in their academic careers.

The overarching purpose of clinical supervision is for a senior member of a profession to oversee and develop the skills of a novice member of that profession (Bernard & Goodyear, 2009). This senior clinician is tasked with providing ongoing guidance, support, and direction regarding techniques or interventions based on identified learning goals (Milne, 2007), and in accordance with the relational and systemic models unique to MCFC (AAMFT, 2014). Beyond the development of skills and knowledge, clinical supervisors must also attend to trainees' development of a professional identity consistent with the MCFC specialty, self-care strategies that prevent burnout, along with personal insight and the ability to self-supervise that result in autonomous and ethical practitioners (Allanach, 2009; Bernard & Goodyear, 2009; Milne, 2007; Schofield & Grant, 2013). As one modality for providing a more hands-on method of clinical supervision, cotherapy is a potential means for accomplishing these goals using social and experiential learning modalities. I discuss these principles in the context of the findings described in the sections to follow.

Conditions Present for Growth

Participants' highlighted several elements that they believed to have contributed

to their overall perceptions of the growth opportunities available in cotherapy. These can be loosely categorized as individual (expectations and anxiety), relational (trust and support with supervisors), and structural (how the cotherapy transpired).

Trainees' expectations and preliminary stress. The first major finding was that participants' expectations for cotherapy and their level of distress entering into the experience impacted their overall evaluation of the experience and their growth throughout. Many of the participants described an eagerness to learn from their supervisor through cotherapy and a level of anxiety that was, for all but one, manageable and facilitative of their performance. Participants who expressed openness to being challenged by the cotherapy experience and an excitement for what it might offer ultimately described their experience as worthwhile and impactful on their professional development. The participant who initially struggled to reduce his anxiety was less sure of the value of the cotherapy experience until such time that his anxiety moved from distress to eustress, at which point he described being more engaged in the process and open to learning.

This finding suggests that trainees who have a positive expectation about participating in cotherapy, and anxiety that is facilitative of growth rather than inhibiting (i.e., eustress as described by Hargrove, Becker, & Hargrove, 2015), may be more likely to perceive the experience and their performance in a positive light and thus be more open to what the process has to offer. This is consistent with Barnes' (2004) assertion that higher levels of anxiety are often predictors of lower levels of perceived self-efficacy in counseling trainees. Consequently, this finding may suggest that trainees who exhibit

high levels of distress or negative expectations of cotherapy may not be ideal candidates for the modality.

Perceived quality of the supervisory relationship. Congruent with other literature, the quality of the supervisory relationship surfaced as an essential element contributing to the efficacy of cotherapy. Three major findings within this theme emerged in the data analysis. First, when supervisees perceived a mutual trust with their supervisor, they described a positive learning experience. This is consistent with the safety described in McCandless and Etough's (2012) examination of the importance of the supervisory relationship in developing reflexive learning in counseling trainees. For participants in this study, trusting that their supervisor(s) were present and capable, and believing that their supervisor(s) believed in their ability to be present and capable, was an instrumental part of developing a positive view of the cotherapy experience and their ability to learn and perform.

Second, perceived compatibility between supervisor and supervisee regarding shared conceptualizations, treatment approaches, and clinical values was an important contribution to a positive perception of the cotherapy experience for participants. This finding is reflective of the features and characteristics described by others who have examined effective cotherapy relationships, which included personality, theoretical orientation, and effective balance of power (Bernard, Drob, & Lifshutz, 1987; Bridboard & DeLucia-Waak, 2011).

Finally, when trainees believed they were supported by their supervisor, trust was established and facilitated the positive learning experience described in the first finding.

Support in a supervisory relationship was described by participants to encompass a variety of behaviors that contributed to their trust. Supervisors who "stood up for" their trainees in difficult situations with clients, encouraged trainees to participate and try new things in session, stepped in when the trainee struggled, recognized and relayed trainees' strengths, and explored self-of-the-therapist concerns with trainees were thought to be supportive. Paez (2010) collected similar responses in a study examining relational factors that facilitated self-efficacy in counseling trainees.

Each of these findings in combination informed my conclusion that supervisory relationships that are perceived by trainees to be trustworthy, supportive, and compatible are more likely to contribute to positive learning outcomes in cotherapy. Supervisors who are unable to develop these relational qualities with supervisees may struggle with the implementation of effective cotherapy, and trainees may be less inclined to perceive the modality as helpful.

Structure and process of cotherapy. Each of the coresearchers in this project described a cotherapy structure that included a preparatory meeting prior to the cotherapy session, processes within the session itself, and a debriefing meeting post-session. While each of these encounters differed within and between cotherapy teams from session to session, they were present for the most part. From this theme, three findings emerged related to structure and process of cotherapy.

First, regardless of length of time, trainees appreciated an opportunity to discuss session goals, review progress, ask questions, and receive feedback or direction prior to the cotherapy session. The process of these meetings shifted over time with trainees

typically taking a more passive role in the early stages of the cotherapy relationship and gradually increasing in their confidence to lead the discussion. This shift was often facilitated when the supervisor, using the support and trust in the relationship, encouraged the trainees to be more active and autonomous in their conceptualizations and reflections. This finding is consistent with Yerushalmi and Kron's (2001) examination of a participant-observer model of supervision in which trainees demonstrated a stronger professional identity through their exposure to supervisors' clinical work and opportunities to further define and expand their own skills and strengths. This finding is also reflective of the developmental process described by Bischoff and Barton (2002), in which trainees perceive themselves to be more competent in their skills and knowledge as they progress in their training experiences.

This was related to the second finding that trainees preferred the same flexibility regarding their participation to observation ratios in session, with gentle encouragement from their supervisors as they went along. Participants cited that the ability to observe their supervisors' work was a valuable component of being in session with their supervisor, which will be discussed further in the context of self-efficacy.

Finally, effective debriefings were scheduled in proximity of the cotherapy session and included solicitation of trainees' perspectives, feedback relating to their performance in the preceding session, and case conceptualizations about the progress and treatment development. Coresearchers' accounts of both structure and process were indicative that the cotherapy session alone is not sufficient to result in a comprehensive learning experience. To maximize the training goals, supervisors must make the therapy

process transparent from start to finish, including the mechanisms being used that translates theory into practice. Respondents agreed that both preparation and debriefing played an integral role in creating this transparency that facilitated effective learning. Consistent with the principles of experiential learning theory, including a debriefing period after cotherapy sessions allowed for the necessary reflection that would assist in learning as the learner interacted with new material (e.g., case conceptualizations, diagnostic quandaries, and application of theory-specific skills or techniques; Fowler, 2008; Kolb, 1984).

Contributions to Professional Development

The primary measures of professional development in this study were clinical competency and self-efficacy, each of which was operationalized for the participants using commonly understood definitions and professional resources to guide their reflections. The coresearchers in this study provided information that suggests cotherapy as a supervision tool provided specific learning opportunities in these areas of development.

Clinical competence. For this study, I defined clinical competence as occurring when a professional has the knowledge and skills necessary to practice his or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards (Falender & Shafranske, 2004). Miller, Todahl, and Platt (2010) added that MCFC competencies are continually developing in response to changing professional climates and values. I chose to utilize the core standards of practice published by AAMFT (2004) as a reference for self-evaluation and reflection, knowing that each

professional who participated in the study was working with AAMFT-approved clinical supervisors and were likely to be familiar with the resource. When invited to reflect on their areas of perceived competence, participants identified several core skill or knowledge areas that they believed to have been augmented by their cotherapy work. Participants spoke to having had valuable exposure to the lifespan of a case from intake to termination, increased intentionality through the translation of theory into practice, improved confidence and ability in navigating ethical situations and thinking critically about their work with clients, and improved confidence and accuracy with assessing and diagnosing client systems. This finding led to the conclusion that specific skills and knowledge areas can be developed through the cotherapy process, particularly when that process is inclusive of preparatory and debriefing meetings before and after the clinical session in which those skill and knowledge areas can be addressed.

Self-efficacy. I defined self-efficacy for respondents as a person's state of believing in his or her ability to perform a given task with some degree of confidence that success, however that may be defined, is possible (Bandura, 1982; 1989). This definition was shared without the added background theories of social and experiential learning to preserve the purity of reflections and to reduce biased or overly theorized responses. Responses reflected the underlying functions of those theories as having been perceived to be important elements of the cotherapy experience.

The primary functions described by the coresearchers included a perceived value in the ability to directly observe the work of their supervisors (who most categorized as being at the master level), an appreciation for the feedback they received about their

work, and the ability to experiment with new skills and ways of being in session with the safety of their mentor beside them. Through this process, each noted the development of a sense of self-efficacy over time with repeated exposure and feedback. Each of these elements bears consistency with the premise of social learning theory, which posits that a combination of direct experience, observation of others, feedback, and successes serve to promote repetition of those behaviors and a developed sense of self-efficacy (Bandura, 1971). Similarly, the experiential learning model proposes that taking both a participant and observer role in a learning process and having opportunities to think about and enact the knowledge areas in different ways is a highly effective means of learning (Kolb, 1984). Features of these learning theories were evident in reflections on competency and self-efficacy and were also throughout the trainees' descriptions of their preparatory and debriefing meetings and client sessions. This has informed the conclusion that cotherapy is a training modality that can encompass many of the essential processes of both social and experiential learning theories to provide a meaningful experience to MCFC trainees.

Limitations of the Study

The primary limitation in this study relates to my own postgraduate MCFC training. I once met the inclusion criteria for this study myself as a licensed MCFC intern in the state in which this study was conducted who was participating in cotherapy with my clinical supervisor. My positive experience with the principle phenomenon under study created a potential for bias and a threat to the trustworthiness of the research had I not chosen an appropriate research design and taken active steps to mitigate the risk. I selected a transcendental phenomenological research design, which has a process of

separating a researcher's own experiences from those providing accounts of their lived experiences built into the analysis procedure. Additionally, I used colleagues and dissertation committee members to review my final analysis against accounts of my own experiences to ensure that I provided the purest description possible as relayed by the research participants. By including direct quotes in my final reporting of findings in addition to the raw transcripts, I also sought to reduce any misconstrued interpretations of what I learned from respondents. Direct quotes also served to provide readers the opportunity to determine the relevance of these findings to their own professional environments.

A second limitation of the study arose from the limited population from which to draw a sample. At the time of research design and participant recruitment, there were 300 licensed MFT interns (BOE, personal communication, May 28, 2014) working under the supervision of 89 approved supervisors statewide (AAMFT, 2014b); in the Northern counties those numbers are drastically reduced to 27 approved supervisors (AAMFT, 2014b) overseeing an unknown proportion of the statewide number of licensed MFT interns (BOE, personal communication, May 28, 2014). Due to the restricted number of MCFC interns who identified as having done cotherapy with one or more clinical supervisors, I decided to expand the participant pool to include licensed professionals who could provide retrospective accounts of their experiences. My university's IRB approved an amended application detailing this expansion (approval #11-15-16-0291209), and through this modification I was able to recruit a sufficient number of colleagues to achieve saturation of data and themes. A related limitation reflected on the

supervisors practicing in the identified region. Since there were so few MCFC interns who had experienced cotherapy with a clinical supervisor, there were consequently only two supervisors represented in the data collected from the research cohort. The phenomenon of cotherapy as described by the seven professionals who volunteered their time for this study is specific to their professional culture, and the training and supervision approaches unique to their clinical supervisors; it cannot be considered representative of the larger professional population of MCFC interns and supervisors.

Finally, this study only represents professionals in the northern part of a Mountain-West state who hold a MFT internship or license. The other primary mental health counseling license in the state, that of CPC, has been undergoing a scope of practice transition over the course of several years that has sought to expand the scope of that license to include systems therapy; however, at the time of research design and recruitment the parameters had not been clearly delineated and no CPCs were identified that met the inclusion criteria. Therefore, I was not able to obtain a range of perspectives about cotherapy from other licensed professionals who identify as marriage, couple, and family counselors.

Recommendations for Further Study

Further research surrounding the applications of cotherapy as a training tool is necessary to expand upon the qualitative information provided in this study. While this study focused on the lived experiences of MCFC trainees, an augmentative study may next focus on the lived experiences of clinical supervisors and the benefits, costs, and impact on professional development they perceive to be associated with cotherapy.

Inclusion of a broader range of specific license holders who identify as MCFC (e.g., CPC or LCSW trainees who specialize in systems therapy) may also provide a more comprehensive description. As an adjunct to this work, researchers might use similar studies to broaden their focus beyond MCFC trainees to other mental health professions and associated competency areas (e.g., substance abuse counselors or psychologists). Additionally, with the elements described by coresearchers in this study as having been impactful on their perceived development of self-efficacy and clinical competency, more specific inquiry is warranted on the process or function of those elements (e.g., a more systematic breakdown of the pre- and post-session consultations, or how the supervisors incorporated specific learning goals into the cotherapy process). Furthermore, quantitative research could augment and expand the qualitative perspective in such a way that highlights outcomes of cotherapy as a learning tool. Comparing licensing exam preparedness or final scoring of trainees who did and did not have opportunities for cotherapy may be one such examination.

Implications

There are several implications that these findings may offer to the MCFC community, inclusive of consumers, providers, and supervisors. I outline the former in more detail in the social change section below, while I address the latter in the recommendations for MCFC supervisors section to follow.

Social Change

In 2012, there were a reported 24,837 Adverse Action Reports in the United States, 132 of which were in the state in which the study took place (U.S. Department of

Health and Human Services, 2017), indicating that there are tens of thousands of consumers nationally who believed that they received harmful care from a mental health professional, specifically someone who identified as a therapist or counselor, and acted to remediate that perceived harm. Examining and implementing effective training modalities is a critical piece of the gatekeeping role with which clinical supervisors are tasked. Understanding the experiences of postgraduate MCFC interns who participate in cotherapy as part of their supervision plans, especially as it relates to their confidence and skills as clinicians, may add to supervisors' repertoire of clinical training tools and ultimately help reduce potential for harm to consumers and sustain the future growth of the counseling profession. Good supervisors help develop good clinicians, and good clinicians are better equipped to carry forth the basic values of the profession.

Recommendations for MCFC Supervisors

Given the findings and associated conclusions in the preceding section, I will offer several recommendations based on the underlying principle of intentionality. Intentionality in supervision, much like in therapeutic work, is a tenet of responsible and ethical practice and thus serves as the most appropriate basis for how other supervisors might utilize these additions to the body of knowledge. Based on the findings of Nelson and Graves (2011), which suggested there is a sizeable gap between the skills and knowledge of newly graduated counselors and the expectations of their clinical supervisors upon entrance into postgraduate internship practice, attendance to specific skills development is a critical part of the process of MCFC development. Should

cotherapy be selected by supervisors as part of their development plan, there are many ways the impact may be maximized.

One of the primary steps for practitioners or supervisors in selecting a cotherapist is to assess for goodness of fit and working to establish the basis of a collaborative relationship (Dugo & Beck, 1991, 1997). Based on my findings, having a trainee as a co-therapist is no different, albeit with some distinctive initial areas of focus. Clinical supervisors wishing to invite trainees into a cotherapy relationship would likely benefit by first screening potential partners for their interest in and openness to the process of cotherapy, with a comprehensive discussion of the risks and benefits, as well as any concerns the trainee may have about what is expected of them. For trainees who express anxiety that the supervisor deems at a level of distress, these new professionals may require assistance to reduce their distress prior to initiating cotherapy, or receive close monitoring by the supervisor during the early phases of cotherapy to work through their distress (assuming that client care is not compromised in doing so).

A second measure of goodness of fit was expressed by participants as relating to trust and support. While these constructs are of the key elements in any supervisory relationship, regardless of modality (Beinart & Clohessy, 2009), they do seem to have particular relevance when cotherapy is introduced based on the information provided by the cohort of trainees in this study. Supervisors using cotherapy as a training tool may consider having open conversations throughout the cotherapy relationship to assess for perceived trust and support, and to operationalize what these constructs mean to each co-therapist trainee. In so doing, supervisors may increase trainees' sense of security in the

supervised sessions and thus increased independence (e.g., experimenting with new skills) that enhance learning and, ultimately, self-efficacy and competency (Hauer et al., 2015).

With consideration made for individual and relational elements, supervisors wishing to invite supervisees into a cotherapy relationship might next consider very carefully how they structure the process of the sessions, including pre- and post-session consultations that address needs of the trainee, the clinical dyad (trainee and supervisor as a cotherapy team), and the client system. Coresearchers in this study cited many overlapping themes in their reflections of how their supervisors structured their consultations before and after client sessions. This time was used for personal reflections and exploration of countertransference, specific needs identification and skill development, case conceptualizations, and any feedback areas relevant to the particular trainee involved. Isomorphic principles were discussed in particular by one participant, who highlighted the importance that conversations about roles and power both in and out of the cotherapy session had for his professional growth, showing consistency with research that has emphasized attendance to such constructs in supervision (Green & Dekkers, 2010; Tuckman & Finklestein, 1999). Through these pre- and post-session conversations, coresearchers described a growth in their perception of trust and support in the relationship, and their confidence to continue their clinical training by taking more risks and leaning in to the feedback their supervisors had to offer them. Therefore, supervisors should plan for additional time before and after cotherapy sessions to allow for this process to occur.

Finally, the core learning theories serving the basis for this study were described in nearly every thematic area, either directly or indirectly. Thus, supervisors using cotherapy may strive to incorporate relevant principles into the structure and process to maximize learning potential. For example, knowing that direct observation of mastered skills was instrumental for respondents' learning of new skills and techniques suggests that supervisors can incorporate skills identified as areas for development into their own practice to demonstrate more specifically for the trainee how he or she is expected to perform in the given area. Additionally, professional development in core competency areas can be maximized by making them more explicit in the pre- or post-session consultations (e.g., by using them to drive session goals or in discussing how a trainee either did or did not perform in certain areas), and through their demonstration in session by the supervisor. Intentionality and overt attendance to competency areas in clinical training is not a new concept, as they have been identified as important foundations for medical trainees (Saucier, Paré, Côtë, & Baillargeon, 2012).

Recommendations for Academia

While I limited the scope of this research to postgraduate practitioners, institutions that accredit MCFC graduate programs may have interest in the utility of cotherapy in the earlier stages of training and, by extension, the accredited institutions themselves. For example, CACREP (2015) has defined standards for professional practice that include audio, video, or live supervision of students' direct work with clients, and exposure to a variety of clinical experiences and professional practices. With a licensed, experienced supervisor as a co-therapist, graduate programs may become

better able to provide trainees with broader exposure to client systems that may otherwise be too complex or out of their current scope of competence to work with in an unsupervised session.

Conclusion

This study began with my own experience as a MCFC Intern who was offered an opportunity to do cotherapy with my primary clinical supervisor and the inspiration that followed toward wanting to understand more deeply what that experience was for others, and whether it may serve as a more widely used modality to train effective and competent therapists who would one day become my colleagues and stand beside me and my predecessors to further the profession I respect so much. Given that bias, I used a modified version of the Stevick-Colaizzi-Keen method as a procedural guide for this transcendental phenomenological study (Moustakas, 1994) and discovered that a variety of elements were present for participants that described their overall experiences and cotherapy's perceived impact on their self-efficacy and clinical competency. With attention to individual and relational elements such as anxiety and expectations and perceived trust and support in the supervisory relationship, respectively, cotherapy has the potential to create a learning opportunity that trainees may view as effective and facilitative of their professional growth. On a larger scale, supervisors and trainees together may better work toward maintaining integrity in their chosen profession and striving to provide the most ethical, competent services possible to the myriad of people who entrust them with their care.

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Appendix A: Letter of Invitation

Dear Colleague,

My name is Jennifer Dustin and I am a doctoral candidate in the Department of Human Services at Walden University. I am conducting a research study as part of the requirements of my degree in Counselor Education and Supervision, and I would like to invite you to participate. Specifically, you are receiving this letter because your name has appeared on a list of marriage, couple, and family counselors and counseling interns published by the State of Nevada Board of Examiners for MFT/CPC.

I am studying the use of cotherapy as part of the clinical training process for clinicians specializing in working with couples and families, specifically as it relates to clinical competency and self-efficacy. The research project is titled: *A Phenomenological Exploration of Counselor Development Using Cotherapy in Post-Graduate Training*.

If you decide to participate, you will be asked to meet with me for an interview about your experiences as an intern working with couples and families <u>who has participated in cotherapy with one or more clinical supervisors</u>. In particular, you will be asked questions about how your cotherapy sessions are/were conducted, how you believe your self-efficacy and clinical competency has/was developed during the course of your internship and cotherapy experiences, and the aspects of cotherapy that you have found to be helpful or not.

The meeting will take place at a mutually agreed upon time and place, and should last about 60-90 minutes.

Your participation in this study will not pose a risk to your health and safety. Potential benefits to your participation in this study include an opportunity for self-assessment that may contribute to your own development as a counselor, and which can be shared at your discretion with your clinical supervisor as part of your supervision plan (for current interns). On a broader level, your experiences may contribute to a deeper understanding of cotherapy as a training tool that can help those in the counselor education field develop more effective practices for the training of competent counselors to strengthen the counseling profession.

If you are interested in participating in this study and would like more information, please contact me at your earliest convenience. If you are not interested in participating but know of a colleague who may be, please feel free to share this information with them.

Many thanks and warm regards,

Jennifer Dustin, MFT, LCADC

Appendix B: Interview Protocol

Thank you for talking with me today. Your participation is completely voluntarily, and you can ask me to stop at any time. I will have the audiovisual recorder here to document our conversation, and a transcript of this interview will be written and used in the data analysis process. Your name will be kept confidential in the data analysis process, and in the final reporting of results.

The purpose of this interview is to examine your experience of cotherapy as part of your supervision process. You are here today because you have been identified as an MFT Intern who has participated in cotherapy with one or more of your clinical supervisors. In particular, I will be asking you questions about how you have perceived your own clinical efficacy and competency during the course of cotherapy.

If you have any questions or would like clarification about anything during the interview, please feel free to stop me at any point.

You have a right to review the final findings once they are complete, and I will provide you with a way to contact me should you be interested. If you are willing to review the results prior to publication to assist me with ensuring that I have accurately represented your experience, please let me know and I will make contact with you about this within the next several months.

Before we begin, I would like to review the informed consent document with you and obtain your signature. A copy of this form will be provided to you for your records.

Do you have any questions before we begin?

Demographic Information:

Gender:

Age:

At which university/college did you complete graduate training?

Was the program accredited?

If yes, by which organization?

Background info:

For how long have you been an MFT Intern?

For how long (or how many sessions) have you used cotherapy in your supervision practice?

With how many other partners have you done cotherapy?

Who sought whom for the cotherapy relationship(s)?

About the cotherapy process:

Tell me about how you and your supervisor have incorporated cotherapy into your supervision process.

How often?

How many different clients?

What types/constellations of clients? (e.g. diagnoses, couples, families, etc.)

Describe a typical cotherapy session with your supervisor.

Prep time?

Debriefing?

What happens during session?

When you discuss the events of a session with your supervisor, what do you typically cover?

Structure of the debriefing? (e.g., who leads? Is there a routine? If so, what is it?)

Impact of cotherapy on the identified constructs of self-efficacy and clinical competency:

Self-efficacy is a state of believing in one's ability to perform a given task with some degree of confidence that success, however that may be defined, is possible (Bandura, 1982; 1989).

Describe your current level of self-efficacy as you perceive it.

What, if any, contribution do you believe the cotherapy had on your current level of self-efficacy?

Clinical competency is generally defined as being demonstrated when a professional has the knowledge and skills necessary to practice his or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards (Falender & Shafranske, 2004). For MCFC, competency is collectively defined by professional and

credentialing organizations such as AAMFT (2004), CACREP (2009), and NCA (n.d.). Please consider the knowledge and skill areas included in this summary of competence as AAMFT defines them (*Appendix C to be provided to interviewee*), and consider how you perceive your own level or clinical competence.

Describe your current level of clinical competence as you perceive it.

What, if any, contribution do you believe the cotherapy had on your current clinical competency?

What parts of the cotherapy do you believe to be the most helpful or instrumental in your overall learning process?

To self-efficacy and/or competence in particular?

What parts of cotherapy do you believe to pose a challenge or hindrance to your learning process?

To self-efficacy and/or competence in particular?

What else might you want to add about your experiences with cotherapy that I've not asked you about specifically?

Appendix C: AAMFT Core Competencies

Clinical Competencies as Defined by American Association of Marriage & Family Therapists (2004)

Retrieved from https://www.aamft.org/imis15/Documents/MFT_Core_Competencie.pdf

Domain 1: ADMISSION TO TREATMENT

- Understand systems concepts, theories, and techniques that are foundational to the practice of marriage and family therapy
- Understand theories and techniques of individual, marital, couple, family, and group psychotherapy
- Understand the behavioral health care delivery system, its impact on the services provided, and the barriers and disparities in the system.
- Understand the risks and benefits of individual, marital, couple, family, and group psychotherapy.
- Recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, social context).
- Consider health status, mental status, other therapy, and other systems involved in the clients' lives (e.g., courts, social services).
- Recognize issues that might suggest referral for specialized evaluation, assessment, or care.

- Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors.
- Determine who should attend therapy and in what configuration (e.g., individual, couple, family, extrafamilial resources).
- Facilitate therapeutic involvement of all necessary participants in treatment.
- Explain practice setting rules, fees, rights, and responsibilities of each party, including privacy, confidentiality policies, and duty to care to client or legal guardian.
- Obtain consent to treatment from all responsible persons.
- Establish and maintain appropriate and productive therapeutic alliances with the clients.
- Solicit and use client feedback throughout the therapeutic process.
- Develop and maintain collaborative working relationships with referral resources, other practitioners involved in the clients' care, and payers.
- Manage session interactions with individuals, couples, families, and groups.
- Evaluate case for appropriateness for treatment within professional scope of practice and competence.
- Understand the legal requirements and limitations for working with vulnerable populations (e.g., minors).
- Complete case documentation in a timely manner and in accordance with relevant laws and policies.
- Develop, establish, and maintain policies for fees, payment, record keeping, and confidentiality.

Domain 2: CLINICAL ASSESSMENT & DIAGNOSIS

- Understand principles of human development; human sexuality; gender development; psychopathology; psychopharmacology; couple processes; and family development and processes (e.g., family, relational, and system dynamics).
- Understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis.
- Understand the clinical needs and implications of persons with comorbid disorders (e.g., substance abuse and mental health; heart disease and depression).
- Comprehend individual, marital, couple and family assessment instruments appropriate to presenting problem, practice setting, and cultural context.
- Understand the current models for assessment and diagnosis of mental health disorders, substance use disorders, and relational functioning.
- Understand the strengths and limitations of the models of assessment and diagnosis, especially as they relate to different cultural, economic, and ethnic groups.
- Understand the concepts of reliability and validity, their relationship to assessment instruments, and how they influence therapeutic decision making.
- Assess each clients' engagement in the change process.
- Systematically integrate client reports, observations of client behaviors, client relationship patterns, reports from other professionals, results from testing procedures, and interactions with client to guide the assessment process.

- Develop hypotheses regarding relationship patterns, their bearing on the presenting problem, and the influence of extra-therapeutic factors on client systems.
- Consider the influence of treatment on extra-therapeutic relationships.
- Consider physical/organic problems that can cause or exacerbate emotional/interpersonal symptoms.
- Diagnose and assess client behavioral and relational health problems systemically and contextually.
- Provide assessments and deliver developmentally appropriate services to clients, such as children, adolescents, elders, and persons with special needs.
- Apply effective and systemic interviewing techniques and strategies.
- Administer and interpret results of assessment instruments.
- Screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and others.
- Assess family history and dynamics using a genogram or other assessment instruments.
- Elicit a relevant and accurate biopsychosocial history to understand the context of the clients' problems.
- Identify clients' strengths, resilience, and resources. Elucidate presenting problem from the perspective of each member of the therapeutic system.
- Evaluate assessment methods for relevance to clients' needs.

- Assess ability to view issues and therapeutic processes systemically. Evaluate the accuracy and cultural relevance of behavioral health and relational diagnoses.
- Assess the therapist-client agreement of therapeutic goals and diagnosis.
- Utilize consultation and supervision effectively.

Domain 3: TREATMENT PLANNING & CASE MANAGEMENT

- Know which models, modalities, and/or techniques are most effective for presenting problems.
- Understand the liabilities incurred when billing third parties, the codes necessary for reimbursement, and how to use them correctly.
- Understand the effects that psychotropic and other medications have on clients and the treatment process.
- Understand recovery-oriented behavioral health services (e.g., self-help groups, 12-step programs, peer-to-peer services, supported employment).
- Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.
- Develop, with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans with clients utilizing a systemic perspective.
- Prioritize treatment goals.
- Develop a clear plan of how sessions will be conducted.
- Structure treatment to meet clients' needs and to facilitate systemic change.

- Manage progression of therapy toward treatment goals.
- Manage risks, crises, and emergencies.
- Work collaboratively with other stakeholders, including family members, other significant persons, and professionals not present.
- Assist clients in obtaining needed care while navigating complex systems of care.
- Develop termination and aftercare plans.
- Evaluate progress of sessions toward treatment goals.
- Recognize when treatment goals and plan require modification.
- Evaluate level of risks, management of risks, crises, and emergencies.
- Assess session process for compliance with policies and procedures of practice setting.
- Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes.
- Advocate with clients in obtaining quality care, appropriate resources, and services in their community.
- Participate in case-related forensic and legal processes.
- Write plans and complete other case documentation in accordance with practice setting policies, professional standards, and state/provincial laws.
- Utilize time management skills in therapy sessions and other professional meetings.

Domain 4: THERAPEUTIC INTERVENTIONS

- Comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches.
- Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.
- Recognize how different techniques may impact the treatment process.
- Distinguish differences between content and process issues, their role in therapy, and their potential impact on therapeutic outcomes.
- Match treatment modalities and techniques to clients' needs, goals, and values.
- Deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client).
- Reframe problems and recursive interaction patterns.
- Generate relational questions and reflexive comments in the therapy room.
- Engage each family member in the treatment process as appropriate.
- Facilitate clients developing and integrating solutions to problems.
- Defuse intense and chaotic situations to enhance the safety of all participants.
- Empower clients and their relational systems to establish effective relationships with each other and larger systems.
- Provide psychoeducation to families whose members have serious mental illness or other disorders.

- Modify interventions that are not working to better fit treatment goals.
- Move to constructive termination when treatment goals have been accomplished.
- Integrate supervisor/team communications into treatment.
- Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan.
- Evaluate ability to deliver interventions effectively.
- Evaluate treatment outcomes as treatment progresses.
- Evaluate clients' reactions or responses to interventions.
- Evaluate clients' outcomes for the need to continue, refer, or terminate therapy.
- Evaluate reactions to the treatment process (e.g., transference, family of origin, current stress level, current life situation, cultural context) and their impact on effective intervention and clinical outcomes.
- Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case).
- Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships.
- Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics.

Domain 5: LEGAL ISSUES, ETHICS, & STANDARDS

- Know state, federal, and provincial laws and regulations that apply to the practice of marriage and family therapy.
- Know professional ethics and standards of practice that apply to the practice of marriage and family therapy.
- Know policies and procedures of the practice setting.
- Understand the process of making an ethical decision.
- Recognize situations in which ethics, laws, professional liability, and standards of practice apply.
- Recognize ethical dilemmas in practice setting.
- Recognize when a legal consultation is necessary.
- Recognize when clinical supervision or consultation is necessary.
- Monitor issues related to ethics, laws, regulations, and professional standards.
- Develop and assess policies, procedures, and forms for consistency with standards of practice to protect client confidentiality and to comply with relevant laws and regulations.
- Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting.
- Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence.
- Take appropriate action when ethical and legal dilemmas emerge.
- Report information to appropriate authorities as required by law.

- Practice within defined scope of practice and competence.
- Obtain knowledge of advances and theory regarding effective clinical practice.
- Obtain license(s) and specialty credentials.
- Implement a personal program to maintain professional competence.
- Evaluate activities related to ethics, legal issues, and practice standards.
- Monitor attitudes, personal well-being, personal issues, and personal problems to insure they do not impact the therapy process adversely or create vulnerability for misconduct.
- Maintain client records with timely and accurate notes.
- Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work.
- Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities.
- Bill clients and third-party payers in accordance with professional ethics, relevant laws and polices, and seek reimbursement only for covered services.

Domain 6: RESEARCH & PROGRAM EVALUATION

- Know the extant MFT literature, research, and evidence-based practice.
- Understand research and program evaluation methodologies, both quantitative and qualitative, relevant to MFT and mental health services.

- Understand the legal, ethical, and contextual issues involved in the conduct of clinical research and program evaluation.
- Recognize opportunities for therapists and clients to participate in clinical research.
- Read current MFT and other professional literature.
- Use current MFT and other research to inform clinical practice.
- Critique professional research and assess the quality of research studies and program evaluation in the literature.
- Determine the effectiveness of clinical practice and techniques.
- Evaluate knowledge of current clinical literature and its application.
- Contribute to the development of new knowledge.

Appendix D: Raw Transcripts of Participant Interviews

Each interview began with a review of the informed consent document as well as the gathering of demographic information. For the sake of de-identification, the demographic interviews have been excluded from these transcripts and additional de-identification measures are bracketed.

Belle

JCR: So um . . . So I got some demographic information from you already.

Belle: Mm-hmm (affirmative)

JCR: Um and so that is all complete. Now when you were doing cotherapy over the course of 6 months-

Belle: Mm-hmm (affirmative)

JCR: . . . with your supervisor, what was the average frequency that you were meeting?

Belle: I think every couple of weeks.

JCR: Okay.

Belle: Maybe we weren't just a little longer because of the . . . The . . . The client's schedule.

JCR: Got you. Okay. Perfect so tell me about how you and your supervisor incorporated cotherapy into your supervision process.

Belle: Um [my supervisor] . . . Um [my supervisor] kind of said, (chuckles) "Why don't you do cotherapy with me on this couple?" Um not super formally but I guess that's what [my supervisor] did with [my supervisor's] intermittently. Like we get to a certain point cause we all started and stopped at different times essentially-

JCR: Uh-huh.

Belle: . . . and so I know [my supervisor] had done cotherapy with other interns and I think it was kind of my time.

JCR: Sure.

Belle: And so I wasn't expecting it and it scared me to death [laughter] but then, um, it was probably one of the more, uh, special parts of my internship.

JCR: Got you so it almost sounds like with your supervisor it was almost kind of considered a rite of passage-

Belle: Yes.

JCR: . . . so to speak to be invited to do that.

Belle: Yes.

JCR: Um.

Belle: And it was . . . For me it was an honor.

JCR: Yeah. Fantastic. You had a good supervisor.

Belle: Cause it was checked.

JCR: Right how did you go on with that? Okay and so I have the answer to how often. That was every couple, few weeks-

Belle: Mm-hmm (affirmative)

JCR: Two to four maybe-

Belle: Yeah.

JCR: . . . depending on when the couple was available um.

Belle: It may have gone on a little longer than six months. I can't completely remember.

JCR: Mm-hmm (affirmative) Yeah so I wanna ask you some questions just regarding a typical cotherapy session with your supervisor.

Belle: Okay.

JCR: So what . . . What if any type of preparation did you all do prior to your sessions with the couple?

Belle: Let me think about that a minute. I don't remember us doing anything formal. I know I probably told *[my supervisor]* it made me a little bit nervous-

JCR: Mm-hmm (affirmative)

Belle: . . . because I . . . I have some performance anxiety and [my supervisor]'s someone that I kind of had on a pedestal so I was nervous about how I would but also excited to watch [my supervisor] do therapy with people because I knew that I would learn a lot. Um so I don't remember. I don't remember us . . . Uh [my supervisor] said [my supervisor] had a couple that had contacted [my supervisor] about coming in and I think we saw them . . . I don't think [my supervisor] saw them together before we saw them together together.

JCR: Okay.

Belle: I think we all started out at the same time.

JCR: So they were fresh to both of you.

Belle: Uh-huh.

JCR: Okay so once you . . . Once you went into session, and I'm sure it differed from session to session-

Belle: Mm-hmm (affirmative)

JCR: . . . but what was the typical course of a session with your supervisor in terms of how things flowed and how . . . How your participation-

Belle: Hmm

JCR: . . . occurred?

Belle: [my supervisor] would generally . . . I think [my supervisor] . . . What I remember learning from [my supervisor] was [my supervisor] had kind of the same way that [my supervisor] would always check in with . . . With the couple and it . . . And it started out with the couple and then after three or four visits, um, ended up just being one of them. It just ended up being the wife, um, because after four sessions she decided to not be married to [my supervisor] any more.

JCR: Got it.

Belle: Um which kind of rocked my world cause you know you going thinking you're gonna do marriage therapy and everybody is gonna get better. And, um, so was a perfect couple to get to see really. So it probably was early on in the internship, maybe after about a year.

JCR: Okay.

Belle: Um so Chuck would start and check in with the client and ask some questions about how they had handled different issues during the week, um, or during the intern. And then [my supervisor] would ask them, you know, what they wanna talk about and that seemed natural for me to let [my supervisor] take the lead because [my supervisor]'s the guru.

JCR: The guy.

Belle: Yeah and the professional and the expert. Um but I got a lot watching [my supervisor] to see how [my supervisor] would incorporate information-

JCR: Mm-hmm (affirmative)

Belle: . . . and just maybe throw out some little . . . Little ideas. You know [my supervisor] would hit on some things that had been touched on in the last session, to kind of give everybody a starting place.

JCR: Okay.

Belle: And that, I really liked that.

JCR: So having that process of modelling-

Belle: Uh-huh.

JCR: . . . even just how to get a session rolling-

Belle: Uh-huh.

JCR: . . . and how to do a . . . A session to session summary-

Belle: Yup.

JCR: And um . . . Okay.

Belle: Yeah that was really kind of cool especially with the couple. That was . . . I think that was probably the big deal about it. I don't remember working with many couples before I did that cotherapy with [my supervisor].

JCR: Yeah.

Belle: So they freaked me out.

JCR: Yeah. It's intimidating when you have . . .

Belle: Absolutely.

JCR: . . . multiple people staring at you.

Belle: Yeah.

JCR: . . . expecting you to do things for then, make it better.

Belle: Uh-huh.

JCR: Okay and so once . . . Once everybody was sort of on the same page about, "Here's what we want to accomplish this session," or, "Maybe we don't know what we want to accomplish," but you're kind of getting into the meat of things, um what was expected of you in terms of the role that you played?

Belle: Um . . . It's almost like Chuck had a good understanding of my style and our styles meshed. Um [my supervisor] was . . . It's almost like we had kind of a body language where [my supervisor] could tell that I had a question or something. It's not a reflection of some sort.

JCR: Uh-huh.

Belle: Um and so it was almost like dancing.

JCR: Mm-hmm (affirmative)

Belle: And I didn't know that we both knew the steps but it ended up that we could do the dance comfortably.

JCR: Yeah.

Belle: It was um . . . I was really surprised.

JCR: It almost sounds as if as a supervisor [my supervisor] was tapping into some of that therapeutic skill of reading non-verbals-

Belle: Hmm

JCR: . . . and kind of being able to be like sort attuned to you.

Belle: I'm pretty sure [my supervisor] could read my mind. [laughter]

JCR: Okay so that made it easier for you to . . .

Belle: It did and it felt really . . . And I don't think it . . . It reflected to the other couple but what it reflected to me was, um, a real nurturing stance.

JCR: Mm-hmm (affirmative)

Belle: . . . and almost like I felt this energy from [my supervisor] that was real cheerleading like, "Go for it."

JCR: Yeah.

Belle: "Just throw something out there," and I kind of believed that I wouldn't be judged too harshly.

JCR: That was some real safety in it.

Belle: . . . Which was true. Yeah it was . . . It was completely true.

JCR: Yeah.

Belle: It took me a long time to trust [my supervisor] but once I did, yeah.

JCR: It was all good from there.

Belle: Absolutely.

JCR: Yeah and post-session, what . . .. What type of debriefing did the two of you do if any?

Belle: You know I remember that we would compare our . . . We would compare our, um, thoughts on how the session went-

JCR: Mm-hmm (affirmative)

Belle: . . . and how the couple was addressing their struggles and, um, just making sure we were both picking up the same information.

JCR: Mm-hmm (affirmative) Yeah so let . . . Let me know if I'm sort of over-interpreting but it sounds like there was almost a process of, um, almost conceptualizing the case.

Belle: Absolutely.

JCR: Right.

Belle: And it was . . . That was really good that we did that because it was really complicated. The husband was probably dancing the line of some behavior that could have been sexually predatory to other people-

JCR: Hmm. Oh. Interesting.

Belle: . . . Like almost . . . Um [my supervisor] taught on a college campus and [my supervisor] was inappropriate.

JCR: Oh.

Belle: But a lot of shit.

JCR: Okay.

Belle: Yeah.

JCR: And so having sort of a . . . The . . . Sort of more advanced perspective about what that meant for your work together, what that might have meant for you had you been a counselor on your own with that couple-

Belle: Yeah.

JCR: . . . and sort of learning to trust your instincts about, "Is this a flag or is it not a flag?"

Belle: Or was there anything reportable.

JCR: Right so that legal ethical piece of it.

Belle: Mm-hmm (affirmative) Yeah.

JCR: Okay.

Belle: So we jumped in the deep end with this couple. They were a gold mine.

JCR: Yeah and so . . . This is sort of a repetitive question but just to make sure I capture everything-

Belle: Mm-hmm (affirmative)

JCR: . . . in discussing the events of a session with a supervisor-

Belle: Mm-hmm (affirmative)

JCR: . . . what other things did you typically cover if anything?

Belle: You know a lot of times, I would check in with [my supervisor] about my reflection or my interaction with the client or was this an appropriate way to, uh, kind of draw this out or ask this question, or follow this trail.

JCR: Mm-hmm (affirmative)

Belle: You know I wanted to know from [my supervisor] if I was, um, hearing the important things and, I don't know, being authentic, and supportive, and non-judgmental and . . . And that was really hard to do with the um . . . With the husband.

JCR: Mm-hmm (affirmative)

Belle: [my supervisor] was not likable. [my supervisor] was not likable and, um, I feel Chuck helped me in . . . In . . . In my previous work before I was in the internship, I seemed to have a small talent for working with the people who are kind of repellant.

JCR: Mm-hmm (affirmative)

Belle: Like I could . . . I could interact with parents who maybe had harmed their child accidentally or on purpose when I worked in the pediatric ICU without getting caught up in the right and wrongness of them but to kind of, um, set that aside and treat them like the parents of a sick child.

JCR: Yeah. Yeah.

Belle: And so even though I was kind of repelled by this guy, um, Chuck kind of reiterated to me that that . . . That I was able to pull that up and be respectful and non-judgmental but real and authentic-

JCR: Yeah.

Belle: . . . and so that was kind of . . . That was an important learning piece for me.

JCR: Yeah. It's a big deal.

Belle: Well cause, you know, it's like we . . . We say that we're not judgmental and we accept people where they are but there are some things that are kind of repellant, and sexual predatory behavior is really repellant.

JCR: Mm-hmm (affirmative)

Belle: And um . . . But yet seeing [my supervisor] in the room, that's not all that [my supervisor] was.

JCR: Okay. Okay.

Belle: And yet I also don't wanna be judged too harshly for being accepting of someone like . . . [my supervisor]'s kind of a dirt bag.

JCR: Yeah. Yeah so it's kind of an interesting, um, catch-22 almost-

Belle: Absolutely.

JCR: . . . to be in. I'm going off script a little bit here-

Belle: Mm-hmm (affirmative)

JCR: . . . but I'm curious. Um so working through all of that-

Belle: Mm-hmm (affirmative)

JCR: . . . eliciting that feedback and processing the kind of transference-

Belle: Mm-hmm (affirmative)

JCR: . . . and sort of doing all, really some . . . Some depth-

Belle: Mm-hmm (affirmative)

JCR: . . . in the supervision work, how did that compare for you to say doing like a case presentation in a supervision group or showing a video? Like the . . . The type of feedback that you got, did you find it of a different quality or caliber-

Belle: Hmm mm-hmm (affirmative)

JCR: . . . post session?

Belle: It was actually . . . It's one thing to sit and report something kind of flat in two dimensional like a case. No matter how you do it, it's people on a piece of paper and you're doing secondhand reporting and this was, for lack of a better word, more intimate-

JCR: Mm-hmm (affirmative)

Belle: . . . and more real.

JCR: Yeah.

Belle: Cause we were there actually doing the deal and I could see how [my supervisor] was with clients.

JCR: Yeah. Very cool.

Belle: And I was like, "Wow I know we are paying so much for this?" Cause it was . . . It was pretty priceless.

JCR: Yeah.

Belle: I felt like there was so much generosity in [my supervisor's] spirit to share that kind of stuff with us and I never felt like [my supervisor] was blowing smoke up your skirt when [my supervisor] had . . . [my supervisor] and I had a challenge sometimes with [my supervisor's] feedback. [my supervisor] could be a little bit rough and um so [my supervisor] . . . I think that [my supervisor] worked real hard to understand my depth of respect and admiration for [my supervisor]. And [my supervisor] was very good about giving me, au, positive and negative feedback.

JCR: Yeah. That's [inaudible 00:17:43]

Belle: I appreciated that. I really took it to heart.

JCR: Yeah [inaudible 00:17:45] the balance.

Belle: Mm-hmm (affirmative)

JCR: Great. Okay so switching gears a little bit, I wanted . . . I want to focus now on the impact of cotherapy on the constructs of self-efficacy and clinical competency.

Belle: Hmm.

JCR: So, by definition, self-efficacy is a state of believing in your ability to perform a given task with some degree of confidence that success is possible-

Belle: Mm-hmm (affirmative) mm-hmm (affirmative)

JCR: . . . however that maybe defined.

Belle: Mm-hmm (affirmative)

JCR: So describe your current level of self-efficacy as you perceive it?

Belle: Hmm.

JCR: And I should, I guess, specify in your . . . In your work as a-

Belle: Mm-hmm (affirmative)

JCR: . . . as a, um, marriage couple and family counselor.

Belle: Um I believe that I've done it . . . I mean it was amazing to have the couple we had to start with cause they were hard.

JCR: Yeah.

Belle: Um and . . . And when we started, I kind of thought that there was like this recipe for how you did and I wanted to get the parts in there right. What I found out was or what I took away from it it was my perception of it is that, um, the more real and authentic I was, um, that's where the better therapy came from.

JCR: Mm-hmm (affirmative)

Belle: Um so it took a lot of pressure off me to learn that recipe-

JCR: Yeah.

Belle: . . . and try to make every couple fit in that recipe and not be the right ingredient. So when I had couples that I would see after that, I wasn't afraid of them any more.

JCR: Yeah.

Belle: I knew that I could handle two people. I knew that I could authentically check in with them at the end of the session and . . . And ask them about their experience, uh, to make sure that nobody felt ganged up on-

JCR: Yeah.

Belle: . . . or-

JCR: Yeah.

Belle: . . . that everybody got to say what they thought they needed to say in that amount of time. Um and I don't know that I would have known to do that before.

JCR: Yeah.

Belle: So it's kind of like what [my supervisor] taught me was to trust my instincts. And the more I did, the more comfortable I was with couples-

JCR: Mm-hmm (affirmative) That makes sense.

Belle: . . . and almost to the point where I really loved working with couples, and I didn't think I would, I thought I'd just rather have individuals.

JCR: So having that positive experience really contributed to . . .

Belle: Completely.

JCR: Even just your level of interest.

Belle: Absolutely.

JCR: Yeah.

Belle: Yeah. It opened up another door for me cause I was really afraid of it.

JCR: Yeah.

Belle: Like not just . . . You know I was like, "Okay I'm not just gonna screw up one person, what if I screw up both of them?" And I found out I didn't have that much power. [laughter]

JCR: A relief.

Belle: Yeah but, um . . . Yeah. It just . . . It gave me a level of confidence-

JCR: Yeah.

Belle: . . . that I didn't expect to achieve that early.

JCR: So again, you sort of already spoke to this-

Belle: Mm-hmm (affirmative)

JCR: . . . but I want to ask you this specific question that I have here to make sure I capture everything-

Belle: Okay.

JCR: But . . . But what was it specifically about the cotherapy process in addition to all the things you've said? Um did you think. What . . . What contribution do you believe that had-

Belle: Oh wow!

JCR: . . . on your level of self-efficacy?

Belle: Um . . . It may . . . You know I . . . My . . . My experience in supervision, my perception of it is that I got the best supervision anybody's ever had in the history of getting supervision.

JCR: Hmm

Belle: It was the way that it all dovetailed together in my life, the people that I was with, the things that were going on in my life outside of school and work, um the timing was perfect and the s . . . The support was incredible and it was just a place where

-----video cut out; see part 2/2------

JCR: Okay. I'm so sorry.

Belle: No worries.

JCR: So [crosstalk 00:00:03] gave you complete freedom . . .

Belle: It gave me complete freedom to listen to my gut.

JCR: Okay.

Belle: Um, to try to put authenticity in everything that I did, because I think when you're starting out and you're new in a role like that, um, it can be real easy to think you should be something else.

JCR: Yeah.

Belle: And that's always been a personal challenge, likem who do I need to be to do this, and always trying to be authentic, and like going okay, you don't really need to be anybody but you. And that's, that is what it gave me. Um, and even more so doing cotherapy with Chuck, um, to sit there with [my supervisor] and watch [my supervisor] and be an equal partner in the process . . .

JCR: Mm-hmm (affirmative).

Belle: . . . of working with this couple that had some really important stuff going on.

JCR: Yeah.

Belle: It assured me of, like it gave me the confidence that, um, we were together providing the best setting, the best holding of a place for this couple to figure out what was going on.

JCR: Excellent. Thank you.

Belle: You're welcome.

JCR: So moving on to clinical competency.

Belle: Yeah.

JCR: So, it's generally defined as being demonstrated when a professional has the knowledge and skills necessary to practice [my supervisor's] or her trade in a manner consistent with legal and ethical codes . . .

Belle: Mm-hmm (affirmative).

JCR: . . . and closely aligned with best practices and standards. So. For marriage, couple, and family counselors, competency is collectively defined by a few major entities, including AAMFT . . .

Belle: Mm-hmm (affirmative).

JCR: . . . CACREP, and the National Counseling Association.

Belle: Mm-hmm (affirmative).

JCR: So, I'm going to hand you, and it's, it's a lot here . . .

Belle: Mm-hmm (affirmative).

JCR: . . . so don't feel like you have to read it in its entirety . . .

Belle: Uh huh.

JCR: . . . but that is the AAMFT current standards of practice . . .

Belle: Mm-hmm (affirmative).

JCR: . . . when they consider what is truly a competent, um, marriage, couple, and family counselor. And as you can see, there's a lot there.

Belle: Mm-hmm (affirmative).

JCR: Um. So I want you to take a look at that, and you certainly don't have to speak to all of those points . . .

Belle: Mm-hmm (affirmative).

JCR: . . . but maybe use that as a guideline . . .

Belle: Mm-hmm (affirmative).

JCR: . . . for how you would describe your current level of clipitent-, clinical competence, the way AAMFT would want you to demonstrate it. And take as much time as you need to.

Belle: Yeah.

JCR: Just peek at that.

Belle: I, um. I'm thinking of, uh, specific couples that I've had in the, in my practice. Um. That's a lot. (laughs)

JCR: (laughing) It's a ton.

Belle: Um. I think I am probably, I don't think I'm novice, um, and I don't think I'm expert, but I think that I am comfortable with knowing what I know and what I don't know and when to ask questions and when to ask for help.

JCR: Yeah.

Belle: When to consult. Um. You know I feel like I got a really good, um, background and basis about theory and how to make that real and alive, um, a lot, I feel like I got a really good foundation of ethical critical thinking . . .

JCR: Mm-hmm (affirmative).

Belle: . . . from Chuck and Elizabeth.

JCR: Yeah.

Belle: Um. I would've loved to have got to do pet therapy with Alyssa.

JCR: Yeah. Okay.

Belle: Um. So, I don't think I'm expert yet. I don't know when I would ever think I was expert.

JCR: Yeah.

Belle: Um. But I think that every, probably every six months or so, after seeing couples I think I feel a little bit more solid in that I'm doing ethical beth-, best practice.

JCR: Yeah. And so when you think about that six months or so that you spent doing cotherapy with Chuck, um, what contribution, if any, do you believe that had . . .

Belle: Um.

JCR: . . . on developing any of these major domains?

Belle: Uh. I think it moved me past beginner.

JCR: Mm-hmm (affirmative).

Belle: I think it moved me past novice. Um. And that was part of the generosity and the spirit that I speak to. Um. Because [my supervisor] was supportive for me to do as much or as little, um, although actually pushed a lot more for much instead of little.

JCR: Mm-hmm (affirmative).

Belle: Um. Which is good.

JCR: Yeah. You said [my supervisor] pushed or you pushed?

Belle: [my supervisor] pushed.

JCR: [my supervisor] pushed.

Belle: Yeah. I'm kind of a "sit back and wait and take stock of the whole thing" and, and sometimes that's good and sometimes that's not.

JCR: Right.

Belle: So [my supervisor] kind of gave me the boot.

JCR: Yeah.

Belle: Sometimes and that's great.

JCR: Which, as intimidating or annoying as that may have been at times . . .

Belle: Horribly intimidating.

JCR: . . . it was ultimately . . .

Belle: Mm-hmm (affirmative).

JCR: . . . really . . .

Belle: Yeah.

JCR: . . . facilitating your growth.

Belle: Absolutely.

JCR: Okay.

Belle: It has to be uncomfortable I think before you grow.

JCR: Yeah.

Belle: Yeah.

JCR: Okay. So, again, you've spoken to some of this, but I want to ask this . . .

Belle: Mm-hmm (affirmative).

JCR: . . . specific question to make sure I get it all. Um. What parts of cotherapy do you believe to have been the most helpful or instrumental in your overall learning process as a marriage, couple, and family counselor?

Belle: Watching someone who's an expert. Seeing [my supervisor] put into practice what [my supervisor] was teaching us in theory . . .

JCR: Mm-hmm (affirmative).

Belle: . . . and in [my supervisor's] skillful way, guiding us to do with the questions [my supervisor] asked and, um, the way [my supervisor] would kind of set us up to do things and push us a little bit.

JCR: Yeah.

Belle: But watching [my supervisor] do that made it alive.

JCR: Yeah.

Belle: And that was huge. And then knowing that it was a safe place to try my wings.

JCR: Mm-hmm (affirmative). Fantastic. And, um, again, maybe slightly redundant . . .

Belle: Mm-hmm (affirmative).

JCR: . . . but what parts of the cotherapy did you find to be the most helpful or instrumental, um, with specific regard to self-efficacy and/or your clinical competence?

Belle: Mmm. The fact, the fact that [my supervisor] expected me to participate . . .

JCR: Mm-hmm (affirmative).

Belle: . . . and be a therapist in the room with [my supervisor].

JCR: Yeah. That it was more than just observing.

Belle: Absolutely.

JCR: You had to put those skills to use.

Belle: Mm-hmm (affirmative). Yeah.

JCR: Okay.

Belle: And it, it really, even as a very much an adult woman in age, um, to be new in a, in a career like I was, cause it wasn't my first career, um I had a lot of, of, kind of hold back and see how other people did it . . .

JCR: Yeah.

Belle: . . . and for [my supervisor] to have that generosity and kind of belief in me, like I, I know that you can do this, and I knew that [my supervisor] wouldn't set me up to fail . . .

JCR: Yeah.

Belle: . . . and [my supervisor] wouldn't set me up with something over my head. And there were times in that room I thought, "Shit, this is over my head."

JCR: Mm-hmm (affirmative).

Belle: But you know that it wasn't.

JCR: And having [my supervisor] believe that . . .

Belle: Mm-hmm (affirmative).

JCR: . . . really helped you.

Belle: It did.

JCR: Yeah.

Belle: Modeled it for me.

JCR: So a different kind of question then for you.

Belle: Right.

JCR: What parts of cotherapy, if any, do you believe posed a challenge or a hindrance to your overall learning process?

Belle: I didn't. There wasn't any hindrance.

JCR: Okay.

Belle: There wasn't anything negative about it.

JCR: Okay. And so again, redundant, but were there any parts of the cotherapy that posed a hindrance or a challenge to the development of your self-efficacy or your clinical competence?

Belle: No.

JCR: Okay. What else, um, would you want to add about your experience with cotherapy that I've not asked you about specifically?

Belle: Hmm. I don't think there are any. Um. It's really interesting and it, it was such a good experience, I love getting to revisit it in my memory . . .

JCR: Mm-hmm (affirmative).

Belle: . . . to, to talk to you about it. Um. It was just really special for me to get to work with [my supervisor] as a colleague. And to get to work with the couple that we got to work with.

JCR: Mm-hmm (affirmative). Yeah, hearing you talk about it reminds me why I wanted to do this research.

Belle: Yeah.

JCR: Mm-hmm (affirmative).

Belle: And it wasn't, I mean I didn't expect it, you know. We kind of went along and, and I think the group that I was with was, you know, we were tight and we were real, and we were deep, and, and I guess I just thought that was all there was going to be to it and then there was this whole extra layer of salted caramel chocolate goodness. (laughs)

JCR: (laughs) Awesome.

Belle: Yeah. It was delicious.

JCR: Yeah. Thank you so much for taking the time to share that with me.

Belle: You're welcome.

JCR: And if you think of anything else after you leave . . .

Belle: Okay.

JCR: . . . um, you know where to find me.

Belle: Okay.

JCR: And, uh, we'll be in touch.

Belle: Right on.

JCR: Thank you.

Chantelle

JCR: Okay. So, we're just going to talk then a little bit about the cotherapy process itself, um, because that is of interest to me too, just kind of how supervisors are structuring that experience. Um, so how often were you doing the cotherapy sessions?

Chantelle: We, so we had a, a client couple who agreed to have cotherapy, co-therapists, and then we would see them once a week.

JCR: Okay.

Chantelle: So, two different couples.

JCR: Okay.

Chantelle: We were seeing once a week, so that would have been twice a week for a little while.

JCR: Got it.

Chantelle: Over two different couples.

JCR: Perfect. Those hours add up really fast.

Chantelle: Mm-hmm (affirmative).

JCR: So, you said it was to different couples.

Chantelle: Mm-hmm (affirmative).

JCR: And what was the general kind of, um, demographics or presenting problems of those couples.

Chantelle: (Clears throat) Well the, the presenting problem, um, say couple number one, was, um, they were trying to decide whether or not to follow through with a divorce.

JCR: Mm-hmm (affirmative). Okay.

Chantelle: So, the papers had been filed and it, it had been drawn out for quite a long time, like over, like about two years.

JCR: Oh wow. Okay.

Chantelle: Um, they were in this contemplation place about that.

JCR: Yeah.

Chantelle: And then the other couple, um, was . . . They were, had just had a child and they were trying to blend their family.

JCR: All right.

Chantelle: And having trouble with that.

JCR: And were there ever any different constellations of those families that came in? Other people who joined them, or. . .?

Chantelle: In, uh, in the session?

JCR: Mm-hmm (affirmative).

Chantelle: Um, with couple number two their . . . They would sometimes have to bring their young child into the . . . Like their new, pretty infant child . . .

JCR: Got it.

Chantelle: . . . Into the room, which . . . That probably changed the dynamics of the room.

JCR: I bet, completely. Okay, so, when you think about a typical cotherapy session with your supervisor and couple number one and two, um, describe a typical session. So, that would include, like, any kind of prep that happened before the session, um, all the way through. Any sort of debriefing that happened after.

Chantelle: Okay. So, couple number one had a, um, a schedule that we had made it so that we would meet very early in the morning, so we tried to arrive beforehand, so that we could meet.

JCR: Yeah.

Chantelle: Before the couple arrives, we could discuss, sort of, if there was anything we wanted to particularly talk about, um, or, uh, at first, um, my supervisor kind of lead a little bit, I would say. And then [my supervisor] started asking me and prompting me to . . . What do you want? How do you want this to go? What do you think should happen? And was really, um, I think guiding me to think about my . . . The intention of the session and what I wanted the intention to be.

JCR: Yeah.

Chantelle: And sort of where I thought things should go.

JCR: Great.

Chantelle: So, [my supervisor] sort of modeled it to me at first.

JCR: Mm-hmm (affirmative).

Chantelle: And then let . . . Tried to get me to do the same thing.

JCR: Okay. Cool.

Chantelle: And then . . . And that happened the same with the other couple. Um, tried to get there a little bit early. Didn't always work because sometimes [my supervisor] would have, um . . . My supervisor would have, uh, other clients beforehand so, um, so then we'd have a session, uh, we'd, we'd go together to go get the couples . . .

JCR: Mm-hmm (affirmative).

Chantelle: . . . In the waiting room, bring them back to the, the therapy room. And then, um, sort of, kind of start. So, at the beginning, like I said, [my supervisor]'d start and then, and then [my supervisor] like encouraged me to sort of begin the sessions.

JCR: Yeah.

Chantelle: So. And then, um, (Phone rings) sorry, and then, um, we would, we would debrief afterward and sometimes for an hour, an hour and a half. [crosstalk 00:08:35] If there was time.

JCR: Oh, so you had a lot of time.

Chantelle: If there was time. Usually, at least a half an hour. Um, yeah I could meet most of the time.

JCR: And with that debriefing, um, who sort of led, or what kinds of things did you, um, review?

Chantelle: Let's see. Well, we, we discussed . . . It was a little bit different every time, honestly. Um, the process was, you know, did we, did we talk about . . . Did we guide the session in that way that we kind of wanted it to.

JCR: Mm-hmm (affirmative).

Chantelle: And, um, sometimes we talk about theory. Sometimes we talk about personality structure and how that played into the couples, um, and what was going on with them sometimes. Um, I, [my supervisor]'d give me recommendations to, for reading, or, you know, resources. Things like that. [my supervisor] was very interested in my perspective, um, what I thought was happening.

JCR: Okay. Sorry, I'm just taking a few notes in case, for some horrible reason this stops working.

Chantelle: (Laughs) okay.

JCR: (Laughs).

Chantelle: I'll let you know if I notice the light going off.

JCR: Yeah. (Laughs). Okay, so now I want to take, um, sort of your experience of doing that cotherapy and apply it directly to those constructs. Um, starting with self-efficacy. So, the way that I'm defining that is based off [inaudible 00:10:22] work, um, so it's a state of believing in one's ability to perform a given task with some degree of confidence that success, however that may be defined, is possible.

Um, so, talk to me about where you believe your level of self-efficacy is and what, if any, contribution you believe the cotherapy may have had on where that level is. Does that make sense?

Chantelle: Mm-hmm (affirmative). Um, I have a . . . Especially now, I think the cotherapy really contributed to a higher, a high level of self-efficacy. Um, high being that I still have a lot to learn and I know that.

JCR: Yeah.

Chantelle: But know that I'm kind of very capable in, in a session, um, and it was interesting to, especially with couple number one, I, I was very hesitant to, to jump in. I was very hesitant to talk.

JCR: Mm-hmm (affirmative).

Chantelle: It was a rapid-fire couple. I mean, really dynamic people, just, uh, both of them.

JCR: Yeah.

Chantelle: And then I have a supervisor who I really respect and I'm like, you know, go ahead and handle this.

JCR: Mm-hmm (affirmative).

Chantelle: (Laughs). And, uh, so I was very timid at first to . . . It took quite a while for me to know that the confidence in myself and the self-efficacy, as you point out, um, that I, I could jump in and I have really valid statements and thoughts to contribute and reflections to make and, you know. Um, and even if it didn't go well, we could, we could recover from it, you know.

JCR: Yeah.

Chantelle: And, um, and I learned that. I really learned that. Like, I could, I could throw something out that I was thinking and if it didn't, if it didn't go well or if it wasn't receive really well, we could, we could work it out. And that's something I really learned and I really love being a part of the cotherapy relationship because we could help each other kind of recover if we, if we needed to, or . . .

JCR: Yeah.

Chantelle: . . . Support each other. Um, so I really . . . I think it was a, a period of being pretty shy and standoff-ish and unsure and then, um, seeing the process of having somebody believe in me and know that they believed that I could do it and then figuring out that I could . . . That I believe in myself too.

JCR: Yeah. That's amazing. And, you know, something that you said kind of caught my attention, that was the idea of helping each other recover and I wanted to clarify that because, I think, when I hear that, then it leads me to believe that your supervisor may have stumbled or sort of, like, thrown something out that didn't stick and so, were there times that you got to sort of see your supervisor kind of do . . . Navigate that process?

Chantelle: Um, maybe, yeah. I mean, I think, sometimes . . . Not, not usually, honestly. Like, most of the things that [my supervisor] says, people are like, "Yeah. So true."

JCR: (Laughs).

Chantelle: But, you know, if [my supervisor], if [my supervisor] . . . Sometimes if some . . . If [my supervisor] maybe reflected something and someone was like, "No, not really." [my supervisor], I could maybe translate it in a different way. Particularly with, um . . . I was thinking about with, um, in couple number one, the female.

JCR: Mm-hmm (affirmative).

Chantelle: We ended up having a really good rapport and, um, connection which, I don't know if that ended up hurting . . . I don't know. I don't know. I have some opinions about that, but, um, but anyway. So, I could . . . [my supervisor] could say something and then I could almost know . . . I, I understood what [my supervisor] was saying and then I could almost translate it and then . . . I guess that's what I mean by recover.

JCR: Yeah.

Chantelle: Not that [my supervisor] said anything wrong or that was off-putting, but, "Oh, I think. . ." You know, we could, we could come back to it and I could translate it so . . . And she was like, "Yeah, that's exactly it." It was the same thing that [my supervisor] said.

JCR: (Laughs).

Chantelle: (Laughs).

JCR: So, yeah, the relationship helps then too.

Chantelle: Yeah, yeah.

JCR: Very cool. Okay. Is there anything else that you would add about that before I move on to the next construct?

Chantelle: I . . . The other thing that I, I personally believe about myself, um, and building self-efficacy and just believe . . . I, I think it just takes practice. You're in a new . . . Something new, something foreign. It, it takes time and practice so I . . . Um, and that's what helps me building confidence, is to sort of take the risk of jumping in.

JCR: Mm-hmm (affirmative).

Chantelle: And saying, "Yeah, I will do cotherapy with somebody I completely respect and admire and who's been doing this a really long time." And jumping in and saying, "Okay, I'm not, not going to be like them. I can be as good as, as, they are, [my supervisor] is." And that I want to learn. I want to get to that place.

JCR: Mm-hmm (affirmative).

Chantelle: So, um, I'm going to practice and work hard and then that will slowly build up my belief in myself.

JCR: Yeah. Awesome. Okay, so, clinical competency, uh, is generally defined as being demonstrated when a professional has the knowledge and the skills necessary to practice their trade in a manner consistent with legal and ethical codes, and closely inline with best practice standards. So, for M, um, for MFT competency, is collectively defined by organizations such as AAMFT, CACREP and the NCA. So, please consider the knowledge and skill areas included in that lovely document you have, which is appendix A.

Chantelle: Yeah. It's in here somewhere. I've looked at some of these.

JCR: Yeah. And definitely don't . . . You don't have to go through point by point, but it's just sort of a general idea about how the AAMFT defines a, a competent MFT.

Chantelle: Mm-hmm (affirmative).

JCR: And so, the question is exactly the same as it was for self-efficacy. So, I'm just looking to know sort of where you believe your level of clinical competency is, based on those standards and what role you think, um, the cotherapy might have had on developing your competency.

Chantelle: Um, well . . . (Clears throat). It's hard to know with out sort of like a scale. I'm a scale person.

JCR: Yeah.

Chantelle: Um, and if I . . . I don't know, like on a . . . I'm, I'm, I'm not completely novice and then I am certainly not an expert. I'm, I'm very intermediate.

JCR: Mm-hmm (affirmative).

Chantelle: Um, and I recognize that there's still so many things that I, I, I think "Gosh. When I look back on this in the future, I'm going to be like, my God, what was I thinking?" You know.

JCR: (Laughs).

Chantelle: And not that I'm . . . Not that it's horrible or bad, just, I think there's, there is probably, you know.

JCR: Mm-hmm (affirmative).

Chantelle: Better practices . . .

JCR: Mm-hmm (affirmative).

Chantelle: . . . That could happen, I just don't know about it.

JCR: Sure.

Chantelle: Um, so I think, um, so yeah, I'm, I'm intermediate. And my . . . The cotherapy. (Phone rings) I apologize. The cotherapy experience showed me where I want to be.

JCR: Awesome.

Chantelle: It showed me, um . . . I mean I, I know, I knew that that was the case with my supervisor. That [my supervisor] was, um, you know, advanced.

JCR: Yeah.

Chantelle: And at the highest level and, um . . . But to see it in action, to see [my supervisor] interact with clients, to have such intention, um, every time.

JCR: Mm-hmm (affirmative).

Chantelle: And not just, not just with one session, but at the . . . From the very first phone call, to have sort of this intentional case formulation and then, to the very last conversation with, with the clients. Um, were just master-

JCR: Okay, Part two and we're almost done. I, I literally have two more questions for you.

Chantelle: That's okay.

JCR: Okay, so as I was saying, on the flip side to that coin of what was beneficial, I'm curious what parts of cotherapy might have posed a hindrance or a barrier to your development of self efficacy or competence?

Chantelle: I, I didn't have that experience.

JCR: Okay.

Chantelle: I experienced it as really positive, um, and supportive.

JCR: Great.

Chantelle: Yeah. I, it, it actually made me want more in more envir . . . more of it.

JCR: And so if you were to imagine if there was something that your supervisor could have done to create a hindrance or to make it not a positive experience, is there. Oh, your client.

Chantelle: Yeah.

JCR: Okay, thank you. Um, is there any thing that you can think of that would've made it a worse or a not helpful kind of experience?

Chantelle: Yeah, I suppose. Um "laughs." Uh, I'm sorry I'm imagining kind of the [inaudible 00:02:55] of things that could have happened but um . . .

JCR: Yeah and it's fine if nothing really comes to mind but I just want to make sure that I'm capturing . . .

Chantelle: Yeah.

JCR: You know.

Chantelle: I imagine if, if a supervisor had sort of just said good luck and or, or, not let . . . If it was, if it was extreme in one way or another.

JCR: Okay.

Chantelle: Rather than a little balance, uh, just, here's the intern and let them . . . They're here to give you therapy and I'm just watching.

JCR: Um hmm.

Chantelle: And, or vice versa. You know, I don't know if it would have been horrible had I just been watching but I think I was very um, it was, I really liked being able to participate.

JCR: Yeah.

Chantelle: So, yeah those extremes. And then um, I don't know.

JCR: Okay. So, the final question is just to kind of round things out. Is there anything that you would add about your experience with cotherapy that I have not asked you about specifically?

Chantelle: I don't think so.

JCR: Okay.

Chantelle: I think it's, I think it's super cool.

JCR: "Laughs."

Chantelle: I really liked it.

JCR: Awesome. Okay, thank you.

Chantelle: Absolutely.

Darcy

JCR: And thinking back on your time doing cotherapy, for how long or about how many sessions did you utilize cotherapy in your supervision practice?

Darcy: Ooh, that's challenging to say. Um, I know I had at least, minimum of three clients cotherapy that we just started right out with the client um, together or I was invited in. There was at least three. There was probably more but three is a safe bet. Three to six. Um, and then one of them went most of the three years, is still going on. Um, that- we probably met about once a month. Um, that's the most frequent one. Sorry, I'm doing the math as we're talking.

JCR: No, it's okay.

Darcy: Um, and then I think we had a couple that we saw for maybe six times. And then there was a family that we saw, a mom and a son, we probably saw them maybe ten times.

JCR: Okay, so you did a lot.

Darcy: Yeah. I did quite a bit and that's probably the minimum. I know there were maybe some other shifts-

JCR: Sure.

Darcy: Those are the big, the ones that we did like, that period of time, yeah.

JCR: I think of anybody I've spoken to so far you definitely have the most breadth of experience in cotherapy, which is cool.

Darcy: Yeah, I liked it.

JCR: Uh, let's see. With how many other partners or supervisors had you don't cotherapy?

Darcy: Uh, just one supervisor did I do cotherapy.

JCR: And who sought whom for that relationship.

Darcy: Uh, my supervisor asked me if I wanted to do cotherapy with [my supervisor].

JCR: Okay, so now I want to shift a little bit into just getting an idea about what the cotherapy process looked like.

Darcy: Yeah.

JCR: Um, and you already answered some of that, so there may be some redundancy.

Darcy: It's okay.

JCR: (laughs)

Darcy: As long as you don't mind, I don't mind (laughs).

JCR: Just don't want to miss anything.

Darcy: Yes.

JCR: Um, okay so you, you spoke a bit to how often you met for cotherapy, that there was um the one client system that you saw uh monthly-

Darcy: Yes.

JCR: For about three years or so, and you- that was the most frequent or . . . ?

Darcy: That was the longest-

JCR: Okay. Got you.

Darcy: The three years. Um, the most frequent, let's see, well the couple we saw over two weeks and the family, I believe- it's been a while. I believe we saw them weekly at least for a little bit and then they went to every two weeks. Maybe weekly for like two or three weeks just to kind of get them uh, settled in with us and then um, you know there's some urgency from the mom-

JCR: Sure.

Darcy: And then I think it sort of fell to two weeks just because of everybody's schedule.

JCR: Yeah. So, um because that was happening with private clients, it sounds like through your supervisor the frequency kind of reflected the life of any other case where it started off more intensely and then kind of, sort of tapered.

Darcy: Yeah.

JCR: Based on client need.

Darcy: Yes.

JCR: Okay. Perfect, and you already answered how many different client systems.

Darcy: Yes.

JCR: So, it sounded like you said about three to six.

Darcy: Mm-hmm (affirmative).

JCR: Okay, and I want to make sure I have [clear 00:07:03] of the constellation of clients. You've mentioned a family.

Darcy: A family which was a mom and a son. She had two younger kids but they were a little young, um for therapy and really she wanted to work on her

relationship with her son because he was by a different father, and then the two younger ones with, were with the, with her current husband.

JCR: Got it.

Darcy: So, she was kind of really looking at her relationship with her older son. He was um, sixteen and the other two siblings were um, probably under six.

JCR: Oh, that would have definitely change the dynamic.

Darcy: Yeah. Yeah, so it was mom and so, and um, and then one couple. I don't know if you want approximate ages?

JCR: Sure.

Darcy: Um the, the one couple we saw, not the one we saw for three years, the one we saw for less time. Um, that couple was a younger couple, probably in their twenties. Um, and then the couple we saw for many years were in their fifties.

JCR: Okay. Okay, um so describe, and you've had so many so it, it may be difficult to, to answer this in any particular way but, uh describe a typical cotherapy session with your supervisor. So, from, from start to finish if there was any kind of prep time-

Darcy: Mm-hmm (affirmative).

JCR: Um, the structure of the session and then if you had any debriefing after.

Darcy: Okay. All right, so um most typically we had a little bit of time before the couple or family arrived, not long, maybe fifteen minutes, and we might just sort of say you know, what are thoughts were about what we wanted to do. Any particular um, agenda or tasks. Those were held pretty loosely. Uh, we made a, you know, we would come in with something. We always had an agreement that we would go into the session with something but of course if, if something emerged from the family or the couple that was more urgent we would switch. Um, but we started out with sort of a plan, and then uh, and then we would go, because we would meet in [my supervisor's] office and then we'd go down the hall and, and get the couple or the family, bring them back.

Um, typically, especially when we first started cotherapy I let [my supervisor] sort of lead. Like, welcome and I just sort of watched [my supervisor] introduce people to the space and uh, um, kind of lead the assessment process. And then I would chime in here and there, and as we developed a

better cotherapy relationship and I got more skilled, uh that was more collaborative and egalitarian. Um, after the session we would uh, debrief, sometimes just briefly if we both had other clients or places to be. We might take fifteen minutes, and [my supervisor] was always really thoughtful about pointing out things [my supervisor] thought I did well. And then, if [my supervisor] had feedback about- oh, I remember one time [my supervisor] said, "You might want to speed up your responses." and I recognized immediately that I was delaying because I was kind of cautious about jumping in, and then I was trying to be really thoughtful about what I said and how I said it. And so there's these pauses, and then I would speak, right?

And so, feedback like that. Like, just gentle, sort of, "You might want to consider, you know, speeding up your response times."

JCR: Sure.

Darcy: And then I would sort of have that in mind for the next time we met.

JCR: And was there, was there room in that debriefing space or somewhere else in the supervision process to kind of talk about what that barrier was, or sort of what was leading to that lag time?

Darcy: Yeah, if I needed it. So, if we had like fifteen minutes we would usually just debrief kind of casually and um, if [my supervisor] gave me feedback in that, in the shorter debriefing times uh, if I needed to bring it up again later I always could and I knew that. Um, or sometimes it was like, oh yeah I am doing that and it was just kind of quick because it's easy for me to recognize. Like that one I recognized right away and I'm like, "Oh that's just me being insecure. I can handle that one." Right?

JCR: Yeah.

Darcy: Like it wasn't a, a need for me to process that further, but if there were times where something came up, like I remember we were working with a couple one time, this is the couple we worked with for three years, um [my supervisor] said, "You're having trouble with the male of the couple." [my supervisor] said, "You're kind of having some trouble with [my supervisor]." and [my supervisor] didn't over interpret that. [my supervisor] just said, "It looks like you might be struggling with [my supervisor]."

JCR: Mm-hmm (affirmative).

Darcy: And then there was a lot of opportunity for me to talk about what I thought that was, and then sort of leading into how that might shift how I work with [my supervisor]. Um, and then, and then certainly times that fifteen minutes,

if we had more time, turned into maybe an hour of supervision. Um, especially if we, they were the last client of our day sometimes and that was sort of arranged intentionally, then I would have time to have solid supervision. Like really trying to process this kind of [means 00:12:05] after.

JCR: Okay.

Darcy: I don't think I, I get a lot of talking about our cotherapy in group supervision. Sometimes if [my supervisor] brought it up I would talk about the case, but I sort of had a sense that it was mm, trickier to talk about cotherapy in groups supervision.

JCR: Mm, mm-hmm (affirmative).

Darcy: Or maybe a better way to say that would be, since I had so much time to process with [my supervisor] and be so immediate with with me, maybe I just didn't need it.

JCR: Okay, makes sense.

Darcy: That might have been more of the issue.

JCR: Yeah.

Darcy: Because that was sort of well processed, and then there's all these clients that I'm on my own with that maybe took priority in group. Okay. I might have wandered off topic.

JCR: No, no, no. You're absolutely right on it, and so, and again, you spoke to this um, already but I want to make sure that I have it straight. During the debriefing, um you mentioned there would be feedback and sort of brief opportunity at least to kind process the session and then you could continue it if, um, needed later.

Darcy: Mm-hmm (affirmative).

JCR: Was there, or who typically led what was talked about in that debriefing.

Darcy: Uh, I would say most of the time [my supervisor] led it. Uh, especially at the beginning um, because I probably didn't have enough confidence to, to bring something up.

JCR: Uh-huh.

Darcy: Or really know what to ask. It was really new and [my supervisor], I was really nervous around [my supervisor].

JCR: Mm-hmm (affirmative).

Darcy: [my supervisor]'s really good at what [my supervisor] does and uh, [my supervisor]'s really smart so I kind of took a cautious path and that sort of reflects part of my personality, not necessarily the dynamic [my supervisor] set up. Um, and then as we did more cotherapy, I would bring up more of it. I might kind of go, "What did you think?" But there were often times where I would just launch in and say, "I thought such and such went well." or "I have a question about how such and such went and what did you think about that? And how do you think that was received?" Um, so it got easier for me to bring things up all the time.

JCR: Great, so like a kind of evolution of the relationship.

Darcy: Yeah.

JCR: Is a theme that I-

Darcy: Is hear- you're hearing that over and over?

JCR: Yes.

Darcy: I would bet.

JCR: Yeah, it's very cool to sort of see the pieces congeal-

Darcy: Yes, the similarities in our experiences?

JCR: Yeah, yes. Exactly. Okay, so now I want to shift into just the final part of the interview, um which is looking at the constructs of self-efficacy and clinical competency.

Darcy: Mm-hmm (affirmative).

JCR: Um, so we'll start with self-efficacy which is a state of believing in one's ability to perform a given task with some degree of confidence that success, however that may be defined, is possible.

Darcy: Mm-hmm (affirmative).

JCR: So, that's based on social learning theory. Um, it's kind of a big question so we can break it apart if we need to.

Darcy: Yeah.

JCR: Uh but I'm just curious to know about your current level, your, your perceived level of self-efficacy and what contribution you think cotherapy might have had, if any, to developing that.

Darcy: Yeah, um oddly I was more confident not in cotherapy.

JCR: Okay.

Darcy: Uh, I had a good amount of experience uh, doing sort of like peer counseling before I started the in, in a professional way.

JCR: Mm-hmm (affirmative).

Darcy: So, I had some confidence sitting in the room with people, and listening to them and um, and responding in a way that I thought was useful. And then doing cotherapy, because I had so much admiration for my supervisor, I was more nervous and I was more timid. Um, so that was the beginning and, and I intentionally did that because I wanted to be better at what I did, and I knew I could be better at what I did. And, so I wanted to be in situations where I would be watched and I would get better feedback, you know, kind of more finely tuned feedback about me not just sort of general and um . . .

And so, I would say that, that ultimately kind of putting myself in that place to learn more, kind of on an edge where it would be maybe more challenging or, or scarier, that, that I would be a better therapist as a result of that and that was true. That was definitely true. I got a lot more feedback about my sort of particular um, I can't think of the word, we'll got with quirks (laughs). Like my personality, right? And like, you know, like the delay in responding or um, or things that I might say that weren't carefully worded, or could be worded more carefully and, and better thought out, as well as things I did well that I would not have thought of, um got pointed out. So, to me that helped me grow as a therapist, probably more than any other supervision I had really, uh because it was so personal and we were in the same room with the same people.

And it's even different, I think, than watching a tape of my uh therapy work. Uh, so I would say hands down it was the most growthful, if not initially in a way the most difficult and stressful. It was the most [inaudible 00:17:19].

JCR: Okay, good to know. So Lilly um, relatedly um, but I think maybe more specific-

Darcy: Yes.

JCR: Um, is the idea of clinical competency and I have a little something for you while I read the definition.

Darcy: Okay.

JCR: I know you've seen this bad boy.

Darcy: (laughs)

JCR: I'm sure you've seen this bad boy through your own doctoral work, and probably even before. There you go. Don't feel like you have to re-read it verbatim.

Darcy: Aww. We love this.

JCR: We love it.

Darcy: We love it. We love it so much.

JCR: Okay, (laughter) back in business.

Darcy: Okay. (laughter)

JCR: All right. (laughter) I apologize for that interruption.

Darcy: That's okay.

JCR: We were talking about diagnoses. (laughter)

Darcy: Diagnoses. Yeah. So, um, so I would say that was an area where I really hadn't seen somebody that, uh, talented and uh, effective, uh, to do that. Um, and then help me learn to do that.

JCR: Mmm hmm. (affirmative)

Darcy: So I don't know if I can pick out bullet points specifically but I know just in general my assessment process and diagnoses process improved. Even being able to pick up things like, uh, traits of personality disorders which are much more . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . subtle and certainly when other people don't have, uh, you know, full blown personality disorder that would be recognizable in the room and then how to pick up on those subtle things because that's not necessarily something you can get from a client report.

JCR: Right.

Darcy: It's gonna be more noticeable in the interactions.

JCR: Yes.

Darcy: So, uh, so subtleties were, uh, nice to learn, uh and have them pointed out to me. Okay. Uh, treatment plan, any case management. Only in the most informal way I think. I kept notes on the clients for the, for a case file.

JCR: Uh huh.

Darcy: Um, and my notes were really brief. Just kind of a, a super simple draft note, um, with just a couple sentences and that was sort of the, I guess the philosophy for lack of a better word of, you know, not keeping a ton of detailed notes in a private practice in case records are ever subpoenaed. Um, and then treatment planning was much more, um, relaxed. Sort of like, "What did you notice," and then, "What are we noticing over time and week to week in our discussion," rather than coming up with a formal written treatment plan. Uh, which I actually like and even though I still do, a plan for my files, it seems more organic to me after my co-supervision, my cotherapy. Um, like, oh, this really just emerges and sometimes it's not so formally, uh, praised in a session. Sometimes it's, "This is what you're here for, this is what we talk about every week."

JCR: Yeah.

Darcy: And it just becomes sort of fluid. Um, and then therapeutic interventions. This is probably one of the bigger places that I learned a lot is just what to do in the room and how to do it well and timing and pacing. [my supervisor] went a lot slower than anybody I had worked with and uh, and I've definitely adopted that in my style, just letting people talk, listening, pulling up the feelings, having sort of a relaxed pace in the session and then . . .

JCR: Right.

Darcy: . . . more seems to happen by the end. It's like, wow, we did a lot even though we were really relaxed about it.

JCR: Yeah.

Darcy: Uh, and my own anxiety (laughter) . . .

JCR: (laughter)

Darcy: . . . way down after supervision cotherapy. Um, so . . . Certainly using different techniques and noticing how they impact the client, uh . . . Um, interventions. Delivering them in a way that sensitive. Our family, uh, she was, I'm going to embarrass myself on tape by not remembering her ethnic origin. Um, she's raised in the US but her dad was from the Middle East and I . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . I don't want to venture which country because I'm probably likely to get it wrong but she experienced a lot of discrimination just in her work and just being who she was in the world, um, at this time and, and the US anyway. So, um, so noticing how [my supervisor] handled that and how fluid [my supervisor] was, uh, and how we sort of, I don't know, maybe more sensitivity in certain interventions to ensure that . . .

JCR: Sure.

Darcy: . . . there was a power dynamic or we weren't being condescending or uh, or not taking into account her race and the difficulties that created for her in work and life.

JCR: So that you could use those, those interventions that we know to be effective but to apply them in a culturally sensitive way that has some flexibility.

Darcy: Absolutely.

JCR: Okay.

Darcy: Softer, more respectable, more um, cautious. Like sort of venturing out a little bit. Like, I wonder if this could be part of it and, and certainly bringing up things like, you know, she was having trouble at work. Certainly acknowledging that if a good piece of that was likely because . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . of the way she was perceived by other people in her judgments . . .

JCR: Yeah.

Darcy: . . . and their prejudice and sort of, had to take the lead in that without sounding like I'm sort of a white person just being naïve, right? (laughter) But like, "Oh, I can see how that might be also related to, um, to your boss treating you that way because of your background," and, and that just sort of being part, sort of the lead of the conversation and then she could pick that up . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . or just, sometimes she would just go through relieved that like, okay, you're not gonna fight me on that, you know? (laughter)

JCR: Right.

Darcy: You know, you're not going to challenge that or you're even going to notice . . .

JCR: Right.

Darcy: . . . that that might be part of it and I don't have to be the one to say it.

JCR: Mmm hmm. (affirmative)

Darcy: That did a lot for rapport and for, um, and for the, the particular way therapy shaped up for her.

JCR: Mmm hmm. (affirmative) I would imagine so, that's good.

Darcy: Yeah. Um, so, multiple perspectives. Uh, certainly respecting multiple perspectives. Thinking about how the clients saw an intervention and how we saw it, what we wanted to happen, what did happen. Um, how, like a husband and wife might see that intervention differently. If we kind of left the session and there was maybe a piece or two that we thought, that didn't go the way we wanted, sort of being able to keep track of that thread and, and . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . correct it overtly or, or in a more subtle way in the session.

JCR: Yeah, yeah.

Darcy: Um. Okay. I didn't have a ton of, um, anything out of the ordinary in terms of ethical and legal issues.

JCR: Mmm hmm. (affirmative)

Darcy: Uh, certainly we did due diligence with the boy and [my supervisor's] mom, see if we could get dad's agreement . . .

JCR: Sure.

Darcy: . . . but dad really was not anyway, in any shape or form somebody who we could reach. (laughter) So we just, you know, just sort of made our best effort but those weren't huge issues other than just, you know, the ethics of good practice and uh . . .

JCR: Yeah, I like that. That's a very succinct way of putting what we do, the ethics of good practice.

Darcy: Yes. Um, we didn't talk about research or programmable language. (laughter)

JCR: Okay. Right.

Darcy: Yeah. (laughter)

JCR: That didn't come up or? (laughter)

Darcy: No. (laughter)

JCR: Yeah, that's happening now. (laughter)

Darcy: (laughter) Yes, exactly. That's today.

JCR: Okay.

Darcy: What's my homework tonight? (laughter)

JCR: So, um, so just a couple of final questions . . .

Darcy: Yes.

JCR: . . . to kind of wrap a little bow around it. Um, so if you had to think about you know, just cotherapy as part of your internship as a whole, um, what parts of the cotherapy specifically do you believe to have been the most helpful or instrumental in your development as a marriage and family therapist?

Darcy: You kind of want me to go back to this or you want me to be more vague? (laughter)

JCR: I'm, [crosstalk 00:07:19] just, 'cause you've talked about, I mean, you really have talked about so many parts of . . .

Darcy: Yeah.

JCR: . . . sort of like the, the direct observation piece and that immediate feedback and having feedback that was sort of time and space congruent. Um, so, of all the things about how cotherapy worked, what, were there any pieces that you though were better than others in helping you get to that place of being competent, um, competent [crosstalk 00:07:43]?

Darcy: Okay. Yeah. Um . . . Ah, it's difficult to piece it apart in that way.

JCR: Yeah.

Darcy: Um. All of it certainly contributed and, and there's still this piece for me about being in the room with somebody whose a master of this.

JCR: Mmm hmm. (affirmative)

Darcy: Like just being able to be part of that dynamic, um, that [my supervisor] established in the room and that I could just, sometimes witness and sometimes have a felt experience of it and sometimes sort of join in it and, and then of course, more and more being able to create that sort of environment myself. That is so difficult to teach somebody because it's not a technique. Like I could learn motivational reviewing techniques and, and my supervisors was good at knowing that that was something I did and wanted to do more of and so [my supervisor] would frame feedback in that way and help me . . .

JCR: Sure.

Darcy: . . . continue to grow and develop those skills, um, phenomenally useful. But even things I didn't know I was doing [my supervisor] would point out. Um, and yet, for me all of that could have probably been done by watching a tape of mine. You know, technique, intervention, timing, pacing, there is low down, um, something about just the felt experience of being in the room, um, with the intent for this to be healing and uh . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . an intimate and private and deep and personal and then what do we do to create that? Like, what do we actually do with our own emotions, with our presence in the room, with what we say and don't say and the timing of that. That is so hard to teach.

JCR: Yeah.

Darcy: I don't know that there's another way to teach that except for invite somebody in the room and say, "Watch this, and then try to do it with me."

JCR: Uh huh. Yeah, very personal.

Darcy: Yeah, yeah. That intimacy we establish, it, it, you and I both know who I talk about and [my supervisor] has a big impact on most of our lives I think and that level of intimacy in the room is just so profound and I think I would have eventually learned to do that but not as fast as I did.

JCR: Yeah, yeah. Sure.

Darcy: Yeah.

JCR: And it sounds like perhaps maybe not even with a different supervisor, had you . . .

Darcy: Yeah.

JCR: . . . not had that particular person.

Darcy: Absolutely, absolutely. Hands down, that's something [my supervisor] just does.

JCR: Mmm hmm. (affirmative)

Darcy: It's sort of the way [my supervisor] walks through the world and it's just nice to learn a little bit about that. Can I have a little slice of that in my repertoire of being a therapist.

JCR: Yeah, yeah.

Darcy: Yeah.

JCR: Fantastic. Okay, so the other side of that coin would be . . .

Darcy: Yes.

JCR: . . . were there any parts of that cotherapy process that you believed, um, either did or could have posed a barrier or hindrance to your development as a marriage, couple and family counselor?

Darcy: Um . . . The only thing that I think could have happened, just because of my personality and, and [my supervisor] was really careful to not let that sort of happen was if I had taken to much of a back seat and sort of . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . been like, okay. [my supervisor]'s a master and I'm just gonna kind of watch and absorb passively. Um, and even small ways because I would push myself to, to interact, um, and then if, you know, I think maybe two or three weeks went by onetime and I was having a really rough time with something else in my life, um, and i just wasn't as, I wasn't pushing myself as much and . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . [my supervisor] said something really kind like, "So, you know, you've kind of been in the back seat the last couple of times and I'm not the only one that's noticed," and I said, "Yeah, right?" (laughter)

JCR: (laughter)

Darcy: But [my supervisor] caught it really soon, [my supervisor] didn't let it go on very long but [my supervisor] didn't jump . . .

JCR: Okay.

Darcy: . . . on me like the first time it happened either. [my supervisor] sort of waited to see, like, is this like something, Mary's just having a bad day or is this, now it's starting to become like . . .

JCR: A pattern?

Darcy: Yeah. And um, and if [my supervisor] hadn't caught that it might have turned from just a bad couple of weeks to a pattern in the room. It very well could have because of my level of insecurity and, and being intimidated. If I was like, oh, okay, well, now that I'm in the back seat, I'm just going to stay in the back seat, right? It would have been hard to move back up.

JCR: It's comfy here.

Darcy: Yeah, it's comfy and it would have been hard to change the dynamic but he was like . . .

JCR: Uh huh.

Darcy: . . . "Why don't you change it?" And I said, "I'll get back in the front seat," and [my supervisor]'s like, "Well, you know, somewhere in between would be okay." You know? (laughter)

JCR: (laughter)

Darcy: Like, you don't have to like, jump in all the time but do a little bit more than you're doing.

JCR: Yeah.

Darcy: And uh, so that sort of . . .

JCR: Yeah.

Darcy: . . . playfulness, um, helped that not become an issue but I think that's a risk and, and certainly if I, I haven't done a lot of cotherapy with my interns but if I were to do it, I see that as a place to be attentive to.

JCR: Mmm hmm. (affirmative)

Darcy: Because there's an expert in the room and a novice in the room, it's really easy for the novice to kind of just follow.

JCR: Yeah.

Darcy: Yeah.

JCR: That's, that's the other side of this research that I want to do one day, it's from a supervisor's standpoint.

Darcy: Yeah, yes. Yeah, absolutely.

JCR: Um, okay. Is there anything else that I didn't ask you about, um, your experience with cotherapy that you think would be useful for me to know?

Darcy: Um . . . The only thing I would add is, is my supervisor's ability to elicit my feedback of [my supervisor's] work. Um, and not expecting me to do that right away but somewhere along the way, [my supervisor] started asking me about that and then [my supervisor] would ask me even more and then sometimes [my supervisor]'d be like, "That was, that might not have been the best thing to do," and I'd be like, "No, I didn't see it that way."

JCR: Yeah.

Darcy: So it really, and, and part of that is we continued after my internship so I don't know how you would include that, but that last piece happened after my internship but . . .

JCR: Sure.

Darcy: . . . even during my internship, just saying, "What did you see that could have been more [inaudible 00:13:58]?"

JCR: Well, and it seems to me that that was indicative of [my supervisor's] respect for you as a clinician and kind of [my supervisor's] . . .

Darcy: Yeah.

JCR: . . . [my supervisor's] belief in, you know, your, that, that you probably would . . .

Darcy: Yeah.

JCR: . . . have something of value to say and that . . .

Darcy: Right. And that I could think critically about a session . . .

JCR: Mmm hmm. (affirmative)

Darcy: . . . whether it was my work or [my supervisor's] work, there's always room to sort of go, "Well, we could tinker with that a little bit."

JCR: Yeah.

Darcy: Yeah.

JCR: Very nice.

Darcy: Yes.

JCR: Okay.

Darcy: Okay.

JCR: Thank you.

Grace

JCR: Okay. And when you think back to just the portion of it um, that you did co therapy in particular, for about how long or about how many sessions um, did you utilize co therapy with your supervisor [inaudible 00:03:26]?

Grace: Uh, gosh you know I guess I would say I probably did . . . Maybe two dozen co therapy sessions.

JCR: And how many co therapy partners as an intern? So, I guess how many . . . With how many supervisors did you do co therapy?

Grace: Well, predominantly one. I did do a co therapy session though, with um, a secondary supervisor [inaudible 00:04:13].

JCR: And as best you can recall, who sought whom for those co therapy relationships?

Grace: Well, I don't know that it was a who sought whom, it was just more of a this is what we're going to do. It was just a mutually agreed upon um, that we would do that and that it would be helpful. So, I would say it was mutual discussion or . . .

JCR: Gotcha.

Grace: Desire.

JCR: And sort of presented at the outset that this is just part of how supervision happens?

Grace: Um, I don't know if it was presented at the outset. I think it probably um, just kind of evolved into let's do some co therapy.

JCR: So, more now I guess about the co therapy process in particular. Um, and again as we go through, I think lot of the questions start to seem a little redundant um, so if there isn't any new information it's okay to say that you've shared all you have. But I'll ask anyways just in case.

Um, so once you and your supervisor initiated co therapy into the supervision um, how often would be meeting with that client or clients?

Grace: Well, I think it varies. So, I think there were couple of cases where we met maybe once a week. Um, and there were a few cases where we met once a month or even some sessions that were probably just a one time session.

JCR: About how many different clients do you think you saw with your supervisor?

Grace: Hmm, maybe six or so.

JCR: Okay and what types of constellations of clients um, do you recall them being? And that might be diagnoses, presenting issues, um, composed families.

Grace: So, there were some individual clients um, predominantly let's see I would say those folks were probably relationship stressors um, there were family cases for sure. Um, drug and alcohol um, sort of teen you know, op positional defiance. Um, some [inaudible 00:07:31] um, there were couples. Cases with I would say some mutual um, depression issues and um, marital relationship stressors. That's kind of all I can think of.

JCR: Yeah [inaudible 00:07:59].

Grace: Mm-hmm (affirmative)

JCR: So, from start to finish um, including any prep time or debriefing that might have happened before or after, walk me through a typical co therapy session with your supervisor.

Grace: So, there was probably ten to fifteen minutes of meeting prior to the session. Um, and then depending upon the particular case it may . . . I would say back then it was more uh, common place for it to be like an hour and a half session. Um, and then there was typically like half an hour depending upon complexity or whether or not we ended up discussing other cases as well and then there was kind of debriefing after the session kind of concluding how it went and um, what both our thoughts were on, on where we were going with the client. And how would then help them navigate.

JCR: Okay, okay and what would happen during that ten to fifteen minutes prior to the session?

Grace: Um, that was a little . . . Well, that was probably just some . . . A little bit of chit chat between the supervisor and supervisee and kind of, "How are you today?: Um, "How are things? Are you ready? Any thoughts or concerns kind of going into the visit?" Um, it was what either one of us wanted to bring up or thought about since the last visit.

JCR: So, what do you think your supervisor's intent was if, if any intent at all, with that time? It sounds like fairly um, laid back, maybe compared to getting down to business and other parts of the session.

Grace: Um, I would say that my supervisor was fairly laid back. [laughter] And [my supervisor] was not um, at lest at that time, [my supervisor] was not a let's

get down to business and all you know, we're going to talk about the case and we're going to you know, strategize. [my supervisor] was very much um, [my supervisor] would definitely emphasize you know, "How are you doing today?" And just awareness in that regard. But that was all very um, relaxed and casual. It was not an intensely clinical you know, preparation for the visit.

JCR: Okay, and so what would happen um, during the session?

Grace: Um, you know the sessions were let's see. The sessions I men they varied, there were some intense sessions and there were sessions that we ended abruptly. Um, and my supervisor actually asked on of the patients to exit the room. Um, that was just due to some volatility. I thought it was very appropriate given the circumstances. Um, there . . . I would say they were mostly just very mutual. There was not a "This is when I talk, this is when you talk." Kind of scenario. It was um, from the get go we were therapist team and that was client understanding on how we progressed with, um, with them. Then every time that they came in it was um, mutual effort. There was not fear of speaking over somebody or misspeaking in any way.

Um, and that was probably something that early on um, you know I had grown comfortable with. I think [my supervisor] was comfortable with it from the get go uh, would be my take and I had to get more comfortable with it just because it was new dynamic. It wasn't something that we did in school. And so the idea of having somebody right there who has lot of expertise um, can be intimidating at first but the more comfortable that you get with your supervisor the more comfortable and confident you are then being able to um, actively co facilitate the session.

JCR: Yeah, and that seems to be a really common theme that comes up to is that level of comfort and how not having it would really change what co therapy was like.

Grace: Well, and I did a lot of supervision with [my supervisor] prior to. So, just given like case load and things and the fact that I came into a private practice setting and I wasn't in a clinic where I was seeing a ton of clients. Um, there was actually a lot of supervision hours and probably a um, substantial amount of supervision hours before we actually did a co therapy session. So, it generally was an opportunity for [my supervisor] and I to get to know each each other well and then to have a feel for you know, I have a feel for [my supervisor's] supervision style, I think [my supervisor] had a feel for um, some of my clinical styles. But I had a feel for who [my supervisor] is as a person and I think [my supervisor] likewise had a feel for who I am. Um, which I think allowed us to, to have probably more of a fluid um, co therapist relationship in those sessions.

JCR: For sure. That makes absolute sense.

Grace: I wasn't concerned about the things that [my supervisor] was going to say and do and I don't think that [my supervisor] was concerned about the things that I was going to say and do um . . .

JCR: You trusted each other?

Grace: Mm-hmm (affirmative) [coughing] pardon me.

JCR: So, then you mention that for a half an hour or so afterwards give or take you would talk about just sort of how things went and, and what was going on in the session. Talk to me more about um, what went on during those debriefings and how those were structured.

Grace: Um, well I don't know that they were intensely structured. But I think that they were just an opportunity to have a dialogue about how did that go for you. Um, you know, initially I think coming out of school I was pretty anxious about some of the high volatility sessions. Um, and so that was an opportunity for me to then talk about you know, I guess comfort level. My comfort level.

You know, somebody storming out or somebody being um, kind of aggressive. And like I said, we had, we had one case where um, [my supervisor] asked one of the participants to, to exit the room and I think it was appropriate. But those are often times you know, just kind of emotionally distressing for the therapist um, having done it now for a number of years, I would say I still have some of that when you have somebody who you do ask to leave or they storm out or they're angry or upset with you in some way shape or form and draw a line . . . A therapeutic line of things that you won't tolerate and they don't agree to it, that can be particularly distressing. So, I remember those debriefings as an opportunity to um, just kind of talk about that you know. So, from a clinical perspective, a supervisor maybe having done that numerous times already in their career. Versus a co therapist intern having newly experience that you know, the emotional level for the therapist is going to be very, very different.

JCR: Right. Absolutely.

Grace: Um, but it was really just an opportunity to, "How did that go for you?" There were times when I guess it was a little bit more structured. Like, we would do um, the progress note together and just kind of a um, an opportunity to go over what that would look like, which would give me then more knowledge than I had coming out of school. Kind of you know, watching somebody

create their clinical interpretation onto a progress note. Um, not something that I was taught.

JCR: Mm-hmm (affirmative)

Grace: In my program. So, um, that was probably the most structured element to those, was doing um, kind of a progress note together. You know, coming up with the diagnosis together um, reviewing symptoms that you know, we picked up on that may have been slightly different than the other person.

JCR: Mm-hmm (affirmative). Is there anything else you would add about that piece, just the, the structure or the process of kind of how co therapy worked I didn't ask you about?

Grace: Hmm, um, not really. I mean there was an instance . . . For a while there, my supervisor was trying to include me in most of [my supervisor's] new patients. And there was an instance where um, we went to grab the patient from the waiting room, and the patient refused to meet with me in the room. And so that was actually pretty interesting, I guess, looking back.

JCR: Yeah, sure.

Grace: And um, what happened when it was explained that [my supervisor] was working as a co therapy team as . . . You know, as the instructor and teaching um, to the new patient appointments that [my supervisor] established for us to do together. And we did have that instance where um, we went to grab the, the client from the waiting room and it was a couple and they expressed that they . . . Well, one of them was not comfortable with it being a teaching session.

And so um, declined having me attend that session. So, [my supervisor] went in and did the session um, on [my supervisor's] own. And after that we talked um, and [my supervisor] wasn't comfortable with the way that that went. And so then um, [my supervisor] . . . It's my understanding that [my supervisor] then told that client that um, [my supervisor]'s only doing teaching sessions and so if they weren't comfortable with that [my supervisor] would gladly refer them. Um, that indeed those were going to be the sessions that [my supervisor] was doing so they had the option of either continuing with the two of us as a team or discontinuing and being referred and I think that was just a by product of kind of where [my supervisor] was at at the time, that [my supervisor] really wanted to make the emphasis on um, um, the co therapy team so.

JCR: What did they chose?

Grace: Um, interestingly enough . . . So, that first time they came in as a couple, and they declined having me in the room and they met with [my supervisor] for a first appointment. They came back and the wife did not attend uh, and the husband attended with both of us and I think then discontinued after that so yeah. But it was, it was an interesting kind of co therapy dynamic to navigate in that moment because I think it kind of . . . I think it took us both a little off guard. And for a conversation to have happened in the hallway um, okay I guess I'm not in there and as an intern you know, you're in that spot where you're, you're very eager and you're very anxious to learn everything and then to hear um, you know we don't want you in the room or, or there's something that was uncomfortable for that client I remember that was um, I think it created definitely a big conversation between my supervisor and I. Just um, okay what does that mean and how will we navigate that? What is it like not to be wanted in the room?

JCR: Yeah, so your supervisor took that as an opportunity for further processing or a different kind of processing and sort of . . .

Grace: Yeah, kind of "How are you since that happened?" And granted I think it also threw [my supervisor] off.

JCR: I'm sure.

Grace: Um, you know, because then [my supervisor] was on by himself and not that [my supervisor] needed me in the room but that was our . . . You know, just the shift in dynamic because that was how we laid out how we were going to go into the appointment.

JCR: Right.

Grace: Yeah, so I do remember that one. That was interesting.

JCR: Yeah.

Grace: Um, and it was also you know, it was very I guess reassuring in that point that I had a supervisor who stood up for me. Um, and that may be an interesting dynamic for you.

JCR: Yeah.

Grace: Um, because if [my supervisor] had handled that in some way that made me feel less than or perhaps [my supervisor] didn't draw some of those lines you know, I wonder you know, how that would have gone differently. But [my supervisor] was very um, supportive of the co therapy team and [my supervisor] was very supportive of you know, if [my supervisor]'s going to

draw this line of these are joint sessions [my supervisor]'s not going to have me left out at the last minute showing up. I mean my time . . . You know, that kind of thing. So, [my supervisor] was very, very considerate of you know, what that was and establishing those, those boundaries with clients.

JCR: Very cool.

Grace: Um, and I think that that you know, that went a long way in my self efficacy as a therapist I think is that [my supervisor] treated me with that kind of respect and it wasn't going to be a haphazard you know, if the client doesn't want to the client doesn't want to. Um, you know, and you see that in different medical settings you know, like you go in to see your physician if they're a teaching physician, you may choose not to and at the same time I've seen physician offices where they say, "We are a teaching practice and unable to meet you." So, they draw that line. And that has always reminded me of that. Because [my supervisor] drew that line of I am teaching, these are co therapy sessions it's you know, part of the time that [my supervisor] returned phone calls to these folks, [my supervisor] let them know that that's what [my supervisor] was doing.

So, there was this agreement you know, well a head of time if [my supervisor] had let that continue you know, or I would have come in repeatedly for co therapy and last minute you know, I'm being, I'm being brushed aside I think that would have changed things.

JCR: Yeah, for sure.

Grace: You know just in terms of you know, how do I feel I fit into this or you know, my efficacy of, of being an intern and what I offer and yeah.

JCR: So, there are some pivotal moments that have been among the process and that the two primary constructs that, that . . . [inaudible 00:23:29] my research back to um, are self efficacy and clinical competency. And so, I'll read you my little definition here so we're operationalizing it. Um, but on the self efficacy side, like it's a state in believing in one's ability to perform a given task with some degree of confidence, that success . . . However that may be defined is possible. So, that's coming from [inaudible 00:23:55] conceptual learning theory. So, when you think about the course of your experiences with co therapy um, describe your current level of self efficacy as you perceive it and in particular what role if any did the co therapy play in helping you get there?

Grace: Okay. [laughter] That's a broader question.

JCR: It is a broader question.

Grace: So, I think that in the course of my day to day um, I do have good self efficacy. I think that it played a huge part because I think in the course of any given session, some of those early experiences you'll go back to. Um, when I came out of school I was particularly concerned about not being equipped with enough techniques to help people. And those early experiences in co therapy definitely taught me that it was not about having the techniques. And it definitely facilitated that it was more about the relationship that you end up establishing with the clients.

And it's interesting to look back on that because the idea of then both of us establishing that kind of relationship with those clients and moving forward as a team with them I think it impacts my day to day now for sure. Because when you get stuck with someone or you're not particularly sure um, to be able to look at it from that angle and know that those early experiences are also part of what help you form your own belief system in terms of not just theoretic orientation but also um, personal and inter personal beliefs on how therapy functions and how it um, helps folks achieve their goals.

So, I would say it impacts my day to day now still for sure and probably always will. Because I think it laid a foundation that had I not had had that um, there's something very unique to being able to witness someone you respect in terms of how they do therapy. I think there's something very unique about being able to witness that. Um, and them being able to model to you as a new intern some of the ways that you navigate through the therapy process. Be it um, not so challenging sessions or be it particularly challenging sessions. And how they do that.

JCR: Yes.

Grace: So, I would say to my self efficacy today still. Yeah.

JCR: Okay.

Grace: Did I answer that?

JCR: You did, you absolutely did. So, now we're going to . . . Basically, same question regard to clinical competency. So, again to operationalize that I'm going to give you this bad boy, which I think you've seen through AAMFT, definitely don't read word for word. Um, and I know that you've seen that stuff. But that is their core competency is so clinical competency is generally defined as being demonstrated when a professional has the knowledge and skills necessary to practice [my supervisor's] or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards. So, for marriage, couple, and family Councillors, competency is

defined by professional and credential organization such as AMMFT, KCRAB and the NCA.

So, when you consider the knowledge and skill areas included in um, what we're using today, which is the AAMFT core competencies um, talk about your current level of clinical competence based on those best practice . . . Best practice standards, excuse me, and the inner plays that co therapy may have had in your development in that area.

Grace: So, I do believe that I practice with the core competencies. Um, so I think that it was probably a combination of efforts. So, not only was it um, the co therapy but it was also um, I would say then the quantity of supervision that came from my co therapist. So, I mean I had that dynamic so my primary supervisor was my co therapist. I only did one visit with a secondary supervisor. But I think developing the core competencies was also part of not only witnessing um, my supervisor do them but being able to have a discussion about them and being able to um, kind of sort out the not just the how's but maybe the why's behind them as well. Um, or as some of the challenges came up, being able to quickly address them. So, if I had um, you know, questions about documentation or questions about um, how to handle like you described, vulnerable populations confidentiality around um, minors. Things, you know, questions that would just naturally come up in the midst of learning how to do the job and meeting with new clients.

So, not only did I get to see it by doing co therapy which modeled it and allowed me then, I think to be more confident in working with my clients down the road. But I also had the supervision readily accessible for any questions that I had along the way. Um, and I think that that allowed me definitely to . . . It, it still does. It allows me to feel more competent in how I do things but then I also have the opportunity of still being able to case consult with the same supervisor.

JCR: Great.

Grace: Um, so it gives me that opportunity to continue to um, check on some of those maybe ethical challenges or legal challenges that can present themselves um, and bounce those ideas off of somebody. So, to me that's huge because I've had really good consistency in that regard. Um, and I did have other supervisors that played into that. Um, I had one other um, I had one secondary supervisor and I did do a decent amount of supervision with her. I didn't do a lot of co therapy um, and the co therapy I did with her was actually transfer session from me to her.

JCR: Gotcha.

Grace: When I went on maternity leave. Um, and that was different and it was something where you know, looking back, my style very much was impacted by my primary supervisor. Um, I think I got a lot of core competency information from my secondary supervisor through supervision um, but our therapeutic style was very, very different um, in session.

JCR: Yes.

Grace: And that kind of came out when we did that, that joint session. Um, that's [inaudible 00:31:56] but.

JCR: It's good information.

Grace: Okay.

JCR: Okay, so we're almost done. I just have a couple of other really general questions for you that again might be redundant. You've already answered a lot of this but, when you think about the co therapy process as a whole and just your experiences there, what, what component or components of that process do you think were the most helpful or instrumental in your overall learning process um, and developing that ethicacy and competency?

Grace: What parts of the co therapy?

JCR: Mm-hmm (affirmative) that if there, if there were any sort of highlights to pull out that okay, this really made a difference and that really made a difference. Was there anything that sort of stood out?

Grace: Um, I would say it was probably the discussions after the sessions um, because that was probably the opportunity where I was able to check my clinical skills in the session and get either guidance to do things differently or reassurance that I was doing things um, clinically appropriate.

Um, so I would say that would probably be the main thing is the opportunity to discuss my clinical competencies in the session. And that probably facilitated not only my competencies but my efficacy.

JCR: And would you say that that happened in a different way or to a different degree than say doing a a case presentation in, in like a group supervision or showing a video?

Grace: Oh, absolutely.

JCR: Yeah.

Grace: [laughter] because I did those too. And you know, there's something very different about I think individual supervision. I really liked my group supervision that I had as an intern. Um, but there is something very, very different about opening it up to the entire room. And I think that the whole dynamic function is different and maybe even some of the feedback might be slightly different with your supervisor versus having been in the same session, have the exact same understanding. Or a similar understanding or feel off of what was going on in the room versus uh, your supervisor or your uh, supervision group reviewing your tape and somehow trying to present exactly what was going on.

JCR: Sure.

Grace: Um, I was never a huge fan of the group supervision. And that being said, my supervisor offered me a lot of individual supervision not just post co therapy. Um, which quite honestly I think was instrumental and very, very different. So, the supervision group, that I had was very um, everybody had very diverse um, occupational settings I guess would be the best way to describe that. Um, it wasn't that the case presentations were um, all that different or um, that you couldn't relate to the cases being presented because the settings were different, we definitely could. But it was just, you could tell it was a different way of approaching the cases versus sitting with your supervisor individually and being able maybe to talk through more of the details.

And that's probably um, an individual comfort level difference as well. I think that I may have chose to say far more in an individual supervision session or post co therapy with just my supervisor than I would have with an entire group of supervisees. Um, so I think it changes the setting. Or the setting changes the you know, the comfort level and then the benefit that you can you can get out of it.

JCR: Sure, the process that happens.

Grace: Mm-hmm (affirmative)

JCR: Okay, so on the other side of that question, um, were there any parts . . . Or what were the parts of co therapy that you thought posed a challenge or a hindrance to your learning process or the development of those constructs we've been talking about?

Grace: Um, I don't know that there were a lot of challenges . I guess if I had to pick out something that I would have liked to be more present which we could look at it maybe as it was a challenge, I would have liked to see more of um, the structural process. So, um, my supervisor was not huge into paperwork. And the hard part is I think that coming into I think that was a discrepancy

just in terms of like when [my supervisor] kind of came into doing this work and as um, younger folks are coming into doing this work there's a different belief system maybe on what needs to be there in terms of maintaining paperwork.

And so, sometimes that was vague. Um, and I would have liked to have seen that more. But I think over the years part of what I've realised is that in turn was that you know, everybody not only has their own style of doing that um, but one person's comfort level in terms of documentation or what would necessitate more documentation is different.

JCR: Mm-hmm (affirmative)

Grace: Than someone else's. I think I would have enjoyed seeing more of what that actually looked like. Um, versus just some of the discussion on what was you know, maybe appropriate um. But that being said I think that I've developed my own mechanism for doing that that fits within guidelines. Um, but it's also probably a by product of how I was supervised and how I was encouraged to do and not do. Yeah, so if, if I had to pick something I mean I would pick that. But I would have liked to have just seen more of the actual you know, structure behind doing the job and, and the business. Which I think is different maybe for me as well. Because I didn't go into an agency where those were set up very clinical, here's how we're gonna have you do it.

It was up to me to figure out what was going to work for me and I was trying to get information off of what worked for my supervisor. Which may not have worked for me at the time. And that was probably just based on you know, anxiety as a new intern and, and am I doing it correctly, am I not doing it correctly? And the desire to want to do it correctly so [laughter].

JCR: I think that's one of my biggest complaints about most of the grad programs out there is that nobody teaches us how to do the administrative part of our job. So, all the clinical stuff and put you out there. I have to send those and like . . .

Grace: Well, and the idea that if you're working in a . . . If you're working in a clinic, a lot of that is structured for you. But in order to come up with how to do it yourself, I mean I spent an inordinate amount of time creating forms. If I look back on it and it wasn't that my supervisor um, told me I needed to do that um, but I think my supervisor was in a spot where forms were not as big of an issue for [my supervisor] as I felt like they would be helpful for me.

And so I ended up creating a ton of things just to help me navigate the fact that there wasn't some of that structure already in place. And so I was kind of grabbing from all sorts of different resources to come up with what I thought

would actually help me feel um, like I was doing it in a way that I could . . . You know, in a way that was going to keep doing it that way. So, that would be one.

JCR: Okay. Um, is there anything that I haven't asked you about that you would want to add that would further describe your experience um, as an intern doing co therapy?

Grace: Um, no, not around the co therapy. Well, I think that they go hand in hand. To me the co therapy was an opportunity to have more supervision. So, from a supervisory perspective I think that it's immensely helpful for folks to have access to their supervisor. So, whether I was concerned about um, a co therapy session or whether I was concerned about an individual session that I had with a client my supervisor was highly accessible to me. Um, and I would say that that was immensely helpful in terms of my efficacy and competency.

And I can remember um, I can remember one instance in particular where I had to um, very early on I had to um, call for um, it wasn't really a welfare check it was a welfare pick up by PD um, for a client who was suicidal. And um, my supervisor noticed that I was upset because it was emotionally very draining um, the way that it laid out. And [my supervisor] canceled one of [my supervisor's] appointments to sit and talk to me about what just happened and I think that goes a long way in helping you feel like the stuff that you're doing matters. And that you have a supervisor who cares.

JCR: That's huge.

Grace: So, looking back on that event or . . . I mean I can think of numerous events even . . . Um, you know, because you get to know your co therapist and your supervisor pretty well. Um, you know where [my supervisor], [my supervisor] could recognize that if I was struggling in some way um, you know just in passing that there was an opportunity to have a conversation about it. And it wasn't uh, dismissed and so I do think that plays into the co therapy side. Like I said, if [my supervisor] would allow [my supervisor's] um, the mutual clients that we were supposed to have to just mislead or if I felt dismissed because I was struggling with a particularly difficult case at the time or something like that I think that that would have been probably devastating in terms of my efficacy a therapist. So [inaudible 00:44:13] that piece, that was um, yeah it said a lot.

So, the belief in your supervisor and co therapist that you have the ability to grow and learn how to do these things I think is very, very valuable.

JCR: Yeah. Okay, I don't have any more questions for you. I have all of them. Thank you so much.

Grace: You are very welcome.

Jane

Jane: Okay. Um . . . So there were two of them that I did cotherapy with, and I would say probably maybe close to year.

JCR: Okay, and were those typically an average of weekly sessions or were they spread out?

Jane: Mm-hmm (affirmative). Yeah, weekly sessions.

JCR: That's awesome.

Jane: Yeah.

JCR: That's a lot of sessions.

Jane: Yeah.

JCR: Who sought whom for that cotherapy relationship?

Jane: Um, I really think it was an opportunity presented to multiple interns, and I think . . . so that there was the, the opportunity there, but I think I spoke up and said that I wanted to be a part of that.

JCR: Good job. So that was a voluntary part of your supervision.

Jane: Yes. It was not required.

JCR: Okay, so now I just want to move into talking more specifically about the cotherapy process. Um, so you sort of already answered this part about how often you incorporated cotherapy into the supervision, um, and so you said that was about weekly?

Jane: Mm-hmm (affirmative).

JCR: How many sessions per week were you doing typically?

Jane: Of the cotherapy?

JCR: Mm-hmm (affirmative).

Jane: Um, I, probably not more than one because I think I staggered them with each of the supervisors.

JCR: Got you. Okay, and how many different clients did you see doing cotherapy with those supervisors?

Jane: Um . . . I saw a family and a couple with one supervisor and saw two couples and children of a family with another supervisor.

JCR: You really got to be exposed to several different family systems throughout that process.

Jane: Mm-hmm (affirmative).

JCR: Okay. Awesome, and so the next question was about the type [inaudible 05:46] consultations of clients, but you already answered that, so I won't make you repeat it. Um, so now I would like to talk about just a typical cotherapy session with your supervisor. That might include any prep time, um, how the session would typically go, and then whatever type of debriefing you might have done afterwards, so kind of from start to finish, um, when you came to the office. What did that normally look like?

Jane: Um, well, I think . . . I don't know that we did too much prep work before the session, um, because I think that was really done during supervision, um, preparing for and discussing how we were gonna move through the, the next session, um, and then during the session I think that really evolved and changed. Um, in the beginning I wasn't really comfortable speaking. Just as an introvert I was shy and not really sure what to say or when it was my place to jump in, so I think that changed and I got more vocal as each of those relationships developed, um, and then after, I think, was crucial, the debriefing after the session, because I think that was a safe place to share all of my doubts and all of my questions to get affirmation and learn to be confident about doing it again.

JCR: Awesome.

Jane: Yeah.

JCR: Okay. Um, and so, again, I warned you this might get sort of redundant, but, um, so during that debriefing when you discussed the events of the session with your supervisor, um, you know, I know you mentioned being able to, um, just debrief about doubts and questions and that kind of thing.

Jane: Mm-hmm (affirmative).

JCR: Um, what else did you typically cover during those debriefings?

Jane: Um, diagnosis. That was extremely helpful. Um, having the, the, the experiential part of the session and then being able to have a face and move through the criteria in the DSM with supervisors was extremely valuable to me. Um, so diagnosis, um, and then also thinking about goals, really doing treatment planning and assessing how much the clients had progressed towards those specific goals, and then how to pinpoint exactly what we were seeing in the session to show that progress.

JCR: So really kind of the lifespan of a case.

Jane: Yeah.

JCR: Sort of almost in room.

Jane: Yes.

JCR: Okay, and with the structure of that debriefing, who typically led that discussion?

Jane: Hmm.

JCR: (Coughs)

Jane: I think that one evolved also. I think in the beginning there was a lot more structure. In the beginning with each supervisor there was a lot more structure, a lot more questions, a lot more guiding me toward making observations, um, but I think toward the end, especially in the end of, of different cases, um, I think that was much less structured and more, um, I guess maybe I took the lead more on that.

JCR: Yeah. As you sort of gained confidence and knew what was expected and what you looking for.

Jane: Mm-hmm (affirmative). Yeah.

JCR: Okay, um, is there anything that I didn't ask you about just how the cotherapy worked from session to session, um, that you think would be important to know?

Jane: Um, with both of them, one was a male and one was a female. Um, and I was in supervision group with them together, so I got to have the experience of processing a case in my supervision group with the supervisor there, and it

wasn't, it was more than one experience of it, so I got to experience case consultation with a supervisor who was also a co-therapist in the room and then do that again with another supervisor.

JCR: Very cool.

Jane: Yeah.

JCR: [inaudible 09:52]

Jane: Mm-hmm (affirmative).

JCR: [inaudible 09:54]

Jane: Mm-hmm (affirmative).

JCR: Okay, so the, um, sort of the heart of this study is looking at self efficacy and clinical competency.

Jane: Mm-hmm (affirmative).

JCR: Um, since, since I'm examining, um, cotherapy as kind of a, a piece of the supervision process, so I want to start with the self efficacy piece, and I know you know this, but I'm gonna say it anyway. Self efficacy is a state of believing in one's ability to perform a given task with some degree of confidence, that success, however that may be defined, is possible, and that's from Bandura. Um, so please describe your current level of self efficacy as you perceive it. (Coughs)

Jane: Um . . . I'm not really sure how to describe it in a level.

JCR: No?

Jane: Um . . . I . . . Professionally, I really believe in the work that I do, and I believe that I can do great work, um, and I have made a lot of reflection about how I've evolved in that way. Um, so I don't, I certainly wasn't efficacious in the beginning, um, but I do, I do have a certain level of confidence now in the work that I do.

JCR: Okay. Great.

Jane: Yeah. Is that answering?

JCR: Absolutely. Yeah, and so to piggyback on that then, what, if any, contribution do you believe the cotherapy had on the evolution of your self efficacy?

Jane: Um, a lot.

JCR: Okay.

Jane: A lot. I, I think, even, I would say, um, probably . . . That was probably the most . . . It had the most impact on me throughout my whole internship and in my whole supervision experience.

JCR: Wow.

Jane: Yeah.

JCR: So more in the supervision group process or more in any individual supervision?

Jane: That was hard because they were intertwining so much, so I got to use group supervision as a way, and individual, really, as a way to process through that, um, but it just allowed me to trust my own observations of what was happening in a session because I could compare and contrast with what my supervisors were observing.

JCR: Sure.

Jane: I didn't have to rely on my own self report, um, so when I, when I did something in a session with one of my supervisors there, um, and I believed it was great or I believed it was terrible or I believed it was something else, um, I, I at least had somebody that was observing me that could say, "You know, perception is really off," or "You're right on," or just reinforcing what I was observing about myself.

JCR: Yeah. Great. Okay, so, um, the other, the other side of then then is clinical competency, and, um, I'm sure you've seen this in your doctoral work. I'm gonna hand that to you. It's kind of a monster. You certainly don't have to read it word for word, but it's sort of the, the general core competencies that the American Association of Marriage and Family Therapists says, like a competent MFT would demonstrate. So I'll read you this definition.

Uh, clinical competency is generally defined as being demonstrated when a professional who has the knowledge and skills necessary to practice his or her trade in a manner consistent with legal and ethical codes and closely in line with best practice standards. Um, so for marriage, couple and family counseling, competency is collectively defined by professional and credentialing organizations such AAMFT, CACREP and the NCA.

Jane: Mm-hmm (affirmative).

JCR: Please, uh, consider the knowledge and the skill areas included in the summary that you have there in your hands, um, as AAMFT defines them and consider how you perceive your own level of clinical competence, and so when you're ready, in as many words as you need describe your perception of your current level of, um, clinical competence.

Jane: Um, I would say I'm, uh, I'm competent. I don't see any of these that stand out that I wouldn't say I have clinical competence. Right now just with where I am in my studies, um, I would say that the research on program evaluation domain is probably my weakest domain, um, and I really think that's just not experiencing it. I'm doing more of the clinical and less of the research.

JCR: Sure.

Jane: Um, for the [inaudible 15:39] I believe I'm a competent therapist.

JCR: Okay, so just with the last area, what if any contribution do you believe the cotherapy had on your development of clinical competency based on those standards?

Jane: I absolutely think it was, it was a contributing factor. Um, I mean, I can look at each of these and I think that there are, there's the nuanced level of the experience that I, that I got in just watching and observing and being a part of and trying out, um, all of these different areas in cotherapy in my being able to reflect back with not just my eyes but my supervisors eyes and then being able to take that into a supervision group and, and be able to consult and have case conceptualization with my experience, so reinforcing that I'm on, on point with what the experience was like because I knew that somebody else was in the room experience it too.

JCR: Sure.

Jane: So I, I, I really think that these were all . . . Some I might have developed in, um, in my studies, in my Master's program, but I think the, the application of all of them certainly was from cotherapy.

JCR: Perfect.

Jane: Yeah.

JCR: Okay. Um, so in a more sort of general sense, what, what particular aspects of the cotherapy, and you have already speaken to several . . . spoken to several.

What parts of the cotherapy do you believe to have been the most helpful or instrumental in your overall learning process?

Jane: Um . . . I think some, some are just so nuanced and intangible that I can't even really pinpoint what they are, but walking through the whole process, because I think I can read about it and I can learn about and I can talk about it, but actually doing it and then getting feedback, um, or even watching how somebody else does, you know, like, um, in here one of the standards, I think, that I just read was, um . . . I can't find it right now, but even just learning how to accept money from clients, how to, how to talk about, "Okay, your copay for your insurance is this much," or, um, "You know, we end at this time," or how to, how to deal with silence or how to deal with seating arrangements or how . . . All of those small things that created anxiety for me in the beginning, I didn't even have to ask the questions. I just was . . . It was just like osmosis being in the experience of it and being able to have somebody else guide that helped me and, I think, really helped form the way that I structure a session, the way that I do therapy.

JCR: Yeah, that makes absolutely sense. Even, even some of the just small sort of practical or, or the business . . .

Jane: Yeah.

JCR: . . . side of, yeah, getting therapy . . .

Jane: Yeah.

JCR: . . . um, which gave you sort of the, the [inaudible 18:48] view of things. That was different than, like, say even in an agency setting.

Jane: Yeah. Absolutely, and I think, um, that's a really good point because at the time when I was doing cotherapy, I was also working at an agency, and it was helpful for me (ring tone) in, in showing that, um, I didn't have to do everything the way that I had in the agency setting.

JCR: Oh my gosh.

Jane: Um, in the agency we didn't have to deal with copay. We didn't have to deal with money. We didn't have to deal with, um, how to . . . Just there was so much of it, um, and so it helped because in an agency if that was my only experience, and it was at the time, that was the way that I say therapy, and so being able to step outside of that and have a completely different experience, um, but still within the safety net of knowing that I could take risks therapeutically with clients and that no harm would really be done because I was, there was a safeguard there.

JCR: Absolutely.

Jane: Yeah.

JCR: That's huge, and so, again with the redundancy, but, um, is there anything in addition to what you've said, um, or anything in particular about what you just said, um, that you believe was the most helpful or instrumental to self efficacy or competency in particular?

Jane: Mm-hmm (affirmative). Well, yeah. I think, for me, um, just in my personalty, I don't like to take risks. I'm a cautious person. I like to be in my comfort zone, um, and if I figure out a way with a client that's, that's working enough, it is effective enough, then I think especially early on my anxiety was high, and so I would just stay within those bounds. Um, and watching my supervisors take risks and me knowing, because I have relationships with each of them, knowing that they weren't comfortable yet trying something new, maybe trying a different technique or working from a different theory or establishing a different, a different dynamic in a relationship, knowing that they were uncomfortable and watching them work through that discomfort or uncertainty or anxiety about it, watching them model that I think was really helpful, showing me that I could do that and showing me that even though they weren't perfect at whatever they were demonstrating, um, it still had a really positive impact on a client. It didn't have to be perfect.

JCR: Yeah.

Jane: Yeah.

JCR: Right, and then so you don't have to be perfect.

Jane: Exactly.

JCR: Yeah.

Jane: Exactly. Yeah.

JCR: Do you think, um, just based on lots of conversations with various interns, that's, I think a pretty common belief, that you have to kind of come out of the gate doing it . . .

Jane: Yes.

JCR: . . . just so.

Jane: Yes. Yeah, and even watching them, my supervisors or the, my co-therapists, um, fumble, um, or do something that needed a repair later in, in the therapeutic relationship, just watching that and being a part of that, um, was just so valuable.

JCR: Good.

Jane: Mm-hmm (affirmative).

JCR: Nice.

Jane: Yeah.

JCR: Um, so then on the other side of that, what parts of the cotherapy, um, did you believe to pose a challenge or a hindrance to your overall learning process?

Jane: Um . . . I don't know if it was a hindrance, but it certainly was a challenge to balance different ways of doing it because I think early on I had a tendency to, to want to know the right way to do therapy, um, and so it was a challenge for me to have two really completely different people, different mentors, different supervisors doing therapy in a different way, um, so balancing that, and I think in the end it just helped to show that there's not a right way to do therapy . . .

JCR: Yeah.

Jane: . . . um, and then we can meet all these competencies in a really different style, um, so I don't know that it was a hindrance as much as it was a benefit, but it was a challenge for me trying to figure out what's right and how do I do this right, and . . .

JCR: Sure.

Jane: . . . she does it this way and [my supervisor] does it this way, um, but I don't, I don't feel . . . It was a challenge, but I don't think a hindrance.

JCR: Okay.

Jane: Yeah.

JCR: Um, and then so to narrow that down, if there were an parts of cotherapy that were a challenge or hindrance to self efficacy or competency in particular, did you find that there were any?

Jane: No. Nn-nn (negative).

JCR: Okay.

Jane: No, I was just thinking about competency. There were so many times early on when I would just question my competence and, and self efficacy, really, um, so I know that there were points where I might have answered that yes, but now being on the other end of it, certainly no.

JCR: Yeah.

Jane: No. There were challenges and it was hard and scary and uncomfortable, and I think that created [inaudible 23:57] change, but I don't think in the end it ever hindered me.

JCR: Yeah, and so when you think back to a time that you might have answered that question differently, um, maybe put a few more words to that. Um, was there a point that you thought, like, "Oh, I shouldn't be doing this," or "I don't want to be doing this," or "This isn't helping me"?

Jane: With cotherapy?

JCR: Mm-hmm (affirmative).

Jane: Um . . . Yeah. I, I probably would've answered that in that way, um, but it really, looking back now I can see that it was really just about fear. Fear of taking a risk, fear of being outside of what I already knew, um, and what I already knew how to do well, um, and being in a session and feeling like I don't know what to say or I don't know how to be, um, but I don't know that . . . I . . .

Well, but I think also the debriefing part and being able to process in group supervision, um, I think that helped move me up pretty quickly because I'm thinking about times I did cotherapy with other interns, um, and we just we just didn't have that foundation. We couldn't count on each other's level of competence to challenge our own or to check out own, so I, I think I . . . Comparing those two, being in cotherapy with another intern and being in cotherapy with a supervisor, um, I don't think that being in cotherapy with a supervisor really was a hindrance.

JCR: Yeah. That makes sense. That's, um, kind of like a Part B or C or D to research that I want to do, is that comparing the types because there are some programs who pair interns together to do the cotherapy, but it sounds like you really notice a difference between doing cotherapy in a peer role versus a mentee kind of a role . . .

Jane: Yes. Yes.

JCR: . . . and it really had a different function for you.

Jane: Yes. It did.

JCR: Okay.

Jane: It really did. Yeah.

JCR: Um, so the very last question is just a very broad question, uh, and that is what else might you want to add about your experiences with cotherapy that I have not asked you about specifically?

Jane: Hmm . . . I don't know. Overall it was such a valuable experience for me. Growing, I think personally and professionally, um, and I think for me, any time I questioned my ability or my competency, I could always fall back on, "Well, they believe in me enough to know that I can do this work. Otherwise they wouldn't have invited me to be part of this. They wouldn't have subjected these clients to my . . . to me." Um, so I could always fall back on that, um, and I think that was really important.

Um, I did, I honestly did, um, a group where I, after I was licensed where I had an intern working with me. I wasn't a supervisor, but, um, I think, I think it's just across all . . . because [my supervisor] had a different license, um, but across all clinical licensures, doing the work that we do, I think it's so important to be able to watch and be able to observe and pick up on how to do it, the art of it, but it can't really be studied and can't really be talked about, um, but just being able to observe it and being, being able to witness somebody modeling it all.

JCR: Absolutely.

Jane: Yeah.

JCR: That's really fun.

Jane: Mm-hmm (affirmative). It is really fun, yeah. Mm-hmm (affirmative).

JCR: Okay. Is there anything else you want to add?

Jane: I don't think so.

JCR: Okay. That's all the questions I have for you.

Jane: Okay.

Matthew

JCR: And over what period of time or approximately how many sessions did you utilize cotherapy in that supervision?

Matthew: Um . . . you know . . . it is at least a year and a half. It might even be close to 2 years. Yeah. A lot of sessions it was weekly at first and then, um, I think towards the end we expanded that to like every other week and yeah. So a lot of sessions.

JCR: With how many other partners have you done cotherapy? Or I should specify, with how many supervisors?

Matthew: Um, just 1.

JCR: And who sought him for that cotherapy relationship?

Matthew: The supervisor approached him.

JCR: Okay, perfect. So now I just want to talk with you, um, about the cotherapy process, specifically. So, um, you sort of already spoke to how often; I want to reiterate to make sure I have it right, that for the most part it started as weekly sessions and then when the case reached a developmental point where it was appropriate you tapered back to about every other week.

Matthew: Yeah, mm-hmm (affirmative).

JCR: Perfect. How many different clients did you see?

Matthew: Just one. One couple.

JCR: And was it always the two partners of the couple coming to therapy or were there different constellations of that couple in their therapy?

Matthew: Well, um, this is a situation where um, my supervisor um, had a long term therapeutical relationship with um, with the wife and they wanted to move into couples' therapy and um, actually couples' therapy began with the um, with the cotherapy. They were simultaneously um . . . and as it turned out, after that year and a half or even a 2 year period um, I

started an individual therapeutic relationship with the husband. So um, and then my supervisor maintained the relationship with the wife, so that was kinda neat.

JCR: Yeah, you really got to see it from all angles and [inaudible 00:06:17] across quite a lifespan. So, when you think about um, the life of a cotherapy session, describe for me what that looked like. Just beginning from the moment you and your supervisor got together to begin the session or whatever preparation you did, all the way until the client left and you did whatever you did after.

Matthew: So like an individual session. Is that right?

JCR: Mm-hmm (affirmative), yeah, yeah. One encounter.

Matthew: One encounter, sure. Um, it was um, it was structured in the sense that you know, we purposely set aside time in the beginning to um, to review kind of the what we had seen in the previous session, talk about maybe goals for the session, um . . . and really um, really strategize on how we wanted to structure the session, things that we wanted to make sure to bring up and um, I would, I would actually verbalize maybe personal goals that I would have, like maybe there would be times where I didn't think I was um, you know, participating enough or talking enough and I would take that time to kind of process, you know, what was going on for me in terms of you know, thoughts and feelings during sessions.

And so, the session would begin and the supervisor actually um, put me in a lead role and um-

JCR: Even from the beginning?

Matthew: Yep. Pretty much from the beginning. And so I would be, you know, I would try the best I could, you know, um, to the level of experience that I had, you know, to take that leadership role and um . . . and it was, you know, being guided by what we talked about prior to the session, you know, we'd kind of go down that direction. Sometimes, you know, the couple would certainly bring in things that needed to be talked about right then and there and um, the structure of it . . . was kind of a back and forth. There would be times that my supervisor would maybe see things that um, [my supervisor] wanted to address right away and I wasn't necessarily catching on to it or I was kind of going in another direction and um, or we would just kind of pass things off and kind of include, you know, the other therapist, like, "What do you think about that?" Or, "I know you've had experience with that kind of thing? What might you be able to add?"

JCR: Sure, soliciting that other person's knowledge when you know it was better.

Matthew: Yeah, exactly. And just kind of making sure that it's, you know, we're both present and participating. Um, at the end of the session we would always take time um, to really process, really a fair amount about the session, kind of compare notes on what we saw in terms of um, you know, content, process mostly, you know?

JCR: And who typically led that debriefing?

Matthew: I would actually start out, because I always had a lot to say, you know, and I um, and sometimes my supervisor would be like, "Oh, that seems interesting, what kind of things did you see?" But it was really a back and forth, um, process and I tended to always want to talk about you know, how I'm being affected and um, you know, things that I picked up on and things that I wish I'd maybe done differently and um, often times, not to a great extent, um, [my supervisor] would say, "Hey, yeah, I liked how you brought that in. I haven't thought about doing that."

Not a whole lot of, um, not a whole lot of positive criticism. I think that was actually limited to, "Uh, yeah, try to jump in a little more." You know, and actually [my supervisor] was really good like, we made it a point and I kinda learned this um, through the process that um, [my supervisor] would be kind of checking me out and like how I'm doing and I'd kinda be checking [my supervisor] out, so we would meet eyes a lot of times and kind of communicate in that way. Particularly if we're both realizing that, you know, one of the members is being incongruent, kind of in, you know, what he or [my supervisor] is saying, with kind of um, as a beginning to call him on it or point that out.

And in times where I was being quiet because either I was anxious or kind of unsure with what I was doing [my supervisor] would try to give this little, you know, head nod like that, like, "Go ahead, jump in any time." And I kind of saw that is an indication I needed to kind of step up. Step up a little more.

JCR: So what I think I'm hearing now is that there was, even though there was some structure and a power differential within the supervisory relationship that just naturally occurs that in the sessions it sounds like it was pretty collegial and that that power differential was minimized, at least for the sake of the client to where you had some freedom to be self reflective in your debriefing and to um, try some things out.

Matthew: Yeah, and I think I certainly went through a change in the process where, you know, the relationship with the supervisor in the beginning was certainly supervisor-intern and towards the end, particularly when, you know, I gained my licence it was more, you know, more collegial. And that's been a welcomed change, I think.

JCR: I think that's one of the clearest um, things that I'm learning from people, is, in a word, that's been used a lot is an evolution, that there's been a really clear evolution in relationship among other things. Okay, so I wanted to note down or focus to 2 constructs that I've identified, it's just particular areas of interest when looking at cotherapy and then self-efficacy and clinical competency. So, my operational definition here, "Self-efficacy is a state of believing in one's ability to perform a given task with some degree of confidence and success, however that may be defined as possible."

So, what, if any, contribution do you believe that cotherapy had on your current level of self-efficacy as a marriage, couple and family counselor?

Matthew: My certain or my current self-efficacy, my certain belief in that, or my current belief in that, is that correct? Is that what you're asking?

JCR: Mm-hmm (affirmative), yeah.

Matthew: I think it contributed a lot to that, partly because, well one of the biggest contributors is just watching my supervisor work, you know, and really, in real time, I mean, not really being a fly on the wall, but, um, certainly a part of it being just in this, you know, observational position, where I get to be in the room, with you know, a master therapist and you know, see how it's done and that has helped a great deal, I think. Um, it helped a great deal to get that immediate feedback and the processing of it, um, so I think it contributed a lot and I believe that um, that I am certainly different because of it now and have certain gratitude towards that, particularly when I hear, you know, people's internship experiences and not having included that, you know? So I think it's really valuable, I really do. And I think it should be something that's just part of the process.

JCR: Great. So now I want to go to kind of the more complicated one, which is that clinical competency. So you've got that appendix there and you have a humanist to review it. Um, "Clinical competency is generally defined as being demonstrated when a professional has the knowledge and skills necessary to practice his or [my supervisor] trade in a manner consistent with legal and ethical codes and closely in line with best practice standards. So for a marriage, couple and family counselors competency is collectively defined by professional and credentialing

organizations, such as AAMFT, [K-Crab 00:17:20] and the National Counseling Association." So considering the knowledge and skill areas included in your summary of the AAMFT competencies, describe your current level of clinical competence as you perceive it.

Matthew: Um, should I look at the list and kind of point to things or?

JCR: Absolutely, yeah. You don't have to be, um, you know, needlenose specific, but as you look at sort of this general areas of competence that our professional association says, "Yeah, this is what makes a good therapist."

Matthew: I think, um, I think certainly what um, what guided us was certainly theory and technique driven. I think it was, I started out really incorporating a lot of [Gottman 00:18:19] ideas and we evolved to more emotionally focused once I learned more about that. And I think that was more in line with where my supervisor was and so that. But certainly our approach was theory and technique driven. I was in charge of case note writing. And that was certainly following best practices. One more thing, we certainly talked a lot about um, my experience when I met with the husband individually and actually in couples', although we didn't have the systems of which they were in context, in the room we talked a lot about them and so there was lots of opportunity to um, you know, incorporate a systemic approach to that.

JCR: Great. Were you faced, during that time, with any opportunity or obligation to deal with legal or ethical-

Matthew: Yeah.

JCR: . . . reporting or any other types of sticky situations?

Matthew: Yeah, we had to make a report to CPS, to Social Services, based on information um, you know, provided by the couple. Um, there were opportunities to write letters to various agencies as the couple were one of the individuals who was seeking funding for services. Yeah, those kind of things. I'm trying to think. Those were kind of the 2 big ones.

JCR: So, at the risk of being too redundant, but also for the sake of clarity, um, what, if any, specific contributions do you think the cotherapy process had on you being able to develop your skills and theory and technique and writing documentation and letters and reporting and dealing with all those sort of normal things that come up during the life of a counseling relationship?

Matthew: How did cotherapy further my knowledge base or my competence in that? Again, in real time, you know, it allowed to me to see the process unfold by watching a master therapist and really the nuts and bolts, the technique, the language used, um, you know, the process and that was just a wealth of information. Because all of those things are really important to me and it allowed me to even further advance those. Couples counseling, as you know can be really complex and I think cotherapy really allowed the complexity to be more deeply understood, because you have another set of eyes and for both of our parts, for both of our perspectives and that happened a lot, you know? As my supervisor would be talking with one of the members I could watch the other member and when I saw a need to call out, you know, how they're being affected by what the other two are doing and what the partner is saying, you know, I could call that out and it's a little more difficult when you're alone.

JCR: Absolutely, because you're so engaged in trying to be, you know, engaged [inaudible 00:23:25] active listening skills, you may not be watching the scoff that the other person had or the big sigh or [inaudible 00:23:31].

Matthew: Well, and I had the further ability to, because I was seeing the other partner alone, I knew information of, you know, from his perspective about what, you know, his partner is talking about and so I would often say, certainly, farther long in the process, "Hey, you know, we talked about that in our individual session, I wonder if you could maybe share what your thoughts and feelings are about that?"

So, I think cotherapy in general just allows those complexities, to um, be more deeply understood. I know I'm repeating myself, but um, that's . . . I don't think, if you don't have cotherapy I don't think you're gonna get that with a couple. I don't think you'll even get it with a family. I mean that, that adds so much more complexity when you're having 4 or 5, even more people in the room.

JCR: So you've really spoken to this already, I think, really thoroughly, but it's written on the paper so I'm [inaudible 00:24:46] anyway, so of all the things that you've discussed, what parts of the cotherapy process do you believe were the most helpful, the most instrumental to your learning process, um, and to self-efficacy and clinical confidence, in particular?

Matthew: I think 2 things. I think um, one is watching the master therapist, watching my supervisor, um, again, the language he uses, um, how [my supervisor]'s talking, [my supervisor] body language, [my supervisor] voice, tone, all of those things and what [my supervisor] chooses, what

[my supervisor] was choosing to focus on. That was really, really helpful. The other is the processing beforehand and after.

JCR: That sort of brought all the experience to light.

Matthew: Yeah.

JCR: Sort of the other perspective.

Matthew: Mm-hmm (affirmative).

JCR: Okay. So on the other side of that coin, what parts of cotherapy, if any, do you believe might have posed a challenge or a hindrance to your learning process or to your development of self-efficacy or competency?

Matthew: I think, at least in the beginning, what was really a barrier for me is um, my worry about how I'm being perceived by my supervisor and being judged and I think that really held me back. Certainly there was a lot that I was experiencing and you know, thinking about in terms of things that would be helpful to the couple and I think there were certainly times when I held back or I became quiet and that's kind of, that's my temperament to begin with, and my nature, when I have a certain amount of discomfort and so um, in the beginning there was actually a fair amount of discomfort, to be honest, because of that fear of judgement and to try to manage that I was um, I was really wanting [my supervisor] to um, really explicitly say the things that I was doing well. I'm not sure [my supervisor], I don't believe that [my supervisor] was doing that to an amount that I would be able to manage my anxiety, so I kind of wished that [my supervisor] had, um, that might have been purposeful on [my supervisor] behalf, but . . . and I actually remember in group supervision I really, that came to a head and I had to, I really wanted [my supervisor] to give me that feedback.

So I wasn't forthcoming and actually, in the moment, letting [my supervisor] know that that's what I needed [inaudible 00:28:15] never really had that conversation. So uh, certainly a lot of discomfort and anxiety in the beginning about that.

JCR: Which could have potentially been debilitating-

Matthew: Well, it was.

JCR: . . . had there not been other components of the relationship, so there's [inaudible 00:28:36] that I'm hearing that if you were advising, say, another intern who was going into cotherapy that there's that piece of

self-advocacy for an intern that you might say, "Okay, well, you might ask for this or think about what would make it easier", but what was it about what the 2 of you were doing that got you eventually sort of moving through or even past that worry?

Matthew: I think, um, I don't think it necessarily happened within the cotherapy um, relationship. I think it happened in kind of another venue, in other supervision and I will always remember this, because what I was struggling with um, was meeting expectations, meeting other people's expectations, meeting my own, um, and a supervisor had said that, "You are good enough therapist. You're good enough." What [Gottman 00:29:52] says, "It's a good enough marriage." And that really, really helped a lot. Yeah.

So, that was kind of outside the, you know, the cotherapy you know, relationship, um, but once I heard that I think I was able to relax more and maybe take, you know, more risks or kind of participate more. That was a big shift for me, I think.

When [my supervisor] would maybe point out things that [my supervisor] appreciated about you know, what I had done, it was pretty golden. You know, it was pretty golden and I realized I'm kind of good at this and I'm the right track and that helped me you know, gain more confidence to you know, take more risks.

JCR: Which, I'm really learning through this process, seems to be a really critical part of that, social learning, you know, that positive reinforcement that happens to help develop self-advocacy, finally go, "Okay, yeah. I do get this."

Matthew: Yeah, and you know, I don't know, you know, as supervisor, I hear you guys like take classes on how to supervise-

JCR: We do (laughs).

Matthew: And so it's still kind of a mystery to me and um, that might be something that you know, you learn, that you know, perhaps you hold back. You don't have to tell me whether that's true or not but that's kind of been my experience and maybe it's just the supervisor said I had, and in the long run I think it's probably maybe a better choice on how to do that, because I kind of fostered that myself. Or when it is given, it's given just enough.

JCR: And I have a theory about that, but I'll wait until we turn the camera off. (laughs)

Matthew: All right. Well, see, I've been in supervisory positions as well, and it's a really interesting learning process, since I haven't taken any supervisory classes and so I'm kinda winging it, just based on what my own experience is, I tend to um, I tend to give more positive feedback, maybe to excess, based maybe on my need for it, in my own experience, and so-

JCR: Almost like a love language [crosstalk 00:32:48].

Matthew: Yeah, exactly. Yeah, exactly. So I'm still kinda learning that. I hope that answered the question.

JCR: It absolutely, most certainly did. Um, what else might you want to add about your experiences with cotherapy that I have not asked about specifically?

Matthew: I think um, I think what's critical is the relationship that you have with your supervisor. I think it's absolutely critical and you need to trust them, deeply and I think you need, out of that trust comes a belief that um, they certainly have your best interests in mind that they um, that they're in charge and . . .

JCR: Is that in the sense that they can handle [crosstalk 00:33:48]?

Matthew: Yeah, when things go South, that they're going to be there. I think that's a really key component. And I will say to you, I didn't mention this, there were times when, um, my supervisor was not able to be cotherapy so [my supervisor] allowed me to be the therapist. I noticed a real difference when [my supervisor] was not in the room. It was like, okay, it's just me, um, I had a sense of freedom, more. I certainly had a sense that like, I'm in control, like I'm the therapist here and I had found myself certainly talking more, I was more comfortable, um, and I wanted, I think my approach mirrored what you know, what I was learning in cotherapy, but I might have added maybe more during you know, when I was there by myself, compared to when, you know, my supervisor was there.

So there was all this maybe hesitation with my supervisor, not so much anymore, of course. It's like going on 3 years now. You know, after that, um, and we actually still see the couple.

JCR: Oh, you do? That's great.

Matthew: Yes, and it's really different.

JCR: Yeah, I imagine.

Matthew: It's really different. I'm more how I would be if I was by myself.

JCR: So am I oversimplifying to say that, that no matter sort of the evolution of that relationship during internships and now that you are licensed and it is definitely more of a collegial sort of relationship that, sort of no matter what there's that sort of, in the back of your head, the awareness of being evaluated, that's just, even when it's sort of quiet and low-lying, it's there just enough.

Matthew: Oh yeah, and I don't think that's an oversimplification at all. No. I think that's a really big part of it. For me it was. I was very aware of that, all the time. I valued [my supervisor] opinion, right? And I wanted to make, you know, to be a good therapist was really important. Or a good enough therapist was really important to me, you know? So I was always aware of that. Certainly we create you know, our own responses to things and our own anxiety, of all things, and I was always aware of that.

JCR: Anything else?

Matthew: I can't think of anything. I'm actually really grateful that we continue to become therapists together.

JCR: [inaudible 00:37:25]. Really cool.

Matthew: Yeah. And it's on a much less frequent basis. There was actually quite a hiatus there. And then situations have changed and we kind of [inaudible 00:37:41]. You know, you lose track of people. The people who um, you know, you have really unique relationships with. I guess maybe that's where my gratitude is coming from. I still continue to learn, you know? Because you get your licence, you start doing stuff all by yourself and you never get a chance really to see other people work and um . . . yeah, so I'm grateful of that. I can't think of anything else to say.

JCR: I think that actually my next piece of research that I'm going to do, not for the dissertation [inaudible 00:38:32].

Roger

JCR: Okay. So, um, I'd like to talk to you now just about the cotherapy process in general, just how it worked. Um, so . . . when you saw the client or clients for this over the 10 times that you met, how often typically were you- Were you doing that cotherapy? In terms of, like, weekly, monthly.

Roger: Right. It was weekly and also every other week.

JCR: Okay. How many different clients did you see?

Roger: I recall 2 different client systems.

JCR: Mm-hmm (affirmative). And so who . . . Who participated in those systems? What were the [crosstalk 00:04:24]

Roger: One of the clients was a heterosexual couple. And another was a, um . . . A blended family.

JCR: How many kids were part of that blend?

Roger: I believe 2. Two.

JCR: Okay. So when you think about just the . . . The life of a typical cotherapy session with your supervisor, in terms of kind of the before, during, and after, how . . . Describe a typical session.

Roger: The . . . The typical sessions, well, I think there were also phases. The earliest sessions, the initial session, the earlier sessions kind of the . . . The central sessions and then the terminating sessions. In both of the client system groups, we saw therapy from the beginning to an end, so it was complete treatment, and the initial sessions were initially uncomfortable, just because of all of the people in the room. There was . . . I was the primary therapist, but my supervisor was also in the room, co-facilitating therapy with me. The original sessions were . . .

I would say the first 2 sessions I was somewhat intimidated and nervous.

JCR: Mm-hmm (affirmative).

Roger: Then when I recognized that my nervousness was unfounded, that there was actually a cohesion and a flow, it was actually very comfortable and then developed into being enjoyable and exciting. And the- The determination of the sessions. Of the- Of the treatment, it was actually quite rewarding.

JCR: Nice. How did you and your supervisor prepare. Um, I'm just making sure that's actually moving. How did you and your supervisor prepare for each of those sessions? Or if- If at all. If there was that process.

Roger: Sure, we did it quite extensively actually, because we were . . . We were using this opportunity for co- Co-facilitation as a training opportunity, so we would meet prior to the sessions, to review the treatment goals, the . . . The

systemic opportunities, we- We try to understand the clients. We used, uh, genograms. We talked about systemic patterns. We also shot the elephant in the room that it was an intern with an intern supervisor room. So we- We addressed and identified all of those regularly.

Prior to every one of the sessions, we would . . . Um, really examine the . . . The therapist's sense of self, but it was different, because the therapist was now a dyad.

JCR: Yes.

Roger: So the dyadic therapist is a different beast than a single therapist.

JCR: Mm-hmm (affirmative).

Roger: And again, I think that speaks to the- The nervousness or the awkwardness until that has gelled and become very productive. Very productive. Uh, during the therapy sessions, uh, after the first couple I think our roles kind of, you know, there was a cohesion into our roles, and we . . . The interplay of the therapist with how we align and joined the- The- The client systems really took, you know, formed well, and performed well. And then after each of the sessions, we would debrief and talk about what went well, and again, examine ourselves as co-therapists in that- In that role.

Uh, and then we would plan for the follow-up sessions.

JCR: Okay, and so when you do have debriefing, um . . . Who typically led that process?

Roger: I think that my supervisor led most of that. Led most of that. Those exercises. Uh, I do recall that after some of them were energizing and exciting sessions. I think I probably did the majority of the talking.

JCR: Mm-hmm (affirmative).

Roger: Uh, but again, in the . . . It took a couple of sessions for my nerves to let down.

JCR: Sure.

Roger: And then it felt very collegial. And- And . . . easy.

JCR: All right, then. Okay. So . . . Given then sort of the totality of that experience, I want to talk then specifically about how the cotherapy, um, might have had an interplay with self-efficacy and clinical competency. So, I mean you just

said really down and dirty definition of self-efficacy. It's a state of really believing in one's ability to perform a given task with some degree of confidence, of success, however that may be defined is possible. So I want to start with just describing your current level of self advocacy as you perceive it. As a marriage couple and family counselor.

Roger: As an intern, when I was an intern, or as a licensed practitioner that I am now?

JCR: Well, okay. So . . . Both.

Roger: Because they built on each other.

JCR: Yeah, absolutely.

Roger: As an intern especially, uh, in probably the- The first half of my internship, let alone maybe the- My entire internship. I recognized that I was naive as a therapist.

JCR: Mm-hmm (affirmative).

Roger: I recognized, uh, that I was competent, but not necessarily skilled. And when I worked with . . . Is this the right time to talk about how that might have changed with my supervisor?

JCR: Mm-hmm (affirmative).

Roger: Cotherapy with my supervisor, without a doubt improved my self-efficacy. Because I admired and saw my supervisor as very competent, uh, and talented. And when I then recognized that I could . . . I could hang with them, and we could be productive together, I had to accept that I was also competent and, uh, efficacious as a therapist, because I was doing the work with the person that I saw as competent and efficacious.

So it really [boo-eed 00:11:13] my- My sense of self as a therapist, uh, because I could hang shoulder to shoulder with the person whom I admired. Uh, when they did their work.

JCR: Mm-hmm (affirmative). Yeah, that makes absolute sense, and so throughout that journey of then completing internship, going into practice, that the cotherapy really improved your self-efficacy as an intern. Um, would you say now there's a point in your career that you still believe yourself to have a high-level of self-efficacy?

Roger: I think that I am efficacious as a therapist. And it absolutely helped, uh, perform a cotherapy with my supervisor. Just again, because I- I think of my supervisor as very talented, very, very good at- At the art of therapy, and if my supervisor recognized those qualities in me, my self esteem and self concept as a therapist rised.

JCR: Yeah.

Roger: And that- Yes, that did sustain into, uh, the rest of my work since then as an- And as an individual practitioner when I am just a solo therapist. So the dyadic therapy definitely benefited, uh, my work as a solo therapist.

JCR: Okay. Okay, so then let's stick to the idea of clinical competency. So again, a general definition, uh, clinical competency is demonstrated- When un-scheduled has the knowledge and skills necessary to practice, uh, his or his trait in a manner consistent with legal and ethical- Ethical codes, and closely in line with best practice standards. So for marriage couple and family counselors, competency is collectively defined in organizational and credentialing organizations, like AAMFT, CACREP, and the National Health [Link 00:13:08] Association.

Um, the appendic of there. The appendix A, which is the AAMFT, um, standards in competence, um, so in reviewing . . . what's included in there, and it's- It's kind of a monster of a list, when you break it down. Um, describe your current level of clinical confidence based on these standards.

Roger: As of this date or when I was an intern?

JCR: Mm-hmm (affirmative). Both.

Roger: As of this date, I see that it is very competent with all of the core competencies of our code of ethics. As an intern, in many ways, I didn't know what I didn't know until I had a very talented supervisor, and I did. Who would sit with me and review the core competencies. And several of them specifically as we would prepare for a session together.

JCR: Mm-hmm (affirmative).

Roger: Uh, we would also then review some of the- The core competencies in retrospect after we would do a session together. Uh, we would . . . try to examine and understand, uh, any ethical dilemmas pre and post sessions. And the ones that we would come up with before sessions. We would then come back on and address after a session to see how we, uh . . . If we moved with them at all.

JCR: Yeah.

Roger: If there was development. And there was development, because pre-counseling sessions, we would start to put those on the table, which essentially meant that we were inherently going to work on those during the session.

JCR: Sure.

Roger: And then check for progress or development after.

JCR: Sure.

Roger: So as far as, uh, an AAMFT, uh, clinical competencies, they were an integral part of the pre, during, and post, um, cotherapy.

JCR: So, what . . . So- So you mentioned that- That you really sort of hit on a lot of those, sort of before, during, and after a session. I'm curious. What- What was it that occurred during the cotherapy process? If anything, right, that contributed specifically to the development of your competency in some of those core areas?

Roger: Intentionality. Because we had, uh, discussed some of the core competencies to focus on, because my supervisor and I started peeling apart the systemic lens, and the client systems. We therefore had intentionality during a session, based on the coaching that took place prior to the session.

JCR: Sure.

Roger: So I think that is the difference maker, uh, is we essentially set the table with our ideas. Prior to a session. And that carried into the session, So there was a great intentionality to be on task in a developmental way.

JCR: Mm-hmm (affirmative). Okay, so . . . I want to sort of pinpoint if that's at all possible, um, some of the- Some of the specific aspects of cotherapy, and so . . . Uh, so to start with . . . Um, I'm curious what parts of the cotherapy process did you find to be the most helpful or instrumental in just your overall learning process. So just in a very general way. What parts of that were the most instrumental for you?

Roger: The most instrumental parts of cotherapy with my supervisor ended up being the reinforcement of competency.

JCR: Mm-hmm (affirmative).

Roger: Because again, my earliest time, the majority of my time as an intern, I questioned myself regularly. I questioned if I was knowledgeable, if I was skilled, and cotherapy proved that I was not just competent, but actually productive. Uh, because . . . my supervisor knows what [my supervisor]'s doing. And my supervisor when [my supervisor] tells me that that went well. If- If I can- Can conceptualize that [my supervisor] knows what [my supervisor]'s talking about when [my supervisor] tells me that I did well, I guess I might know what I'm talking about.

JCR: Sure. And you have that experiential connection of this is what going well.

Roger: Exactly.

JCR: Looks like and feels like.

Roger: Yes. So just the . . . The safe- The sense of safety.

JCR: Mm-hmm (affirmative).

Roger: That happened with a- With a comfortable supervisory relationship.

JCR: Yeah.

Roger: There was not . . . There was not a- It was never a threatening relationship or a threatening environment. And while there was always hierarchy, in the supervisor, and supervisee role, that was minimized for the therapeutic benefit of the client system that we are working on.

JCR: Mm-hmm (affirmative). Yeah. Okay.

Roger: So in a word, safety.

JCR: It's huge. So you've already touched on this, and I- I sort of intentionally wrote this to be a bit redundant to make sure I capture everything, but, um, so much of what you just said really does come back to the ideas of self efficance- Of self-efficacy and competency, um, but is there anything else that you found really instrumental about cotherapy that really, specifically to this constructs a self-efficacy and clinical competency in addition to what you just said?

Roger: I am of the notion that cotherapy, especially cotherapy with 2 professionals who aren't necessary . . . Not necessarily equals, so 2 therapists, where one is much more seasoned and experienced than the other, I think that's an ideal therapeutic modality. You have multiple brains, but competent brains in the

room at the same time, so if there is . . . If there is a cooperative, uh, tandem approach-

JCR: Mm-hmm (affirmative).

Roger: Of 2 therapists, I believe that they will be able to recognize, treat, triage, a client system, uh, better than an individual therapist would.

JCR: Yeah.

Roger: Because you had 2- Two therapeutic brains who are pretty well-trained. Who are now combining, and coming up with different ideas. So there's a more comprehensive approach to treatment.

JCR: Yeah. That's a big deal. Mm-hmm (affirmative).

Roger: It's a big deal.

JCR: Okay. So, um, the flip side to that, what parts of your cotherapy, if any, did you believed to pose a challenge or hindrance to your overall learning process?

Roger: I didn't have any negative experiences. However, if I look back at my- With my first couple of sessions with my supervisor, and I really try to concentrate on the fact that I was nervous, intimidated. If my supervisor didn't have . . . Was not effective at minimizing that and transitioning that into comfort and productivity, if that hadn't happened, I see I envision that cotherapy could be disastrous. Ultimately for the client.

JCR: Mm-hmm (affirmative). Sure.

Roger: Ultimately for the client, and secondarily, uh, it would have a negative impact on the intern's growth. It could stifle their growth. That did not happen with me.

JCR: Okay.

Roger: Again, it comes down to, um, safety, and then the supervisor really prioritize that level of comfort in the growth of comfort.

JCR: Mm-hmm (affirmative).

Roger: Had the supervisor not known that, I imagine I would have had a much different taste in my mouth.

JCR: Absolutely. Yeah, that sense of starting to trust yourself and . . .

Roger: It has to come. It has to . . . In order to trust myself as a young therapist, I- I- I found trust in my supervisor. Therefore, I could grow-

JCR: Yeah.

Roger: Into my own trust. If I didn't trust my supervisor, if there was a hierarchical difference, and there was too much of a . . . A threatening distance, then my growth couldn't happen. But it did.

JCR: Okay. Okay, one final question for you.

Roger: And that is simply, um, is there anything else that you would want to add about your experience with cotherapy that I have not asked you about specifically. The only- The other thing that I would add is I sure wish it was a modality that would be promoted more. I had very positive experiences with it. And I believe the educational opportunities are indescribable and open-ended. Because solo therapist. A solo therapist, especially as a- You know, somebody in an internship, or young in their career, they don't know what they don't know.

And a seasoned co-therapist can help them see some of those- Those fuzzier grey areas that escape them.

JCR: Yeah. Perfect.

Roger: That's all.

JCR: Right. That's all I have for you then.

Roger: Okay.

JCR: Easy-peasy.