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The impact of live supervision on the family therapist's level of immediacy, anxiety, responsiveness, and genuineness

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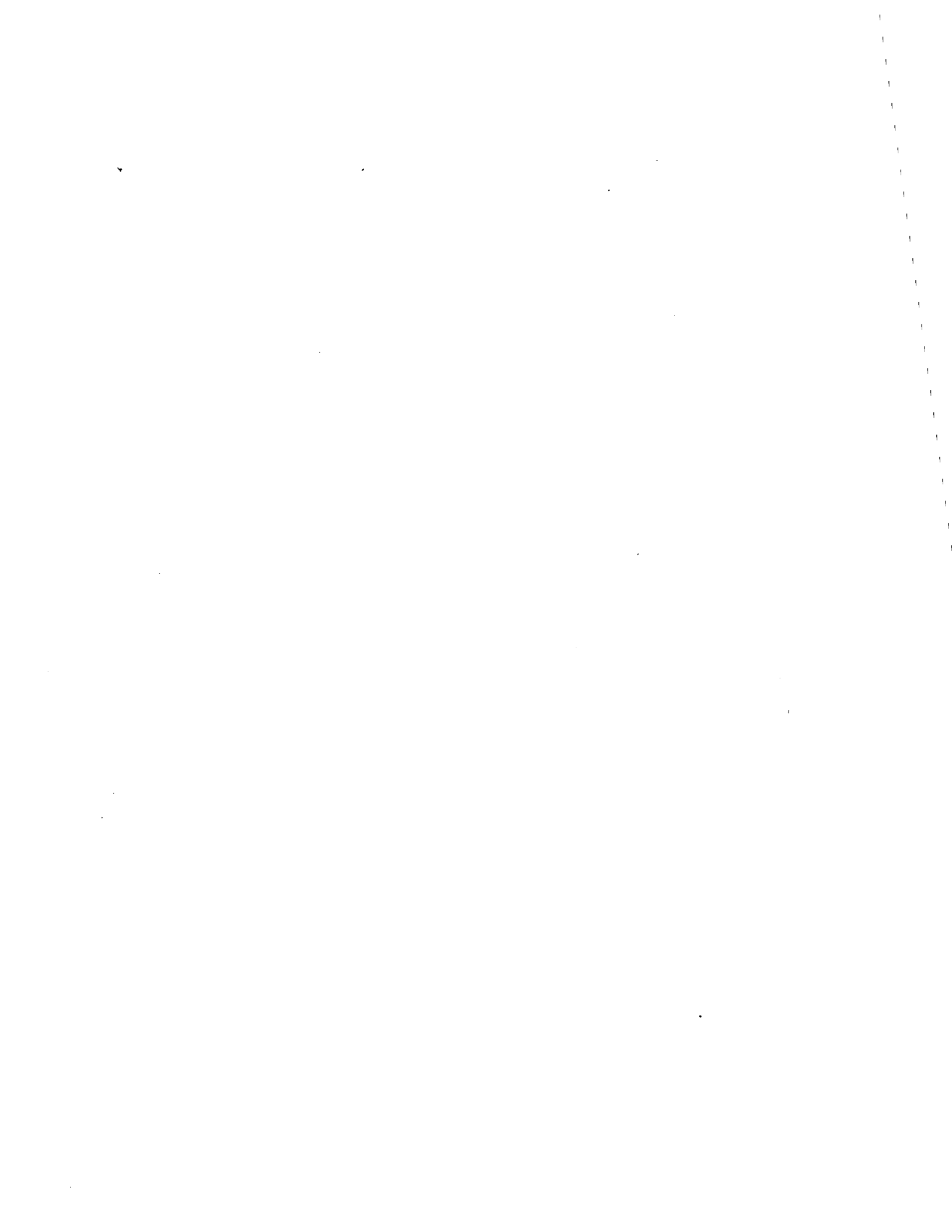
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**THE IMPACT OF LIVE SUPERVISION ON THE FAMILY THERAPIST'S
LEVEL OF IMMEDIACY, ANXIETY, RESPONSIVENESS, AND
GENUINENESS**

The College of William and Mary in Virginia

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THE IMPACT OF LIVE SUPERVISION
ON THE FAMILY THERAPIST'S LEVEL OF
IMMEDIACY, ANXIETY, RESPONSIVENESS, AND GENUINENESS

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

By
John L. Bistline
August 1982

APPROVAL SHEET

We the undersigned do certify that we have read this dissertation and that in our individual opinions it is acceptable in both scope and quality as a dissertation for the degree of Doctor of Education.

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DEDICATION

To Kathy, my lovely wife, who deserves a doctorate degree in patience for being with me during these years.

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To my parents, for supporting and encouraging me through this lengthy endeavor. Thank you for being there.

To my raters, Rick D., Bonnie, Jane, and Rick F. Thanks for the time you unselfishly gave me. Special thanks to Bonnie who gave me the wonderful experience of having an empathic listener, and to Rick F. whose friendship has been indispensable.

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How strange, that so often, it all seems worth it.
Voices 6 No.2, 1970

Learn to forgive yourself, again and again and
again and again.
Voices 6 No.2, 1970

Fifty million Frenchmen can't be right.
George Bernard Shaw

CHAPTER I

INTRODUCTION

Statement of the Problem

As marital and family therapy continues to increase, the technique of live supervision continues to be regularly employed in treatment of marital and family concerns. Because of this, there is a distinct need for clinical experimentation to assess what effect live supervision has on the therapist. The primary questions addressed in this study were: (1) do live telephone interventions affect the subsequent behavior of the therapist (as measured by therapist's level of immediacy, genuineness, responsiveness, and anxiety), and if so how; and more specifically (2) do different supervisors differ in their effects on the therapist's subsequent behavior (as measured by the therapist's level of immediacy, responsiveness, anxiety, and genuineness).

Need for the Study

Kiesler (1973) defines psychotherapy process research as "any research investigation that, totally or in part, contains as its data some direct or indirect measurement of patient, therapist, or dyadic (patient-therapist interaction) behavior in the therapy interview" (p. 2). It appears from the above definition that this study is properly defined as process research.

Pinsof (1981) makes a strong case for process research in the family therapy field. He states that only through process research will one ever be able to operationalize and reliably describe the events that make up effective and/or ineffective therapy. Similarly, it is process research that best tests clinical theories about the nature and relative effects of different techniques and treatment strategies.

Citing the lack of family therapy process research in the literature, Pinsof states:

To test the accumulating mass of clinical theory within the family therapy field, to get beyond normative task definitions and resolve the problems of professional orientation, researchers must attend to the actual events that occur in the process of family therapy. Failure to do so can only hinder the field's efforts to answer the foremost question in the field of psychotherapy research, the specificity question--what are the specific interventions by specific therapists upon specific symptoms or patients types? (Bergin, 1971, p. 245) (p.700).

Live supervision is a specific intervention that appears to be a powerful tool in working with marital and family

concerns. However, it is quite controversial with both supporters (Haley, 1976; Kempster and Savitsky, 1976) and critics (Nichols, 1975; Russell, 1976). This study is warranted because the effects of such a technique need to be established. Further it is believed that a process research format is well suited and particularly needed in investigating new areas such as this.

Theoretical Rationale

A great deal of research has gradually accumulated that indicates that a positive relationship between patient and therapist (individual, marital, and/or family) generally facilitates treatment (Garfield and Bergin, 1978). Most schools of therapy implicitly or explicitly have recommended that the therapist actively work toward developing a positive therapist/client relationship.

However, one school--structural family therapy--by its use of live supervision may implicitly minimize the importance to treatment process and outcome, of the therapist's positive relationship to the client. Live supervision is a process in which the supervisor observes a therapist's work from a one-way mirror. The supervisor may intervene to offer feedback or direct new strategies by calling on a telephone to the therapist in the therapy room, calling the therapist out of the room for consultation, by joining the therapist in the therapy room, or by taking over for him and asking him to observe the family process for a period.

Most often the supervisor uses the telephone to direct the therapist to carry out interventions with the family. The therapist usually carries these suggestions out regardless of whether or not he himself agrees with the suggestion. Although the therapist does have the right to reject a supervisor's intervention, observation suggests that this rarely happens,

probably due to the hierarchal nature of the supervisor-supervisee relationship. Almost always the supervisee attempts the intervention suggested by the supervisor.

Currently no published studies have assessed the effects of live supervision. However, related research (Mehrabian, 1972; Graves and Robinson, 1976) does suggest that the way a communicator reacts when he is directed to convey a message has an important impact on (1) the way he relates to others and (2) how others in turn perceive him.

Furthermore, it is now possible to measure certain aspects of a relationship operationally and reliably, often by analyzing the nonverbal behavior of the interactants. Such dimensions as immediacy, responsiveness, and anxiety can be measured this way.

Given the importance of a positive relationship in counseling there continues to be a burden on the therapist/researcher to identify specific factors that help or hinder the relationships of the interactants. It is important then to study any approach in counseling that may affect the relationship between the therapist and client. Live supervision is an approach that needs to be evaluated.

Definitions

Anxiety: A state of experiencing a strong blend of uncertainty, agitation, or dread about some contingency. Operationally it was measured by the nonverbal behavior of self-manipulations.

Responsiveness: The extent to which a person is important or salient to another person. The degree of involvement with the addressee. Operationally it was measured by the nonverbal measure of speech volume (Appendix A).

Immediacy: Behaviors which increase the mutual sensory stimulations between two people. The extent to which behaviors enhance closeness to another. Operationally it was measured by the nonverbal behavior of forward lean.

Genuineness (congruence): The extent to which the counselor is nondefensive, real, and non-phony in his interactions with the client. Operationally it was measured by Carkhuff's five point rating scale (Appendix B).

General Hypotheses

1. The level of anxiety (as measured by nonverbal behaviors) of the therapists will increase after a telephone intervention by supervisor.
2. The level of responsiveness (as measured by nonverbal behaviors) of the therapists will increase after a telephone intervention by supervisor.
3. The level of immediacy (as measured by nonverbal behaviors) of the therapists will decrease after a telephone intervention by supervisor.
4. The level of genuineness (as measured by judges ratings) of the therapists will decrease after a telephone intervention by supervisor.
5. The therapists rate of anxiety (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.
6. The therapists rate of responsiveness (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.
7. The therapists rate of immediacy (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.
8. The therapists rate of genuineness (as measured by judges rating) after a telephone intervention will vary significantly between supervisors.

Sample and Data Gathering Procedures

Three supervisors were each asked to supervise two therapists until they had made a minimum of three phone interventions per therapist. The interventions made by the supervisors were the segments rated.

The segments consisted of two minutes immediately before the phone was picked up, and two minutes immediately after the phone was hung up for all telephone interventions. These segments were rated or categorized by the raters who were blind to the purpose of the study and whether a given segment was before or after a telephone call. The raters were instructed to score all observable movements. For all measures with exception of the immediacy measure, the raters based their ratings upon watching the entire two minute slice. In regard to the immediacy measure (body lean) an arbitrary point in the slice had to be selected to allow measurement. One minute immediately before and one minute immediately after the phone call was the time when the immediacy measure was rated.

Limitations

A limitation of this study was the small sample of supervisors and supervisees used. The fact that there were only six supervisees and three supervisors involved limits the generalizability of the study. The results have to be interpreted cautiously in regard to other supervisors and supervisees. Unfortunately the size of the agency being used for the study prevented any increase in subject size. Care has been taken to select subjects who regularly use the structural school approach, which hopefully lends some generalizability to the findings as they apply to other therapists using a structural family therapy framework.

Another limitation to this study is the fact that only the therapist's behavior were measured. There is not any direct evidence on how the family itself was affected by the intervention. However, research reviewed gives strong support to the assumption that how the therapists behaves has a strong and predictable effect on the family. Indeed some writers in the field would suggest that family could not not react. Thus, it is important that the therapist's reaction be measured. A hope of this researcher is that this study will be the first of a series of studies in this area, and that at a later date more direct research on the family's reaction can be conducted.

CHAPTER II

Review of the Literature

Marital and family therapy has increasingly in the last few decades become an accepted method of treatment for a variety of mental health problems. Although one cannot know how many therapists are actually working with couples or families, the past twenty years has demonstrated a remarkable increase of interest in this area as shown by the dramatic increase of conferences, workshops, books, and journals dealing with marital/family therapy.

Gurman and Kniskern (1978) believe that marital and family therapies developed slowly, along two parallel avenues; one, being changes that have taken place in technique and treatment structure, and the other concerning the changing ways in which therapists have viewed pathology. In regard to the latter, the history of marital/family therapy has been part of a slow progression from viewing abnormal behavior as part of an individual patient's psyche, to a focus on the patient's interaction with the environment, and finally as a conception of the individual's behavior as functional for the family system.

Couples have actually been treated together as far back as 1932 (Olson, 1970). Family members being seen together seemed to develop later but was being practiced by a variety of therapists by the early 1950's. Originally family therapy developed through work with severely disturbed individuals. It was hoped that this approach would be more successful than

previous approaches. Although family therapy continues to be applied to severe pathology, family therapists now apply their work to all types of troubled families. Marital therapy has also progressed from work with the less severe problems in living to more extreme forms of pathology (Gurman and Kniskern, 1978). In addition, variations of the basic marital/family treatment format also have emerged such as couples groups, multiple family therapy, and crisis intervention.

Along with the increase of marital/family therapy there has been an increase in techniques. The variety of techniques has resulted in the fragmentation of the marital/family movement into schools of family therapy. Usually these schools have a well-known therapist as their figurehead (e.g., Murray Bowen, Virginia Satir, Jay Haley) and each school has developed its own language and techniques. The leadership of these different schools has caused marital/family therapy to be a very diverse as well as growing field. However, as Gurman and Kniskern(1978) state, "family therapy is unified in a belief that relationships are of at least as much importance in the behavior and experience of people as are unconscious intrapsychic events" (p. 819). This is an idea, incidentally, which is shared by the majority of consumers of mental health services as documented by Parad and Parad (1968).

Supervision of Marriage and Family Therapy

Early in the development of marital/family therapy concerns for theory and practice took precedence over the development of

training standards for the field. The earliest marital/family therapists were self-taught, and first generation students coming into the field did so by close affiliation with the recognized leaders and clinical centers.

It was only in 1973 that the American Association of Marriage and Family Therapists (AAMFT) issued a statement of standards for supervision of marital and family therapy. This movement to designate training requirements for approved supervisors grew out of the belief that the field now had an adequate body of knowledge and techniques to teach the student. The AAMFT now requires individuals in training for clinical membership to receive 200 hours of approved clinical supervision and candidates for appointment as an Approved Supervisor to have at least nine months of supervision of their own supervision with a minimum of two continuous students.

The development of supervisory standards has been accompanied by the development of training standards for degree granting programs and clinical training centers. In 1978 AAMFT commission on Accreditation received recognition by the Office of Education (HEW) as the accreditation body for degree granting and clinical training programs in marriage and family therapy. There are now several programs offering this specialized degree (e.g., Brigham Young University, East Texas State University, Purdue University). The general process and structure of graduate clinical education for marriage and family

therapy has been reviewed by Everett (1979).

In addition to these degree programs, a number of free-standing clinical training centers and institutes have evolved in the field. Kaslow (1977) identified forty such programs in 1977 and viewed these programs as offering a major resource for practicing clinicians to gain postgraduate training in the field (e.g., Ackerman Family Institute (New York) and the Family Institute of Boston, Chicago, Philadelphia, and Washington, D.C.).

Process of Marriage and Family Therapy Supervision

As can be discerned from the previous discussion, standards for the training and supervision of practitioners entering the field have grown in maturity. However, significant theories of supervision remain scarce. Liddle and Halpin (1978), in a comprehensive review of training and supervision literature in the field, observed: "Formal theories of supervision and training have not crystallized and hence the reader is faced with the task of abstracting personally useful information from the array of literature" (p. 78). They conclude that supervisory and training goals currently appear to be dependent on the particular theoretical orientation of a supervisor or training center. Everett (1980) suggests that it is possible to separate the supervision process into two broad areas: clinicians who operate from (1) a general psychodynamic orientation and (2) those who operate from a structural or systems orientation. The former tend to follow the model of the supervision of psychotherapy outlined by Ekstein and Wallerstein (1972). This view

is that the supervisory experience is usually inhibited by intrapsychic conflicts and resistances of the student and occasionally the supervisor. The process of learning and clinical performance is dependent on the supervisor's recognition and management of these issues.

An important theoretical concern inherent in this orientation is that marital and family dysfunction are a product of not just interactional and communicational problems, but also concern the personal histories and dynamics of the respective partners from their own early families of origin and developmentally through their mate selection process. A concern then of this type supervision is that the student become capable of making individual diagnoses and recognize and treat any projections from these historical dynamics on the current family relationship.

Supervisors who represent more of a structural or systems view usually focus more on the reorganization of dysfunctional family interaction or communication patterns. Specific dysfunction is viewed generally as either a specific subsystem of the family or as one component among many family dynamics.

A major concern of this approach is that the student learn to enter a family system while maintaining a therapeutic stance in order to recognize and manage the dysfunctional components. Due to this orientation the extensive use of video resources has become prevalent with this approach. The outcome of this experience with video resources has led to the development of live supervision.

Live Supervision

The rationale of live supervision is similar to the case for video taping, but now the supervisor has direct observational access to the interview with the option to directly intervene in the session. Usually the supervisor, and sometimes a training group, observe a student's work from a one-way mirror. The supervisor may intervene to offer feedback or suggest new strategies by calling on a telephone to the therapist in the therapy room, by calling the supervisee out of the room for consultation, by joining the therapist in the therapy room, or by taking over for him/her and asking him/her to observe the family process for a period. The model of live supervision, utilizing telephone communication, developed at the Philadelphia Child Guidance Clinic (Montalvo, 1973).

The live supervision model fits well with the Philadelphia Child Guidance Clinic's orientation toward teaching family therapy from a competency based and skills focused manner. Weiner (1972) characterized this group's structural approach as an "Apprenticeship model." The method " . . . implies that there is a master or an expert with knowledge or skills that he can demonstrate and transmit and a student with the commitment, the capacity, and the trust to receive the knowledge first as the expert gives it to him; then to test it; to integrate it; and ultimately to make it his own" (Weiner, 1972, p.1).

Working from this perspective Montalvo (1973) addresses supervisory skills and goals from the standpoint of utilizing a live supervisory model. Using this approach, the supervisory task is to prevent the therapist from being caught in unproductive

patterns as well as to enable the therapist to use what is happening in a way which enables him to recover control and direction.

This innovative technique permits the supervisor to assume a more active and directive stance. Through live supervision the supervisor can actively guide the therapist during a session by providing corrective feedback through telephone communication between the consultation and observation rooms. Montalvo (1973) stated that "the most basic assumption of all is that any family can absorb and orient the therapist and direct him away from his function as a change agent" (p. 345). This method views the supervisory process as a means of providing an outside base which the therapist can use to help to disentangle himself from cyclical and non-helpful sequences of therapist-family interaction.

In regard to the supervisor-supervisee relationship, Haley (1976) suggests that just as in therapy "one cannot not have a hierarchal trainer-trainee relationship." The supervisor working from a structural theory believes that if the hierarchal nature of the relationship is consistently violated the efficacy of both trainer and trainee is diminished. Haley (1976) does not devote time prior to the family sessions trying to establish a personal supervisor-supervisee relationship with his trainees. Instead he prefers to define, organize, and develop the relationship around the task at hand.

Live supervision although a controversial subject is a very powerful supervisory resource. Kempster and Savitsky (1967) view live supervision as essential to aiding the student in

learning to utilize his own personal style and interactional resources in a therapeutic process. Similarly, Birchler (1975) states live supervision helps the student to recognize and deal with nonverbal behavior in the therapy session. Haley (1976) has stressed the value of live supervision in that it offers the supervisor the opportunity to deal with the unit of the family and the student therapist, and not simply one or the other.

However, Haley does emphasize the need for clarity in the process between the observing supervisor and student. He suggests a contract with the supervisee whereby calls are to be made "reluctantly" by the supervisor and only when essential. The calls should be brief, concise, and to the point.

Montalvo (1973) stressed the importance of adopting a set of ground rules when conducting live supervision. Prior to the initial interview he feels the pair should meet to agree on guidelines. Montalvo cautions that communication problems in the supervisory dyad invariably influence the outcome of the therapy. He concluded that just as elusive relationship shifts occur in families and between families and therapists, similar processes can occur without awareness between supervisor and supervisee. Birchler (1975) echoes this position, cautioning that a live supervisory or instant feedback model ". . . has inherent in it the potential for interpersonal difficulties between supervisor and trainee" (p. 335).

While some writers have advocated "reluctance" and "caution" when using live supervision, others have been critical of the process. Russell (1976) has criticized patterns of misuse of

live supervision. He is particularly critical of the "bug in the ear" procedure as distracting from the therapist's involvement with the family, and of supervisors who are excessive in their interventions with the therapist and family. Nichols (1975) has identified potentially counterproductive aspects of live supervision in terms of the unnecessary production of anxiety for the therapist and the additional difficulty of therapist dependency on the supervisor's immediate availability.

Whereas concerns have been raised regarding the general efficacy of live supervision another issue may be the potential problem of assuming a "uniformity myth" (Kiesler, 1971) in the area of live supervision. Can one assume that live supervision is maximally beneficial (or always counterproductive) for all therapists. It appears that the interpersonal issues between each supervisor-therapist dyad may make such generalizable statements inaccurate. One must not assume that all therapists and supervisors are a uniformed homogeneous group (e.g. more alike than different) without demonstrated evidence for this position. This area is similar of course to the therapist-client matching issue (Carson, 1973, Berzins, 1977). This is an issue that Carson (1981) recently reported as one in which researchers know virtually nothing; but one that is of very great importance. In regard to the area of live supervision, the above statement seems equally true.

Empirical Research on Supervision and Training

Liddle and Halpin (1978) in a review of family therapy

training and supervision state that in a field already scarce of empirical work, the training and supervision area is the least developed.

In regard to structural family therapy, support for the effectiveness of a structural training program was demonstrated at the Philadelphia Child Guidance Clinic between 1969 and 1974. Persons with no previous directly relevant education or experience were developed into full-fledged family therapists (Haley, 1972). The trainees were put through a two-year regimen of "on-the-job" training including live and videotape review methods. However, no objective evaluation of the training was reported. In a brief follow-up one year later it was found that all graduates (N=26) were employed in some capacity as mental health personnel.

Flomenhaft and Carter (1974, 1977) report on a multi-year program conducted by the Philadelphia Child Guidance Clinic to develop a statewide family therapy network for Pennsylvania. The trainees were professionals employed at county mental health centers located in Pennsylvania. The trainees met one day a week for twenty weeks, with the day being divided between a morning seminar and an afternoon practicum. Live and videotape supervisory methods were used. In a second phase of training, the faculty remained available to centers for one day of case consultation a month. A third phase of the program focused on the development of selected graduates as local trainers for each county.

After one year of phase one training, questionnaires were mailed to the trainees (N=53). It was found that direct service

time devoted to working with families had risen ($P < .01$) (Flomenhaft and Carter, 1974).

In 1972, the award of a ten-year grant from NIMH permitted the evaluation of a joint effort between the Philadelphia Child Guidance Clinic and Children's Hospital of Philadelphia for treatment of psychosomatic families. As part of this effort, pediatric residents were provided with structural type skills in working with children and parents. The goal was to increase the pediatrician skill in treating minor family problems. Senior pediatric staff had primary teaching roles, with child psychiatric faculty (family therapists) serving as consultants. Live and videotape supervision was used.

Kaplan, Rasman, Liebman and Honig (1966) analyzed results of training on seven variables of performance in a family interview, including: (1) chief complaint, (2) history-taking, (3) joining, (4) language, (5) relating to parent during the physical exam, (6) relating to child during the physical exam, and (7) closure. Results indicated changes in the predicted direction of improved performance after training, on all variables except chief complaint. The authors claim that this demonstrates the effectiveness of structural training methods.

Summary and Implications: Marriage and Family Therapy

Marital and family theory and technique has grown rapidly in the past twenty years. Unfortunately, empirical studies on what works in family therapy, when, and how have been scarce. A similar development has happened in the supervision and trainings of marriage and family therapy. Many schools have documented

approaches to supervision and training, but few have performed the needed research to assess their methods.

One approach that is given great importance in the structural school is live supervision. However, to date this writer is unaware of any published studies that have been performed to assess what effects (and how uniform are these effects) live supervision has on the therapist and/or family. To allow a variable as controversial and as powerful (it appears) to be introjected into therapy sessions without assessing its impact first, is surprising. Liddle and Halpin (1978) state that if the field of supervision is to advance further, then the work of the many charismatic leaders in marriage and family therapy must be extended in quantifiable and observable directions. Certainly one area that needs to be quantified and explored is live supervision.

Two Levels of Communication

The following discussion is based on communication theory which is embedded in the following traditions: empirical research in nonverbal communication (Argyle, 1975; Knapp, 1972; Mehrabian, 1972); the psychiatric and psychotherapy theory of Sullivan (1953, 1954), Ruesch and Bateson (1951), Watzlawick, Beavin and Jackson (1965), and Beier (1965); and interpersonal theory of personality as presented by Leary (1957), Carson (1969), and Kiesler (1973, 1979).

As one will recall, the purpose of live supervision is to enable the supervisor to intervene into the session by making suggestions to the supervisee. By using the suggestion, it is believed that the therapist will be better able to redirect the family toward facilitative change. Most often this intervention leads to a change in the content of the session. The phone buzzes, conversation stops, the therapist receives the intervention and then relays it to the family. However, perhaps less obvious, but just as important the intervention also enacts a change in the way the therapist relates nonverbally to the family. The live intervention affects communications on two levels, a content level and a relationship level.

The content level is the informational content of our words or symbols on the linguistic channel. This level has been called the "report" (Watzlawick, Beavin, and Jackson, 1967), "representation," (Danziger, 1976) and the "denotative" (Kiesler, 1979) level of communication. Watzlawick, Beavin, and Jackson (1967) state that the

report aspect of a message conveys information and is therefore, synonymous in human communication with the content of the message. It may be about anything that is communicable regardless of whether the particular information is true or false, valid, invalid, or undecidable (p. 51-52).

The other level is the relationship level which has been called the "command" (Watzlawick, Beavin, and Jackson, 1967), "presentation" (Danziger, 1976) and "connotative relationship" (Keisler, 1979) level. This level usually occurs along the nonverbal channels. Watzlawick, Beavin, and Jackson (1967) state that

The command aspect refers to what sort of message it is to be taken as, and, therefore, ultimately to the relationship statements about one or several of the following assertions: This is how I see myself . . . this is how I see you . . . this is how I see you seeing me . . . and so forth in theoretically infinite regress. Thus for instance the message "it is important to release the clutch gradually and smoothly" and "Just let the clutch go, it'll ruin the transmission in no time." have approximately the same information content (report aspect) but they defined obviously very different relationships (p. 52).

For example, when one listens to someone giving a talk, one decodes the linguistic messages (report) by the words the speaker is uttering. But simultaneously, the speaker also sends a package of nonverbal messages to you (mostly unintentionally) which begins to define your relationship with him. By the speaker's nonverbal cues you may see him as competent, stimulating, boring, or anxious. Similarly, while listening, you send back your view of the relationship to him nonverbally, bored, sleepy, excited, or interested. Thus when a person communicates to another he not only conveys information on the manifest or content level but also on the relationship between the interactants.

Similarly when a supervisor calls and has the supervisee carry out his suggestion the supervisee communicates to the family on both levels. Because of this the live intervention must affect the relationship between the therapist and the family. Even if the supervisor calls and states only "you are doing a good job," that communication will be reflected by the therapist's subsequent nonverbal behavior with the family. This appeared to be Montalvo's belief when he wrote that communication problems in the supervisory dyad invariably influence the outcome in therapy. It is perhaps more accurate however to suggest that any communication in the supervisory dyad (in a session) will influence the relationship between the therapist and family.

Thus, when the therapist hangs up the phone to his supervisor on the content level he executes the intervention which was suggested from the supervisor. But also after the hanging up of the phone the supervisee simultaneously communicates by his pattern of verbal and especially nonverbal behavior certain aspects of his relationship to the family. This in turn may be an important factor in the outcome of the family session.

Nonverbal Communication Research

Kiesler (1979) states that the most crucial place to search for relationship is in the nonverbal behavior of the interactants. Nonverbal behaviors have been used to operationalize and reliably measure dimensions of relationships.

The area of nonverbal communication has developed as an empirical science only since World War II (Knapp, 1978). There were, however, a number of scholarly contributions which stimulated interest in the field. Darwin (1872), The Expression of the Emotions in Man and Animals was an important work which, according to some authors (Ekman, 1973; Knapp, 1978), predated Kretschmer (1925) and Sheldon (1946), and searched for correlations between physical appearance and behavior. Efron (1941) examined and classified gestures in terms of cultural determinants.

Coding, classification, and measurement of nonverbal behavior was pioneered by Birdwhistell (1952). Birdwhistell (1955), interested in the study of communication by gestures and bodily movements, developed a system of classification analogous to language structure. His system classified movements (increasing in complexity) beginning with "kine," the least complex movements, "kinemes," and finally "kinemorphic constrictions" which were analogous to syntactically correct sentences.

Trager (1958) advanced the study of paralinguistics which was the study of how words were said (e.g., tone, rate, volume) rather than what was said. During the 1950's psychotherapists (Ruesh, 1956) began the systematic exploration of nonverbal cues

which occurred in therapy.

Interest in the field of nonverbal communication accelerated during the 1960's. Many specialized areas of nonverbal behavior emerged in research: the work of Exline (1961, 1965) on eye movements, Davitz (1964) on personal space, Goldman-Eisler (1968) on pauses in speech, Ekman and Friesen (1967) on facial cues, Rosenthal (1966) on nonverbal experimenter influence.

During the 1970's, publications in the area of nonverbal behavior emerged into the public domain with such "pop psychology" contributions as Body Language (Fast, 1970). Knapp (1978) reported that many authors' efforts were also directed toward synthesizing and integrating the many specialized studies of the 1960's. One of these contributors, Albert Mehrabian, has particular relevance for the current study and will be discussed in detail.

Mehrabian (1972) developed a parsimonious, conceptual framework to facilitate the study of nonverbal communication. Prior to Mehrabian's work, research in the area of nonverbal communication tended to be a catalog of discrete behaviors which were associated with certain specific aspects (e.g., a clenched fist was associated with anger). Some of the problems that existed in this research area were that (1) this literature yielded a large number of discrete, unrelated findings, (2) inconsistencies among the findings could be attributed to differences between the subject populations or experimental methods, and (3) these studies did not have a unifying conceptual framework (Mehrabian, 1972). Attempting to address the

above-mentioned problems, Mehrabian (1972) proposed that feelings which are communicated verbally or nonverbally, could be described in terms of three independent factors: evaluation (or like-dislike), potency or status (dominance) and responsiveness (interest). The evaluation (or like-dislike) dimension refers to whether the impact of one interactant upon the other is pleasant or unpleasant, whether behaviors are interpersonally attractive, likeable, or warm. The second dimension, potency or status, refers to whether the behavior of one interactant reflects dominant and controlling versus submissive and dependent attitudes toward the other interactant. The responsiveness dimension refers to the extent to which one interactant is important or salient to another interactant, the degree to which behaviors of one interactant are interesting to another interactant. Mehrabian's evidence suggested that the evaluation (like-dislike) dimension is communicated via facial and vocal cues (which convey positive-negative affects) and also by postural and positional cues (distance, forward lean, eye contact and orientation). Mehrabian also reported that the metaphor of immediacy facilitates the identification of behaviors that communicate like-dislike (e.g., closeness can imply greater physical proximity and/or increases one's perceptual availability.) The potency or status dimension is expressed via degree of postural relaxation. The behaviors that communicate potency/status are expressed in metaphors of strength and fearlessness. For example, the strength metaphor might be expressed behaviorally in terms of which interactant presents as larger (e.g., standing vs. bowing). Fearlessness metaphors are expressed as muscle

tension-relaxation. Responsiveness is expressed metaphorically as increased implicit behaviors (i.e., facial or vocal activity). Other factor analytic studies of nonverbal communication (Gitin, 1970; Osgood, 1966; Schlosberg, 1954; Williams & Sundene, 1965) have yielded three factors similar to those described by Mehrabian (1972). These findings collectively suggest, as Ekman and Friesen (1968) reported, that nonverbal behavior is a relationship language and that relationship communications can be characterized in terms of (1) evaluation, (2) potency or status, and (3) responsiveness.

Mehrabian also made an important heuristic contribution to the area of nonverbal behavior by specifying measurable behaviors (verbal and nonverbal) for each of the three factors. As examples of the specific behaviors associated with the evaluation dimension, Mehrabian listed distance, forward lean, eye contact (or facial observation) and orientation. Mehrabian (1972) also offered specific objective scoring criteria for each of these behaviors. The present investigation will use several of the behavioral measures described by Mehrabian (1972). These are discussed in detail in the Method section of the paper.

Several studies have been performed on the relationship between anxiety and nonverbal communication. Mahl (1956) was perhaps the first researcher to study a systematically "content-free" measure of speech in relation to his interest in indices of anxiety in interviews. He believed that "the most valid linguistic measure of anxiety would be those based on the behavioral or 'expressive' aspects of speech rather than those

based on manifest verbal content analyses (1956, p. 1). He proposed as a unit of analysis the "non-ah speech disturbance ratio," which he defined as the number of speech disturbances (sentence corrections, sentence incompleteness, repetition, stutters, intruding sounds, tongue slips, and omissions) minus "ahs" divided by total number of words. A number of studies (Mahl 1956), Panek and Martin (1959), Boomer (1963), Krause and Pilisuk (1961), Kask and Mahl (1965), Seigman and Pope (1965), Pope, Blass, Seigman, and Rahe (1970), and Seigman and Pope (1972) have all shown a clear relationship between anxiety and "non-ah" speech disturbances, with "non-ah" speech errors increasing as level of anxiety increases.

Level of anxiety has also been related to other forms of nonverbal behavior. Ekman and Friesen (1972), Freedman and Hoffman (1967), Mahl (1968), Dittman (1962), and Waxer (1977), have demonstrated that as anxiety increases signaling hand gestures decrease, and non-signaling gestures (self-manipulation) increase. Self-manipulation is defined as motion of a part of the body in contact with another (e.g., stroking oneself). Signaling gestures are defined as the number of movements of hands or fingers, excluding the self-manipulatory movements.

There is strong support that "non-ah" speech errors, self-manipulations, and gestures are all correlates of a communicator's level of anxiety or discomfort.

Several studies have also examined the importance of therapist's nonverbal communication in relation to the "core conditions" for effective psychotherapy, i.e., respect, genuineness, and empathy (Fretz, 1966; Shapiro, 1968; Graves and

Robinson, 1976; Tepper and Haase, 1978; and Seay and Altekruise, 1979). Although the data at times has been contradictory, there is strong support that the communication of the core conditions are powerfully influenced by nonverbal communication. Of particular significance for this study is research that demonstrates that an increase in immediacy (i.e., distance and forward body lean) leads to higher levels of judged empathy and respect (Kelley, 1972; Haase and Tepper, 1972; and Tepper and Haase, 1978). Other factors that have been related to the "core conditions" by the researchers above are eye contact, head nodding, smiling, body orientation, and vocal intonation.

Summary and Implications: Nonverbal Communication Research

The above studies have important implications for the present study. A methodological problem was whether measures could be obtained for such dimensions as immediacy, responsiveness, and anxiety. The research clearly suggests that this is possible.

In addition, research indicates that certain nonverbal behaviors relate significantly to the "core conditions." This suggests that as a person increases or decreases certain nonverbal behaviors his perceived level of "core conditions" may likewise increase or decrease.

Persuasion Studies

When the supervisee is given a suggestion by the supervisor his job is to transmit to the family the supervisor's belief. The supervisor's job after a telephone intervention is not to create his own unique intervention, but to follow the supervisor's directive. An opinion of this author is that a telephone intervention to a therapist can affect the way he relates to the family as measured by nonverbal behaviors.

Although there have been no studies addressing how a therapist reacts when receiving a directive, there is indirect support in the literature of persuasion studies that suggest the therapist changes nonverbally after receiving a call.

Mehrabian (1972) reports on experiments in which subjects presented messages to someone else, employing varying degrees of persuasion. The subjects' nonverbal, vocal, and verbal behaviors were recorded and analyzed. The findings from the persuasion studies showed that as a communicator increased his intention to persuade, there was a corresponding increase in the communicator's activity and immediacy. Communicators were more active and immediate to an addressee when they were attempting to be more persuasive.

An important repercussion of the communicators' implicit behavior was the effect it had on the receiver. In the persuasion studies, Mehrabian reported that judges (unaware of the nonverbal behaviors) rated communicators who were more immediate and responsive as more persuasive.

Based on the above research it can be seen that when people are asked to be persuasive they change certain nonverbal behaviors.

Specifically when persuading others, subjects are more immediate, and active/responsive . Furthermore the receiver appears to read these nonverbal behaviors (although probably not consciously) and make judgements about the message and sender. The above studies support indirectly then that a therapist changes his behavior on both a content and relationship level after receiving a directive via live supervision. In addition this area suggests that how the therapist changes has a significant impact on his viewers (i.e., family) and how they subsequently perceive him.

Research on the Therapist/Patient Relationship

The belief that the positive relationship between counselor and family is a critical factor in the success or failure of treatment is also suggested in research on the therapist/patient relationship. Early theoretical statements about the technique of therapy frequently referred to the importance of the therapist/patient relationship. Freud (1910) emphasized the importance of a "working alliance" between the patient and therapist. He discussed this as though it were separate and different from "transference" (Parloff, Waskow, & Wolfe, 1978). By "working alliance" Freud was referring to the patient recognizing (at an early point in therapy) that the therapist understood and "was well disposed toward him/her" (Parloff et al., 1978, p. 242). In later writings, Freud (1912) emphasized that the analyst should actively attempt to facilitate these positive feelings in patients. Although Freud did not believe that the working alliance was curative in and of itself, he underscored its importance by pointing out that it was impossible to analyze a patient who was not there (Freud, 1912). Freud's followers (Alexander, 1948; Horney, 1950; and Sullivan, 1953) also stressed that a good therapist/patient relationship was more important, but again, the relationship facilitated the "work" of therapy rather than being curative in and of itself (Parloff et al., 1978).

Carl Rogers's (1951) theoretical constructs created a new area of research which examined the curative factors of the therapist/patient relationship. Rogers (1957) reported that three conditions in combination were "necessary and sufficient"

to produce "constructive personality change." Research programs followed which examined what has been referred to as the "core conditions" of therapy. To summarize and define the "core conditions," Rogers (1957) stated that the client must perceive the following therapist attitudes:

Genuineness: the therapist should be within the confines of this relationship a congruent genuine integrated person . . . within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself (p. 97).

Unconditional positive regard; to the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard, (p. 98) and

Empathy: the therapist is experiencing an accurate, empathic understanding of the client's awareness of his own experience. To sense the client's private world as if it were your own without ever losing the "as if" quality--this is empathy (p. 99).

In these statements, Rogers challenged the well established practice of training therapists in techniques of psychotherapy and emphasized instead, the importance of the therapist's attitudes. A large portion of the early empirical testing of these assumptions was supportive of Rogers's stance. Halkides (1958) found a positive relationship between therapist's warmth, empathy, and therapeutic outcome. Betz (1963) found that "successful" therapists exhibited characteristics which were consistent with those identified by Rogers. In summarizing the research findings of the Wisconsin studies (Rogers, 1962; Rogers, Gendlin, Kiesler, & Truax, 1967; Truax, 1963; Truax & Carkhuff, 1963, 1967), Truax and Mitchell (1971) reported that patients who received high levels of the core conditions demonstrated improvement on a variety of measures while patients who received low

levels of the core conditions deteriorated.

Truax and Mitchell (1971) in their review of the literature through 1970 concluded that providing high levels of the "core conditions" (empathy, non-possessive warmth, and genuineness) was tantamount to providing the necessary and sufficient conditions for effective treatment. These authors also concluded "that low levels of accurate empathy, non-possessive warmth, and genuineness are important factors leading to deterioration." In their more recent review article, Parloff, Waskow, and Wolfe (1978) assert, however, that Truax and Mitchell ignored inconsistent findings in the data from the Wisconsin Psychotherapy Project, and also tended to deemphasize the findings that did not support Rogers's theories.

Marshall (1977) suggested that the three therapist offered conditions of empathy, unconditional positive regard, and genuineness (1) appeared to have different meanings across studies, (2) are not measured using a standardized procedure across studies, and (3) yield variable reliability levels across studies. Marshall (1977) reviewing the studies by Truax and Carkhuff which claim to demonstrate the importance of the above therapist variables in the treatment of schizophrenics, reported that "the evidence from these studies is inconclusive" (p. 61). Marshall (1977) also reviewed the data from the Wisconsin Study and reported that the data analyzed by Truax and Carkhuff (1967) claiming unambiguous support for high levels of empathy, genuineness, unconditional positive regard in successful outcomes with schizophrenics, was based upon inadequate reporting (note that these data were subsequently lost), and loose methodology.

Data reanalyzed and rerated by the Rogers and Kiesler team was more rigorously reported and suggested support for high levels of empathy and genuineness in therapy with schizophrenic patients (Marshall, 1977). The role of unconditional positive regard was not reported because of problems with the reliability of this scale (Marshall, 1977). In a study of group therapy with schizophrenic patients receiving low and high levels of "genuineness," the surprising finding was that the patients receiving low levels of genuineness "showed a uniform tendency toward greater improvement than those receiving high levels of genuineness" (Parloff et al., p. 246). Likewise, authors also found that "non-possessive warmth," in at least one study (Truax, Wargo, Frank, Umber, Battel, Hoen-Saric, Nash & Stone, 1966) produced negative outcome data. Similar findings have been reported on the empathy variable as well (Bergin & Jasper, 1969). Such findings present a serious challenge to those studies which claimed that the "core conditions" were necessary and sufficient factors for positive outcome.

Recent research in the area of the three "core conditions" (Mitchell, Bozarth & Krauft, 1977) suggests that the evidence is unclear whether there is a direct relationship between these therapist interpersonal skills and outcome. In fairness to this extensive body of research it is important to note that some studies have shown a relationship between one or more of the core conditions and positive outcome (Minsel, Bommert, Bastine, Langer, Nickel & Tausch, 1971; Truax, 1970; Truax & Wittmer, 1971; Truax, Wittmer & Wargo, 1971). These studies suggest a relationship between the "core conditions" and client change, but

these factors were not as potent or generalizable as was previously thought (Mitchell, Bozarth & Krauft, 1977).

Many researchers have not dismissed the importance of the "therapeutic relationship" but rather included it as just one of a number of important factors to be considered." The field is moving, albeit slowly, away from the linear strategy and toward studying a broader range of therapist activities as they interact with differentiated patient groups under a variety of specified treatment conditions" (Parloff et al., 1978, p. 252). For example, Mitchell, an early advocate of core conditions research, now states that the orientation of the therapist, client characteristics, and specific therapeutic techniques as well as number of more specific variables must be considered (Mitchell, 1977).

Many forms of therapy have addressed this issue of the patient/therapist relationship with few exceptions. Behavior therapists in early theoretical statements (Wolpe & Lazarus, 1966) suggested that the relationship between patient and therapist was not central to behavior change. "Therapists who are aware of these nonspecific therapeutic effects are not entitled to claim special virtues for their particular practices, unless they obtain either a percentage of recoveries substantially above the common average, or greater rapidity of recovery" (Wolpe & Lazarus, 1966, p. 154). Current research in the area of what behavioral therapists actually do suggests that they are more similar to analytically oriented therapists than was originally theorized (Bergin & Suinn, 1975). A study conducted at the Temple University Health Sciences Center (Sloane, Staples,

Cristol, Yorston, & Whipple, 1975) found in comparing the audiotapes of behavior therapists and analytically oriented therapists that both groups were equal in their frequency of making interpretations and communicating warmth. In a study by Gelder, Marks, and Wolff (1967) involving desensitization treatment, patients developed "transference" feelings toward their therapists spontaneously and the authors reported that "the positive aspect of the transference was useful in engaging the cooperation of the patient." Wachtel (1977) suggested that a good relationship between patient and behavior therapist served to enable the patient to participate in the therapeutic process.

Wilson and Evans (1977) recommend that modern behavior therapists do and should utilize social influence and social reinforcement techniques to enhance or facilitate behavior change. They suggest that behavior therapists can increase their interpersonal attractiveness to clients by (1) matching therapist to client in terms of criteria designed to heighten attractiveness of therapist, or (2) teaching the therapist a variety of behaviors which increase his attractiveness to clients (Wilson & Evans, 1977). Such techniques facilitate a variety of behavior change techniques such as imitative learning. The authors conclude their paper by recommending a shift in the mechanistic language describing the practices and attributes of the behavior therapist toward more humanized language in an effort to discourage the often held view that man is manipulated by environmental events beyond his control and responsibility (Wilson & Evans, 1977, p. 560). Other behavior therapists (Goldstein, 1973; Goldstein, Heller, & Sechrest, 1966;

Kendall & Finch, 1976) reported that a positive relationship increases the therapist's ability to influence the patient toward therapeutic ends. It appears that relationship factors cannot be ignored even in behavior therapy.

Therapist/Patient Relationship in Marital/Family Therapy

Gurman and Kniskern (1978) in a review on research on marital and family therapy state that "the ability of the therapist to establish a positive relationship with his or her clients, long a central issue of individual therapy receives the most consistent support as an important outcome-related therapist factor in marital and family therapy" (p. 875). Studies have demonstrated that the dimensions of empathy, warmth, and genuineness are related to keeping families in treatment (Shapiro, 1974; Shapiro & Budman, 1973; Waxenberg, 1973). For example, Waxenberg (1973) found that while white family therapists as a group offered higher levels of empathy to white than to nonwhite families, nonwhite families were as likely as white families to remain in treatment when offered high level of "facilitative conditions."

Another factor that appears to be important in keeping families in treatment is the therapist's activity level in the early sessions. Shapiro and Budman (1973) also found that while empathy was important, also salient for family therapists was therapist level of activity. They found that more active family therapists had fewer dropouts than did less active therapists.

Postner et al. (1971) using a process coding scheme developed at the Jewish General Hospital in Montreal for studying

verbal interaction in family therapy (Guttman et al., 1971, 1972, 1973) examined the effects of therapist drive (D) statements (stimulating interaction, information gathering, giving support) and interpretation (I) statements (clarifying motivation, labeling unconscious motivation). They found that clients whose therapists had low D/I ratios dropped out of treatment and that high therapist D/I ratio early in treatment was predictive of good outcome. It appears then that to keep a family in therapy it behooves the therapist to demonstrate the facilitative conditions and to be active, and not to confront family defenses too quickly.

There is also evidence that the quality of the relationship as assessed by trained judges (Thomlinson, 1974), clients (Beck and Jones, 1973; Burton and Kaplan, 1968; Mezyello et al., 1973), and supervisors (Alexander et al., 1976) is positively related to treatment outcome. An excellent study on this area is the research of Alexander et al. (1976). In their study the authors examined the effects on outcome of "structuring" (directiveness, clarity, self-confidence) and "relationship" (warmth, affect-behavior integration) skills. Although structuring skill discriminated between two levels of poor outcome, only relationship skill was able to discriminate between good and very good outcome. The two sets of skills accounted for 60 percent of the outcome variance, and relationship skill accounted for 44.6 percent of the total variance. The authors conclude:

A reasonable mastery of technical skills may be sufficient to prevent worsening or to maintain pretreatment functioning in very difficult cases, but more refined relationship skills are necessary to yield truly positive outcomes in marital and family therapy. Moreover,

the impact of such relationships skills is not limited to more affectively and intrapsychically oriented treatment, but is equally salient in behavioral treatment (Alexander et al., 1976).

In a more recent review Gurman and Kniskern (1980) conclude,

There exists an accumulating empirical literature supporting the relationship between treatment outcome and a therapist's relationship skills (p. 758).

Summary of Research and Relationship to Problem

It can be seen that a positive relationship between patient and therapist (individual, marital, and/or family) generally facilitates a therapist's intervention and outcome. Many schools of therapy implicitly or explicitly have recommended that therapists actively work toward developing a positive therapist/client relationship.

However, one school-structural family therapy - by its use of live supervision may implicitly minimize the importance of the therapist's cultivating a positive relationship. Critics maintain that live supervision may cause anxiety and/or passivity/dependence in the therapist; conditions that are certainly not conducive to a positive relationship with the family. Research from both the nonverbal literature and the therapist/patient relationship literature indirectly suggest that how a therapist behaves after receiving a directive may in turn affect the family's perception of him on such factors as empathy, genuineness, respect, credibility, persuasiveness, and activity/responsiveness.

Hence the important questions addressed in this study were (1) do live interventions affect the subsequent behavior of the therapist; and if so how; and (2) do different supervisors differ in their effect on the therapist's subsequent behavior.

CHAPTER III

POPULATION

Participants

The population consisted of senior child protection workers (supervisors) and child protection workers (supervisees) located in a local county social service agency. All workers had received training in structural family therapy. Families were either self or court referred for counseling. All families were asked to sign an informed consent that signified their willingness to have the sessions video-taped, supervised, and used for research purposes. Families were also informed that they could have their sessions erased at any time they requested.

Raters

Raters were blind to the purpose of the experiment. All raters were requested to have a minimum of a Masters degree in counseling (or a related field) and/or be enrolled in a counseling program (or a related program) at an accredited college or university. All raters agreed to absolute confidentiality.

Rater Training

All raters participated in training sessions during which they were taught and practiced the specific process measurement skills. Raters randomly were assigned and rated the following conditions: body lean; number of self-manipulations; speech volume; and genuineness. Raters were encouraged to practice until acceptable rater-reliability could be expected. Prior to rating the experimental segments, raters were instructed

that they could pause between segments and consider the ratings.
Rater reliability is reported for all ratings.

PROCEDURE

A major strength of this study was that that the data was collected in a "real" setting from actual counseling sessions (process research). In order to keep the study as unaltered, and natural as possible, the sessions used for this research were videotaped allowing the study to take place without the experimenter being present. The supervisors supervised these sessions as they normally do with no influence from the experimenter.

Three supervisors were each asked to supervise two therapists until they had made a minimum of three phone interventions per therapist. The interventions made by the supervisors were the segments rated. If the supervisor had more than three interventions per therapist, the three interventions per therapist used in the study were randomly selected.

The videotape segments utilized consisted of two minutes immediately before the phone was picked up, and two minutes immediately after the phone was hung up for all telephone interventions. These segments were rated or categorized by the raters who were blind to the purpose of the study and whether a given segment was before or after a telephone call. The raters were instructed to score all observable movements. For all measures with exception of the immediacy measure, the raters based their ratings upon watching the entire two minute slice. In regard to the immediacy measure (body lean) an arbitrary point in the slice had to be selected to allow measurement. One minute immediately before and one minute immediately after the call was the time when immediacy measure was rated.

Ethical Safeguards

As mentioned previously all families signed an informed consent (Appendix C) before therapy began that signified their willingness to have their sessions video-taped, supervised, and used for research purposes. Families were also informed that they could limit their audiovisual recordings in any way they wished at any time including having their sessions erased.

Supervisees were informed before agreeing to participate that parts of their sessions would be reviewed by raters. Raters agreed to absolute confidentiality before being allowed to participate in the study. After the ratings had taken place the therapists were informed that the sessions could be erased.

REVIEW OF INSTRUMENTS AND MEASURESMeasures

1. Immediacy:

Forward Lean. This was assessed by the number of degrees that a plane from the communicator's shoulder to his hips was away from the vertical plane. Angles were measured in units of ten degrees; whereas reclining angles were scored as negative, forward-leaning angles were scored as positive. Mehrabian (1972) states rater reliability at .87.

2. Responsiveness:

Speech Volume. This was assessed by a 5 point scale with anchors of "whisper" for zero, and "very loud" for four. (Appendix A) Mehrabian states rater reliability at .88. In cases where the therapist did not speak in a segment, the assumption was made that this is a display of minimum responsiveness and the raters gave minimum scores on responsiveness for that particular segment.

3. Anxiety:

Self-manipulation. Self-manipulation was defined as a motion of a part of the body in contact with another, either directly or mediated by an instrument. Examples are scratching, rubbing, or tapping an arm or leg with finger or pen. Single brief movements were scored once each. A brief (that is, less than five seconds) scratching movement was scored once only. Continuous movements were scored once every five seconds. Mehrabian (1972) rates rater reliability at .90.

4. Genuineness:

Genuineness was measured by the Carkhuff scale (Carkhuff, 1969). (Appendix B) The five-point scale ranges from a low level where the therapist presents a facade or defends and denies feelings; and continues to a high level of self-congruence where the therapist is freely and deeply himself. Reliability has been assessed by obtaining coefficients assessing both an estimate of the average intercorrelation among judges (.40 - .62) and the reliability of the average scores (of the group of judges) for the segment sample involved, .25- .95, with a median value of .72 for over twenty-eight studies.

DESIGN

Three supervisors each supervised two therapists until they had made a minimum of three telephone interventions per therapist. Two minutes before each telephone intervention and two minutes after each telephone intervention was the unit of behavior to be rated or categorized. The units were rated on the nonverbal and genuineness measures listed in the measurement section. There were six segments of supervisees' behavior before interventions for each supervisor, and six segments of supervisees' behavior after interventions for each supervisor. There were a total of thirty-six segments rated.

RESEARCH DESIGN

	BEFORE INTERVENTION	AFTER INTERVENTION
Supervisor #1		
Supervisor #2		
Supervisor #3		

STATISTICAL ANALYSIS

A two-way analysis of variance repeated measures on one factor was conducted to determine the effects of supervisor, and telephone intervention, upon therapist's level of immediacy, responsiveness, anxiety, and genuineness.

STATISTICAL HYPOTHESES

1. The level of anxiety (as measured by nonverbal behaviors) of the therapists will not increase after a telephone intervention by supervisor.
2. The level of responsiveness (as measured by nonverbal behaviors) of the therapists will not increase after a telephone intervention by supervisor.
3. The level of immediacy (as measured by nonverbal behaviors) of the therapists will not decrease after a telephone intervention by supervisor.
4. The level of genuineness (as measured by judges ratings) of the therapists will not decrease after a telephone intervention by supervisor.
5. The therapists rate of anxiety (as measured by nonverbal behaviors) after a telephone intervention will not vary significantly between supervisors.
6. The therapists rate of responsiveness (as measured by nonverbal behaviors) after a telephone intervention will not vary significantly between supervisors.
7. The therapists rate of immediacy (as measured by nonverbal behaviors) after a telephone intervention will not vary significantly between supervisors.
8. The therapists rate of genuineness (as measured by judges ratings) after a telephone intervention will not vary significantly between supervisors.

Summary of Methodology

Three supervisors were each asked to supervise two therapists until they had made a minimum of three phone interventions per therapists. The interventions made by the supervisors were the segments rated. The segments consisted of two minutes before the intervention and two minutes after the interventions. During these segments raters rated various nonverbal and scaled measures to assess the therapists on the dimensions of immediacy, genuineness, anxiety, and responsiveness. Raters scored six segments of supervisees' behavior before interventions for each supervisor, and six segments of supervisees' behavior after interventions for each supervisor.

CHAPTER IV
Analysis of Results

The results of the study will be reported in the same order as the hypotheses were presented in chapter one. Table 4-1 located at the end of this chapter has been included as an aid in the understanding of the data. Rater reliability for the measures in this research were as follows: forward lean .90; self-manipulation .71; genuineness .69; and speech volume .73.

Hypothesis One: The level of anxiety (as measured by nonverbal behaviors) of the therapists will increase after a telephone intervention by supervisor.

The first hypothesis stating that the level of anxiety of therapists would increase after a telephone intervention by supervisor was not supported. A 3x2 (groups x trials) ANOVA as measured by the nonverbal measure self-manipulation before and after a telephone intervention was non-significant at the .05 level. Two groups did rise in anxiety after a phone call slightly, whereas the other group had a small decline. These results support the notion that therapist's level of anxiety do not rise significantly after an intervention by supervisor. Table 4-1 (located at end of this section) presents the means and standard deviations of these data.

Hypothesis Two: The level of responsiveness (as measured by nonverbal behaviors) of the therapists will increase after a telephone intervention by supervisor.

The second hypothesis stating that the level of responsiveness of therapists would increase after a telephone intervention by

supervisor was not supported. A 3x2 (group x trials) ANOVA as measured by the nonverbal measure speech volume before and after a telephone intervention was not significant at the .05 level. In two groups there was a slight increase in responsiveness after intervention with the third group staying the same. The data does not support the hypothesis that a therapist becomes significantly more responsive nonverbally after a telephone intervention by a supervisor. Table 4-1 presents the means and standard deviations for this data.

Hypothesis Three: The level of immediacy (as measured by nonverbal behaviors) of the therapists will decrease after a telephone intervention by supervisor.

The third hypothesis stating that level of immediacy of the therapists would decrease after a telephone intervention by supervisor was not supported. A 3x2 (groups x trials) ANOVA as measured by the nonverbal measure forward lean before and after a telephone intervention was not significant at the .05 level. All three groups did show a modest decline in immediacy after intervention but the effect was not large enough to be significant. Hence there is not enough support to suggest that a therapist becomes less immediate after a telephone intervention by a supervisor. Table 4-1 presents the means and standard deviations for this data.

Hypothesis Four: The level of genuineness (as measured by judges ratings) of the therapists will decrease after a telephone intervention by supervisor.

The fourth hypothesis stating that level of genuineness of the therapists would decrease after a telephone intervention by

supervisor was not supported. A 3x2 (groups x trials) ANOVA as measured by judges ratings of genuineness before and after a telephone intervention showed no significant trial effect at the .05 level. One group did show a slight decline in genuineness after the interventions, but the other two groups stayed essentially the same. There is no evidence then that a therapist becomes less genuine after a telephone intervention by the supervisor. Table 4-1 presents the means and standard deviations for this data.

Hypothesis Five: The therapists rate of anxiety (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.

The fifth hypothesis stating that the therapists rate of anxiety after a telephone intervention would vary significantly between supervisors was not supported. A 3x2 (group x trials) ANOVA did find a significant group effect $F(2,15)=3.68$ $p<.05$ but no interaction effects. A Newman-Keuls multiple range test was performed at the .05 level and it was found that group two differed significantly from group three $4.33>2.20$; that group two differed significantly from group one $2.95>1.81$; but that group one did not differ significantly from group three $1.38<1.81$. The results suggest that therapists rates of anxiety varied significantly between some supervisors but that these differences were not interactive in any way with telephone interventions. Table 4-1 presents the means and standard deviations of these data.

Hypothesis Six: The therapists rate of responsiveness (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.

The sixth hypothesis stating that the therapists rate of

responsiveness after a telephone intervention would vary significantly between supervisors was not supported. A 3x2 (group x trials) ANOVA showed no significance in both the group effect and the interaction effect at the .05 level. The data does not support the belief that therapists levels of responsiveness will vary between supervisors after a telephone intervention. Table 4-1 presents the means and standard deviations of these data.

Hypothesis Seven: The therapists rate of immediacy (as measured by nonverbal behaviors) after a telephone intervention will vary significantly between supervisors.

The seventh hypothesis stating that the therapists rate of immediacy after a telephone intervention would vary significantly between supervisors was not supported. A 3x2 (group x trials) ANOVA was not significant in both the group effect and the interaction effect at the .05 level. These findings do not support the notion that therapists level of immediacy will vary between supervisors after a telephone intervention. Table 4-1 presents the means and standard deviations of these data.

Hypothesis Eight: The therapists rate of genuineness (as measured by judges rating) after a telephone intervention will vary significantly between supervisors.

The eighth hypothesis stating that the therapists rate of genuineness after a telephone intervention would vary significantly between supervisors was not supported. A 3x2 (group x trials) ANOVA was not significant at the .05 level for both the group effect and the interaction effect. These findings do not support the belief that therapists level of genuineness will vary between supervisors after a telephone intervention. Table 4-1 presents the means and standard deviations of these data.

Summary of Data Analysis

In summarizing the findings it appears that for discussion the eight hypotheses can be placed into two groups. The first group contains the first four hypotheses which all dealt with differences between therapists' behavior before and after interventions. Analysis of variance procedures found no significant differences on any of the four measures in this regard. There were modest trends in the right direction for two of the four hypotheses. Hypothesis two predicted a increase in responsiveness (as measured by speech volume) of the therapists after intervention. Responsiveness did increase in two out of the three groups (with the other group staying the same) but the increase was nonsignificant. Hypothesis three predicted a decrease in immediacy (as measured by forward lean) of the therapists after intervention. In all three groups there was a decrease in immediacy after intervention but again this change was not enough to be statistically significant. Overall there was no significant differences in any of the therapists' behavior before and after telephone interventions.

Hypotheses five through eight all predicted differences in therapists' behavior after telephone interventions between supervisors. On three of the measures (responsiveness, genuineness, and immediacy) therapists' behavior after interventions did not vary significantly between supervisors. However on one measure anxiety, (as measured by self-manipulation) one group did vary significantly from the other two groups; as established by Newman-Keuls procedures. This finding was a main effect only. The rate of anxiety for this group was significantly different from the other two groups but this difference was not interactive in any way with telephone

interventions. The group was significantly lower in anxiety from the other groups both before and after interventions with no effect from the interventions. Overall there was little support for the predictions that therapists' behavior after interventions would vary significantly between supervisor.

TABLE 4-1

Means and Standard Deviations (in parentheses) of the Data for Each Group

Measures	Supervisor's Group		
	I	II	III
Self-manipulations			
Before	5.92 (2.18)	3.00 (3.16)	8.08 (3.41)
After	6.42 (2.81)	3.42 (3.55)	7.00 (2.07)
Speech volume			
Before	1.66 (0.52)	1.75 (0.42)	1.58 (0.58)
After	1.66 (0.82)	2.00 (0.32)	1.66 (0.53)
Genuineness			
Before	3.17 (1.13)	3.00 (0.84)	4.33 (0.52)
After	3.17 (0.93)	3.00 (0.89)	3.92 (0.92)
Forward lean*			
Before	22.5 (20.1)	29.2 (12.0)	26.6 (15.4)
After	13.3 (18.8)	22.5 (6.1)	19.2 (12.8)

* For statistical purposes 20 was added to all scores for the forward lean measure.

CHAPTER V
SUMMARY, CONCLUSION, DISCUSSION,
AND IMPLICATIONS FOR FURTHER STUDY

As marital and family therapy continues to increase, the technique of live supervision continues to be regularly employed in treatment of marital and family concerns. Because of this, there is a distinct need for clinical experimentation to assess what effect live supervision has on the therapist. The primary questions addressed in this study were: (1) do live interventions affect the subsequent behavior of the therapist (as measured by therapists' level of immediacy, genuineness, responsiveness, and anxiety); and (2) do different supervisors differ in their effects on the therapists' subsequent behavior (as measured on these same dimensions).

The subject population consisted of three senior child protection workers (supervisors) and six child protection workers (supervisees) located in a local county social service agency. All workers had received training and had experience in structural family therapy.

The three supervisors each supervised two therapists until they had made a minimum of three telephone interventions per therapist. The interventions made by the supervisors were the segments studied. The segments consisted of two minutes before the interventions and two minutes after the interventions. During these segments raters rated various nonverbal and scale measures to assess the therapists on the dimensions of immediacy, genuineness, anxiety, and responsiveness. Raters scored six segments of supervisees' behavior before interventions for each supervisor, and six segments of supervisees' behavior after interventions for

each supervisor. Two-way analysis of variance, repeated measures on one factor procedures were then conducted to determine the effect of supervisor, and telephone intervention, upon therapists' level of immediacy, responsiveness, anxiety, and genuineness.

The analysis of the data found no differences between therapists' behavior before and after interventions on any of the four measures. There were modest trends for two of the dimensions (increase in responsiveness; decrease in immediacy) but these trends were not statistically significant. In regard to differences between supervisors, only on one measure anxiety, was a difference noted. However, although the rate of anxiety of one supervisor's group was significantly different from the other two groups the difference was not interactive in any way with telephone interventions. The group was significantly lower in anxiety from the other groups both before and after interventions with no apparent effect from the interventions.

In brief there appears little support for the predictions that: (1) therapists' behavior would differ before and after interventions; and (2) that therapists' behavior after interventions would vary significantly between supervisors.

CONCLUSIONS

The major findings of this study are:

1. Live supervision via a telephone does not affect the therapists' subsequent behavior (as measured by the dimensions of immediacy, anxiety, responsiveness, and genuineness).
2. The therapists' behaviors (as measured by the dimensions of immediacy, anxiety, responsiveness, and genuineness) after a telephone intervention do not vary as a result of having different supervisors.

The above two conclusions should be generalized only to populations similar to the one used in this research. It may be particularly important to note that the population in this study was one in which the therapists and supervisors were committed to and experienced with a school of therapy that advocates and regularly uses the live supervision format.

DISCUSSION

The present study investigated the effects of live telephone interventions on therapist's level of immediacy, genuineness, anxiety, and responsiveness. The results were in general supportive of the live supervision arrangement as it was found that the supervision did not produce counter-productive behaviors in the therapists. There was no evidence to support Nichol's (1975) concern that live interventions might increase levels of anxiety and/or dependency in therapists. The findings indicate that the therapists were not passively waiting for the interventions to guide them; nor were they nervously applying the interventions in a robotic insincere way. Instead it appears that the therapists have so well incorporated this approach that it had no measurable effect on their behavior in the session.

This belief that live supervision does not impede a therapist's ability has long been assumed by proponents of the method. For example Halsey (1976) has suggested that when the therapist is comfortable with the live supervision arrangement the family will also be comfortable. Although one cannot assess from this study how families feel about live interventions, one now has evidence to support the premise that therapists can indeed become quite comfortable with this procedure.

The fact that this agency has successfully implemented this arrangement, leads to the question of what in particular they did to accomplish this success. The answer may be that this group of workers have implemented suggestions from writers in the field on how to avoid potential pitfalls in the field

of live supervision. Most literature in the field (Bullock and Koboyashi, 1978; Montalvo, 1973; Haley, 1976) suggests that the success or failure of this technique lies in the therapist-supervisor relationship. To be successful the dyad must work out such issues as how the goals are set, who is ultimately responsible for the case, how frequently to intervene, and whether the therapist must act on every intervention or not. These issues of course require a team approach, and for a team to work well continuous and effective communication is needed. This agency appears to have built in ways to accomplish this. For example therapist and supervisor usually meet before and after a session. The therapist is free to leave the room for more clarification if needed. Therapists are relatively free to select the supervisor they wish to work with (depending on supervisor's schedule) for a specific case. The agency as a whole is committed to a structural family therapy approach and the therapists and supervisors have all received training in this format. Finally the arrangement of live telephone intervention is used constantly which provides the therapists and supervisors with a great deal of time in working with this process. The length of time someone has had with this technique may be a particularly crucial variable in the relative comfort one feels with the approach. Supporting the above possibility, Gershenson and Cohen (1978) describe their experiences of being supervised live as a three stage model. The first stage is marked by anxiety and resistance. The writers report in this stage that they had fantasies of being criticized behind the mirror and generally gave an initial half-hearted attempt in

working with and understanding this model of supervision.

The second stage was characterized as the therapists becoming more emotionally involved in the process. There was also a reduction of the feelings of verticality between therapist and supervisor. The therapists found themselves more actively involved in the treatment. A sense of teamwork became present, and a feeling of doing therapy together began to emerge.

The third stage was described as a cyclical process. Here the therapists report that the direction of the supervisor became less important as a technique to be implemented and instead served as a stimulus to their own thinking. In this stage Gershenson and Cohen state that they were better able to initiate their own therapeutic strategies and assume more responsibility for the therapy. A form of camaraderie between therapist and supervisor developed, with therapist and supervisor working together in the therapeutic process. In this stage model then, it appeared that as the therapist became more experienced with the live supervision arrangement, his anxiety level decreased, while his activity/responsiveness level increased. In addition it seems that the therapists became more natural and spontaneous over time, perhaps suggesting an increase of genuineness and immediacy. Overall the therapists moved from a stance of initial fear and resistance to a much more comfortable one and eventually even liked the live supervision arrangement. The early stages seemed to have been relatively brief as the writers reported their reactions based on a two and a half month family therapy seminar. With respect to this research, the therapists' extensive experience with the live intervention process (ranging from six

months to several years) leads one to suspect that this study measured a group of therapists well into the third stage of the above model. It may not be so surprising then that a group of therapists such as the ones used in this research would not find the supervision process uncomfortable or distracting. One final piece of evidence supporting the contention that the therapists and supervisors worked extremely well with each other during the study was that the therapists agreed with their supervisor's interventions 94% of the time (as measured by experimenter questionnaire n=103.) Even taking in consideration that this percentage might be somewhat inflated due to a social desirability factor, the percentage is so large that it suggests that at this time in the agency the supervisors and therapists worked very harmoniously together.

This study also addressed the therapist-supervisor matching issue. It was hypothesized that supervisors would differ in their effects on therapists' behaviors. However, the results found that the supervisors were similar in their impacts on the therapists in three out of four behaviors measured. Only in the behavior anxiety did one of the three supervisor's groups vary significantly. A closer look at the data indicates that the reason for this difference is likely due to one of the therapists in the group scoring markedly low on his level of anxiety during all segments rated. It appears that the difference found may be due to a unique therapist/family situation rather than a supervisor difference. Importantly the other therapist in the group was very similar in his level of anxiety to the other therapists in the other groups. Unfortunately the small sample size qualifies this conclusion. Overall, the effect of

having a different supervisor was not very noticeable. This finding differs from what most traditional theorists in the field would assume. Why wouldn't therapists with different supervisors react differently to the interventions? A possibility may be in the similarity of the therapists and supervisors in this agency. As mentioned, all therapists and supervisors have trained together in structural family therapy. In addition, and perhaps more importantly, therapists and supervisors are free on most occasions to watch each other work either by observing behind the mirror and/or reviewing together videotapes of their work. This constant observation of each others behavior in therapy and supervision may be responsible for the homogeneity of the dyads found in this study. Given the strong impact of modeling on behavior these findings may be more understandable. This close interworking of the therapists and supervisors probably promotes a team camaraderie and may produce some similarities between supervisors and therapists reactions to supervisors. A similar effect is often talked about in the area of sports in which successful teams are often described as having blended members' individuality in order to function harmoniously and effectively. The individual team members become more alike and the team takes on a personality of its own rather than being a composite of its individual members. The results in this study suggest that something similar may occur with this type of team approach to therapy. Given a small group of workers, who constantly work with and observe each other, and who speak the same language there may be a blending of supervisors' and therapists' behaviors. The esprit de

corps feelings among supervisors and therapists probably reduces discomfort with the live supervision approach, while at the same time it may reduce to some degree the individuality of its members. Interestingly, these findings bring in to question the importance of the therapist being able to choose his own supervisor. Although the therapist may feel that this is an important decision, this study suggests that at least on some dimensions this is not a crucial issue. It seems that the therapists in this study are so comfortable with the live supervision format and so familiar with their supervisors that whoever is on the other end of the phone makes very little difference. However, one must not ignore the possibility that the therapist simply having the right to choose a supervisor may in itself produce an effect that accounts at least partially for his subsequent comfortableness with the live intervention process.

In summary, these findings do support the use of live supervision in that in at least one particular agency live supervision was not found to be counterproductive to the therapist. The technique of live supervision did not appear distracting but actually appeared to be well intergrated into the session by the therapists. Although one study does not suggest the arrangement is foolproof, it does support the use of a technique that has as its biggest asset a method for getting closer to therapeutic happenings than the traditional self-report method of supervision. At its best, live supervision may provide a supervisor with a benign and helpful arrangement for guiding the therapeutic process.

IMPLICATIONS FOR FURTHER STUDY

A hope of this researcher was that this research would be a stimulus for a series of studies in this area. It appears that this study has raised a series of questions. For example, if Gershenson and Cohen's three stage model of supervision is correct, then it should be possible to assess differences in therapist's behavior according to the stages. Perhaps a crucial dimension that need to be considered is the therapist and/or supervisor's experience. Closely tied to this issue and relevant to further research is the issue of whether live supervision techniques should be used for training and/or treatment. The agency in this study uses live supervision continuously and not just for training. Perhaps this factor affects the therapist's perceptions of himself and his supervision which are then acted out in his behavior in the session.

Another issue raised by this study is how important it is to have the option to choose one's supervisor. In a small agency with ongoing mutual observation of treatment cases the importance may be minimal, but in other agencies the result may be different. A study specifically designed to test this issue might bear interesting results.

The therapist's level of commitment to a school that believes in live supervision is also a dimension that might need investigation. Would a therapist's behavior differ from the therapists' behavior in this study if he was not trained in a school that promotes live supervision?

More generally, a prospective researcher might want to assess the generalizability of these findings to other agencies and/or

larger n's of therapists and supervisors. Or he may want to employ a single case design and investigate such issues as the impact of one supervisor on one therapist over a complete session; over a series of sessions with one family; or over peak and poor sessions of one therapist. The single case approach has recently been supported in the family literature (Rabin, 1981).

Other areas of exploration include the entire area of the effect of live supervision on the family. Do telephone interventions have a counterproductive effect on the family, or are the families' reactions based on the therapist's comfort as Haley suggests? Another issue is the characteristic of the intervention itself. What effects do the content of the message, the length of the call, the frequency of calls, the supervisors' paralanguage during the intervention have on the therapist? It may indeed be naive to believe that a global effect can be found in reactions to live telephone interventions given the various differences inherent in the interventions themselves. Questions about the actual apparatus of live interventions such as the bug-in-the-ear versus a phone also remain to be addressed. In brief, this study is only one in an area of supervision that has many questions that need investigation.

Appendix A
Speech Volume Scale

<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
0	1	2	3	4
Whisper	Soft	Average	Loud	Very loud

Appendix B

Genuineness Scale

1. The therapist is clearly defensive in the interaction, and there is explicit evidence of a very considerable discrepancy between what he says and what he experiences. There may be striking contradictions in the therapist's statements, the content of his verbalizations may contradict the voice qualities or nonverbal cues (i.e., the upset therapist stating in a strained voice that he is "not bothered at all" by the patient's anger).
2. The therapist responds appropriately in a professional rather than a personal manner, giving the impression that his responses are said because they sound good from a distance but do not express what he really feels or means. There is a somewhat contrived or rehearsed quality or air of professionalism present.
3. The therapist is implicitly either defensive or professional, although there is no explicit evidence.
4. There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. The therapist shows no self-incongruence.
5. The therapist is freely and deeply himself in the relationship. He is open to experiences and feeling of all types--both pleasant and hurtful--without traces of defensiveness or retreat into professionalism. Although there may be contradictory feelings, these are accepted or recognized. The therapist is clearly being himself in all of his responses, whether they are personally meaningful or trite. At stage 5 the therapist need not express personal feelings, but whether he is giving advice, reflecting, interpreting, or sharing experiences, it is clear that he is being very much himself, so that his verbalizations match his inner experiences.

Appendix C

Informed Consent Form

SOCIAL SERVICES

Director

Telephone

I (We) authorize _____ to use any audiovisual recordings made at this agency of myself (us) and my (our) family, for the purpose of (a) evaluation by the worker, (b) supervision by the worker's supervisor, (c) research, (d) teaching to professionals only with the approval of the Agency Director. The videotapes may be used, suitably disguised to the extent practical, in material prepared for publication.

Upon written notice I (we) may have any or all audiovisual recordings erased, and/or restrict their use to one or more of the above stated purposes.

Father: _____ Date: _____

Mother: _____ Date: _____

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Abstract

THE IMPACT OF LIVE SUPERVISION ON THE THERAPIST'S LEVEL OF IMMEDIACY, ANXIETY, RESPONSIVENESS, AND GENUINNESS

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The effects of live supervision via telephone on therapists was explored. Three supervisors experienced in live supervision were each asked to supervise live, two family therapists until they had each made a minimum of three phone interventions per therapist. The therapists' behavior two minutes immediately before the interventions and two minutes immediately after the phone interventions were then rated by judges using non-verbal and scale measures. Therapists' behavior were rated on the following factors: anxiety, responsiveness, immediacy, and genuineness. The results did not indicate any significant differences between therapist's behavior before and after phone interventions, and only modest differences in behaviors between therapists using different supervisors. The findings are supportive of live supervision as there was no evidence the live interventions affect the therapists negatively on the above dimensions. The findings are discussed with implications for the field of supervision.