IMPACT OF CO-THERAPY TEAMS ON CLIENT OUTCOMES AND THERAPIST TRAINING IN MARRIAGE AND FAMILY THERAPY

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ABSTRACT: This study of 33 student therapists, 402 client systems, and three supervisors tested the efficacy of using student co-therapy teams as an aspect of clinical training in a marriage and family therapy program. This study utilizes both quantitative and qualitative methodology. Two research questions were addressed: "Do different pairings of co-therapists affect client outcomes?" and "Is co-therapy a viable option for a training program?" The results indicate that client outcomes using co-therapy are at least as effective as treatment using one therapist and in some circumstances produce more positive outcomes for both clients and student therapists.

KEY WORDS: co-therapy; clinical outcome; family therapy; supervision.

In treatment and training situations there has been a long history of support for the use of co-therapy. Co-therapy, defined here as the use of two therapists meeting with a couple, family, or group, has historically received considerable attention in texts and anecdotal liter-

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ature. Some proponents view co-therapy as a necessity for effective treatment in special therapeutic situations and as a primary training modality. However, co-therapy also has critics who regard the practice as potentially harmful, unnecessarily costly in most therapeutic environments, and as having deleterious effects on therapy trainees. While debates continue in both support and opposition for the use of co-therapy, there is relatively little research supporting the efficacy of co-therapy teams for either treatment or as a training method. The current report attempts to fill the void by assessing the relative outcomes of various co-therapist and individual therapist arrangements in family therapy.

REVIEW OF LITERATURE

Co-Therapy in Practice

The use of multiple therapists in the treatment of clients has received mixed reviews. Much of the support for co-therapy has come from group therapists (DeLuca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; Benjamin & Benjamin, 1994), sex therapists (Masters, Johnson, & Kolodny, 1988; LoPiccolo, Heiman, Hogan, & Roberts, 1985), and family therapists (Napier & Whitaker, 1978; Hannum, 1980; Selvini & Palazzoli, 1991). De Luca and associates (1992) present the typical rationale for the use of co-therapists through the following four reasons. First, two therapists have more resources to offer for treatment than one therapist alone. Second, by working together, two therapists can share responsibilities, thus reducing the workload for each. Third, the presence of two therapists provides the potential for role-modeling appropriate behaviors between the co-therapists that clients can directly observe. Finally, clients can be provided with a greater sense of permanence and continuity by having two therapists, especially when in long-term treatment one therapist may not be available throughout the course of treatment. In addition, Hoffman, Gafni, and Laub (1994) make the case that co-therapy teams provide an opportunity for the prevention of burnout.

Carl Whitaker adds two conceptual justifications for the therapeutic use of co-therapy: the symbolic nature of the arrangement and a protective function (Napier & Whitaker, 1978). Symbolically, the two therapists take on the role of therapeutic "parents," able to function not only as role-models, but also to demonstrate, in person, a more

healthy relationship that clients can both observe in sessions and learn to trust. In addition, having a second therapist provides protection against over-involvement and as hedge against therapist vulnerability with clients. This protective function increases the ability of two therapists to cover each other's blind spots as a means to control countertransference (Benjamin & Benjamin, 1994).

In addition to the above assumptions supporting the use of co-therapists, the complementary nature of the relationship allows for non-summativity, where the whole provided by two therapists is greater than the sum of the parts (Bowers & Gauron, 1981). This extension of the belief that two heads are better than one has been expressed by many in support of co-therapy (Selvini & Palazzoli, 1991) including Bateson (1979) who valued the effect of "binocular vision" where greater depth is achieved by contrasting multiple perspectives. In specific treatments, such as sex therapy with heterosexual couples, a female-male co-therapy team is recommended (Masters, Johnson, & Kolodny, 1988; Baruth & Huber, 1991) due to the increased ability of the pair to model appropriate individual and relationship behaviors. The use of a heterosexual co-therapy team was also adopted as a primary family treatment modality by the Milan group (Palazzoli, Boscolo, Cecchin, & Prata, 1990). The use of a heterosexual co-therapy team allowed the possibility that "a more 'physiological' equilibrium is brought about between them and the family" (p. 10). Additionally, Palazzoli and colleagues (1990) suggest the team can be beneficial to the growth and well-being of the therapists, both as therapists and as people, that comes from the experience of participating in a non-competitive and united team. Finally, there are several pragmatic reasons for using co-therapists, including an individual therapist feeling "stuck" with a client, as a method to mentor a less experienced therapist, or as an intermediate stage when a therapist will be leaving the therapeutic system (Brock & Bernard, 1999).

Perhaps the most notable and pointed criticism of co-therapy comes from Jay Haley. Haley (1987) criticizes that the expense of co-therapy as a treatment technique can not be justified by outcome research. At worst, Haley views co-therapy as primarily for the "security of the clinician and not for the value to the client" (p. 14) and a potential impediment to the therapist's ability to take decisive and immediate action in session without the necessity of consulting with a team member. In summary, Haley (1987) states that "Multiple therapists can make the situation more difficult to change (italics in original). One therapist can do therapy as successfully as two, and one is more econom-

ical. Usually, co-therapy is set up for the sake of uncertain therapists, not for the case" (p. 178). Perhaps in a dark side view of the potential for symbolic therapeutic parenting that Whitaker highlighted, Haley (1987) proposes the possibility that clients could be trapped in a struggle between their therapists to the detriment of the clients. Further caution comes from the potential that the co-therapy relationship may become the primary focus rather than the treatment of clients' issues such as when the relationship between co-therapists is not a model of good dynamics (i.e., disrespectful comments between co-therapists) (Bowers & Gauron, 1981). A final concern expressed by some is that potential erotic issues between co-therapists could become problematic (Russell & Russell, 1980).

Co-Therapy as a Training Method

An alternate rationale for using co-therapy is in the training of therapists. Again there are both proponents and opponents of this practice. In addition to the above reasons supporting co-therapy, trainers add the following in support of having therapists in training perform as team members. Some trainers are concerned with the efficacy of sending inexperienced therapists into a therapeutic situation with a supervisor that is available for consultation only outside the therapy time (between sessions or during scheduled supervision meetings) (Bernard, Babineau, & Schwartz, 1980). Co-therapy can be a relatively safe and gradual entry into the responsibility of being a solo therapist (Latham, 1982). This is most likely an extension of the "two heads are better than one" ideology described previously. Unique here is the assumption that the sharing of responsibility will enable an insecure therapist to take more risks with the support of a second therapist than he/she would alone. As the therapist trainee becomes more comfortable with the therapeutic situation and his or her increasing ability there is a freedom to become more actively involved (Latham, 1982).

Further support for the value of co-therapy in training situations comes from structural therapy where two therapists working together can alternate between roles as active therapist and observing therapist. In this method, the observing therapist is responsible for widening the therapy team's field of vision to include a view of the clients, the active therapist, and the interactional patterns between all members of the therapeutic system (Hannum, 1980). The observing therapist can then choose to intervene at appropriate times to unbalance therapeutic impasses, to provide a "Greek Chorus" in relation to the active therapist,

or to highlight events that the active therapist may have overlooked. In addition, symbolic-experiential therapies encourage the teaming of mentor therapists with trainee therapists as a teaching technique that is isomorphic with the assumptions of the value of experiential learning that is dominant in the therapy (Napier & Whitaker, 1978). Russell and Russell (1980) state this as the potential for the beginning therapist to learn about therapy by gaining "a more intimate understanding of the process of therapy" (p. 403).

While there is support for co-therapy as a training method, there are also opponents of the practice. Latham (1982) cites Sager (1968) as stating the use of co-therapy is a result of inadequate training. A further drawback to the use of trainees as co-therapists is the temporary involvement of the trainee who will reach an identifiable point in training where he/she will leave. This predictable turnover can lead to instability of the therapeutic system that could possibly be detrimental to treatment. Haley (1996) summarizes his hesitation in using co-therapy as a training method by stating "I believe that using co-therapy in training only teaches the trainee to sit back and watch the teacher work" (p. 19). Haley suggests a more appropriate position for the experienced trainer is as an observing supervisor providing direct feedback to the therapist.

Teaming Therapists

When the choice to use co-therapy teams has been made, a new set of concerns arises from the pragmatics of teaming therapists. Some relevant questions include when to use co-therapy teams as opposed to single therapists? Also, should the teams be composed of therapists of similar experience level or should supervisor and therapist be paired as a co-therapy team? The answers to these questions include the belief that co-therapy should be reserved for "stuck" cases or as an entry stage eventually leading to the ability to perform as a solo therapist.

Among those who have considered the mix of experience levels in co-therapy teams there is a range beginning at an "apprenticeship" notion where beginning therapists can learn from working with a master therapist as co-therapist (Bernard, Babineau, & Schwartz, 1980; Napier & Whitaker, 1978). At the opposite extreme are those who avoid co-therapy pairings where there is an experience difference (Hannum, 1980; Bowers & Gauron, 1981) because of the potentially competitive nature of the unbalanced relationship. Additionally, there is concern that the less experienced therapist will take a passive role.

Research Questions

A notable weakness in the discussion over the use of co-therapy is the lack of outcome research linking therapeutic outcomes to various co-therapy and solo therapist treatment techniques. The current report is an attempt to bridge this gap by investigating the following questions.

1. Do different pairings of co-therapists affect client outcomes?
2. Is co-therapy a viable option for a training program?

METHODS

Sample

This study employed a mix of quantitative and qualitative methodology to test the hypothesis that co-therapy will have an impact on both client and training outcomes, with more positive impacts associated with the use of co-therapy. The quantitative aspect of this study includes client outcomes of 402 cases seen in a marriage and family therapy training program clinic with a mix of individual and co-therapy assignments. Clients are drawn from a Midwestern community containing a major university which is surrounded by small towns and rural residences. Primary referral sources are Yellow Pages advertising, other area agencies, and word of mouth. Clients are referred for individual, couple, and family therapy. Presenting problems at intake include individual disorders such as depression and anxiety, couple concerns such as domestic violence and communication difficulties, and family issues such as parenting and child abuse. The primary outcome measures created for this study included the number of therapy sessions clients attended and the reason for termination as determined by the therapist and supervisor. For this study clients attending one or two sessions and terminating services without accomplishing goals were defined as "dropouts." Clients attending three or more sessions and terminating services without accomplishing goals were described as "continuers." Those clients who accomplished goals before termination of services were "completers."

A total of 33 therapists participated in this study. Therapists were 24 female and nine male, ranging in age at the time of their first session from 22.1 to 48.4, with mean age of 29.6 (SD = 8.3). Experience level of the therapists ranged from their case starting on the first day of their clinical training to day 899. Therapists were defined as "low

experience" when their experience level at the beginning of the case was less than 276 days and "high experience" when their experience level at the beginning of the case was 276 days or more. The experience breakpoint of 276 was chosen because this was the median number of days of clinical experience in this training program at the time of assignment of each case and represents roughly the midpoint of the student therapists' total clinical training. For analysis, a four-level co-therapy typology was chosen with levels being (1) individual therapist, (2) low experience co-therapy team, (3) mixed experience co-therapy team, and (4) high experience co-therapy team. Other client factors considered as descriptive information in the analysis included gender, age, marital status, and family status. These other factors are used as moderating variables in the analysis of therapy outcomes.

Procedures

This study used the therapists and clients of a marriage and family therapy clinic operated by a university-based master's level training program. All therapists had one year of didactic preparation and were in their first or second year of clinical experience. The procedure for recruiting clients started with the clients calling the clinic to request clinical services. At that time a brief intake was done to determine who could attend sessions and the nature of the presenting problem. The program director uses the information from the telephone intake to assign therapists to clients. The decision to assign cases to specific individual therapists or co-therapy teams depends on a number of factors. These include the relative balance in caseload among therapists, the training needs of therapists (ex. gaining experience with families, couples, or types of client problems), experience level (new therapists start in co-therapy teams and must attain a level of proficiency to work on cases alone), and overall difficulty of the case as determined at intake. While the decision to assign a more challenging case to individuals or teams with more experience may occur, this is typically done more frequently in the early weeks introducing a new cohort of therapists to therapy. Overall, the decision to assign challenging cases is an important part of the development of all therapists and will routinely be given to all low experience therapists.

At the time of the first session, clients complete background forms that include descriptive information about all members of the client system. Clients also complete the 20–item couple or family version of the cohesion and adaptability scales (Olson, McCubbin, Barnes, Larsen,

Muxen, & Wilson 1982), a 10–item relationship satisfaction instrument, and a 10–item communication instrument. The couple relationship satisfaction instrument and the couple communication instrument are 10–item subscales from ENRICH (Olson, Fournier, & Druckman, 1987). The family satisfaction instrument and the family communication instrument are subscales from Olson's (1989) *Health and Stress Profile*. Olson and Stewart (1990) reported scale reliabilities for the above assessments as follows: couple cohesion (.78), couple adaptability (.82), family cohesion (.81), family adaptability (.75), couple satisfaction (.91), family satisfaction (.91), couple communication (.85), and family communication.(79). As part of the background forms clients are asked two questions "How serious is this problem?" and "How likely is this problem to change?" At the end of the third session, or last session if dropout occurs before the third session, therapists complete a five-axis diagnosis including assigning a Global Assessment of Functioning (GAF) score (American Psychiatric Association, 1994). The diagnosis is checked and signed by the therapist's supervisor. At the completion of services, the therapists fill out a termination form detailing how many sessions clients attended and reason for termination. This study utilizes data collected from the background form, cohesion, adaptability, satisfaction, communication, diagnosis, and termination report.

RESULTS

Quantitative

Of the 402 cases initially included in this study, 90 (22.4%) were seen as individuals, 220 (54.7%) were seen as couples, 75 (18.7%) as families, and 17 (4.2%) were seen as a mix of individual and conjoint. Of the total sample, 119 (29.6%) attended one or two sessions only, and 283 (70.4%) attended three or more sessions. Of the 402 cases, 107 (26.6%) were classified as dropouts, 182 (45.3%) as continuers, 89 (23.5%) as completers, and 24 (4.6%) were not included in analysis due to missing data. Individual therapists were assigned to 209 (52.1%) of the cases and co-therapy teams to 192 (47.9%) of the cases, and one case was dropped due to missing data. The student co-therapy teams consisted of 77 (44.8%) teams of two low experience therapists, 55 (32%) teams of one low and one high experience therapist, and 40 (23.3%) teams of two high experience therapists. Table 1 includes a more detailed description of client and therapist variables.

TABLE 1
Client and Therapist Demographic Variables

Client Demographic Variables (n = 665)		
Gender	Female	369 (55.5%)
	Male	296 (44.5%)
Mean Age		30.19 years
Education	Professional Degree	75 (11.3%)
	College Graduate	103 (15.5%)
	Some College	230 (34.6%)
	High School Graduate	49 (7.4%)
	Some High School	49 (7.4%)
	Other/Missing	33 (4.4%)
Mean Income		$19,200
	Therapist Demographic Variables (n = 33)	
Gender	Female	24 (72.7%)
	Male	9 (27.3%)
Age at first clinical experience		22.1–48.4 years (M = 29.6, SD = 8.5)
Therapy experience (in days)		1–899 (median = 276)

Testing the research questions. Two research questions were identified: (1) Do different pairings of co-therapists affect client outcomes? and (2) Is co-therapy a viable option for a training program? Because data addressing the above questions were primarily ordinal in nature categorical analysis, using Chi-square, was chosen to test these questions. Tables 2 through 4 are the results of these analyses. The first test of the impact of different therapy team structures on client outcome used a 5×3 chi-square analysis with five levels of therapy team structure by three levels of client outcome (see Table 2). The five levels of therapy team structure were individual student therapists, co-therapy teams of two inexperienced student therapists, co-therapy teams of two advanced student therapists, co-therapy teams of one advanced student therapist and one inexperienced student therapist, and co-therapy teams with one student therapist and one faculty therapist. The 20 teams with student and faculty co-therapists includes 16 (80%) teams with male faculty therapist/female student therapist, two (10%) teams

TABLE 2
Client Outcomes by All Types of Therapy

Variable Studied	*n*	*Completers*	*Continuers*	*Dropouts*
Type of Therapy Teams				
Low experience individual therapist	106	26%	34%	40%
High experience individual therapist	88	19%	42%	39%
Individual therapist	194	23%	44%	33%
Low experience team	73	18%	42%	37%
High experience team	38	21%	42%	37%
Mixed experience team	52	23%	48%	29%
Faculty/student team	20	55%	40%	5%

$X^2 = 22.2$; $p < .005$.

with female faculty therapist/male student therapist, and two (10%) with female faculty therapist/female student therapists. The three levels of client outcome are completers who have accomplished goals by termination, continuers who have attended three or more sessions but have not completed goals, and dropouts who discontinue therapy before the third session and have not completed goals. While the analysis showed significant differences ($p < .005$), the teams with faculty members appeared to account for the majority of the differences, having 55% completers and only 5% dropouts. Teams of inexperienced therapists had the highest rates of continuers (63%) but the lowest rate of completers (18%). The highest rate of dropouts came from the co-therapy teams of two advanced student therapists (37%).

Since the majority of teams including faculty therapists were male faculty therapists with female student therapists (80%), issues of gender and power are potential moderating variables that could influence the results. In supervision literature, this mix of male supervisor with female therapist is seen as potentially problematic due to the greater power imbalance that results from both experience and gender (Turner & Fine, 1997). To control for the impact of the power imbalance expected when mixing male faculty therapists with female student co-therapists, a second analysis was conducted. This second analysis used a 2×3 chi-square analysis with two levels of therapy team structure (individual student therapists and student co-therapy teams) and the

TABLE 3
Client Outcome by Student Individual and Co-Therapy Teams

Variable Studied	*n*	*Completers*	*Continuers*	*Dropouts*
Type of Therapy Teams				
Individual therapist	194	23%	44%	33%
Student co-therapy teams	144	24%	52%	24%

$X^2 = 6.0$; $p < .17$.

same three levels of client outcome as above (see Table 3). This analysis yielded no significant differences ($p < .17$). Individual therapists had nearly the same rate of completers (23% individual and 24% co-therapy) with a slightly lower rate of continuers (44% individual and 52% co-therapy) when compared to co-therapy teams. Individual therapists also had a slightly higher rate of dropouts (33% individual and 24% co-therapy). However, none of these differences reached statistical significance.

As a final analysis of the impact of experience level on client outcome a 3×3 chi-square analysis was conducted. The chi square analysis examined three levels of student co-therapy teams (eliminating cases with individual student therapists and teams with faculty therapists) and the same three levels of client outcome as above (see Table 4). After establishing a baseline for all cases (Table 2), subsequent analyses focused primarily on student co-therapy teams and differences in their experience levels. This analysis yielded no significant differences ($p < .19$). While teams of inexperienced student co-therapists had the lowest rate of completers (18% inexperienced, 21% advanced, and 23% mixed

TABLE 4
Client Outcome by Student Co-Therapy Teams

Variable Studied	*n*	*Completers*	*Continuers*	*Dropouts*
Type of Therapy Teams				
Low experience teams	73	18%	63%	19%
High experience teams	42	21%	42%	37%
Mixed experience teams	48	23%	48%	29%

$X^2 = 6.0$; $p < .19$.

experience), they also had the highest rate of continuers (63% inexperienced, 42% advanced, and 48% mixed) and the lowest rate of dropouts (19% inexperienced, 29% advanced, and 37% mixed). Since there was no difference in the number of completers between student co-therapy teams, completers were excluded from the analysis and the comparison became a 3×2 table with three levels of student co-therapy teams by two levels of client outcome (dropouts and continuers). This allowed for an increased focus on the differential impact of the experience levels of student co-therapy teams. This comparison yielded results that approached significance ($Chi^2 = 3.5$, $p < .06$), with low experience student co-therapy teams having lower dropout rates and higher rates of clients returning for 3 or more sessions than more experienced student co-therapy teams.

The research team saw the non-random assignment of cases as a potential source of bias in the results. Since assignment of cases can be made for a number of reasons, including the perceived difficulty of the case at intake, the researchers tested the hypothesis that there was a systematic bias in the assignment of cases with inexperienced student therapists being assigned to less challenging cases. To test this hypothesis a one-way ANOVA was used to examine the difference in GAF scores, and couple and family assessments of cohesion, adaptability, satisfaction, and communication of clients assigned to individual therapists, inexperienced teams, experienced teams, and teams with mixed experience. Of the nine client characteristics assessed, seven yielded non-significant differences between the various teams. To determine which groups were different on the two client characteristics yielding significant differences (couple cohesion and couple adaptability), a Tukey post hoc analysis was utilized. Couple cohesion was only different between individual therapists and teams of low experience therapists ($p < .05$). In the most important difference, couple adaptability was lowest for the most experienced teams ($p < .02$). This finding suggests that couples assigned to high experience teams were less flexible and may account for the slightly higher dropout rate for experienced co-therapy teams. While there were two areas of significant difference in the cases assigned to various therapy types, the majority of characteristics were not different. See Table 5 for complete results.

Overall, results indicated no significant differences in client outcome due to the various combinations of individual therapists, co-therapy teams, and inexperienced compared to experienced student therapists. The client outcomes for co-therapy were at least as good as individual therapists in terms of clients becoming dropouts, continuers, or completers.

TABLE 5
Client Characteristics at Intake for Four Modes of Student Therapy—Means, (Standard Deviations), and F Values

	Mode of Student Therapy				
Client Characteristics	*Individual Therapists*	*Low Experience Teams*	*High Experience Teams*	*Mixed Experience Teams*	*F Value*
GAF Score	64.9 (10.3)	63.3 (12.2)	68.6 (8.4)	64.4 (9.6)	F = 1.8
Couple Cohesion	33.6 (9.5)	29.2 (9.7)	31.2 (11.3)	33.1 (9.3)	F = 2.7*
Family Cohesion	34.1 (9.1)	35.3 (8.2)	32.9 (8.1)	36.5 (7.1)	F = .59
Couple Adaptability	26.8 (7.5)	26.9 (6.7)	21.9 (5.8)	26.7 (5.9)	F = 3.2**
Family Adaptability	24.5 (5.4)	26.1 (5.2)	25.2 (8.2)	27.1 (6.5)	F = 1.2
Couple Satisfaction	30.4 (8.2)	29.0 (8.0)	29.5 (11.2)	30.7 (7.4)	F = .49
Family Satisfaction	29.9 (8.0)	30.0 (7.3)	27.5 (9.7)	32.2 (6.6)	F = .98
Couple Communication	30.1 (7.8)	28.3 (8.4)	29.0 (10.2)	28.6 (7.8)	F = .72
Family Communication	31.8 (7.7)	30.7 (8.4)	27.1 (8.3)	32.7 (6.0)	F = 2.0

*$p < .05$; **$p < .02$.

Qualitative Results

Researchers added a qualitative component to this study, in order to better ground the findings in a clinical context, that includes the subjective experience of the therapists involved. The balance of quantitative and qualitative methodologies strengthens the description and understanding of the complex interactions between supervisors, therapists, and clients. The qualitative portion of the study included the use of three focus groups; group one consisted of four experienced therapists (second year of clinical experience), group two was composed of five inexperienced therapists (first year of clinical experience), and three faculty supervisors comprised group three. A facilitator asked the therapist groups to discuss the rewards and challenges of co-therapy, the benefits and cost for clients, their experiences working with multiple supervisors, and the challenges of mixing therapist experience levels in one team as opposed to more homogeneous pairings. The supervisors, as a group, discussed how they could use different therapist combinations for therapeutic effect.

Therapist rewards. There were four consistent themes student therapists presented as rewards for co-therapists engaged in co-therapy. The trainees identified one reward of co-therapy being more willingness on the part of the therapist to take risks knowing there was another therapist sharing responsibility. This response was consistent among both experienced and inexperienced therapists, regardless of the type of experience pairing used. A second identified reward was that a co-therapist provided another world view and increased insight into the relational system of the clients. The ability of the team to practice meta-communication as an intervention in the presence of clients was also seen as a reward. Therapists identified a final reward as the exposure to more knowledge and resources that came with working as a co-therapy team.

Therapist challenges. The therapist focus groups also identified the following challenges. When multiple therapists are used, control issues between the therapists are important to recognize and resolve. A further challenge identified was the enhanced likelihood that the therapists would learn something about themselves as they worked together on the case. A final challenge highlighted was the necessity for the therapists to develop an increased awareness of the therapeutic system, including the therapists and clients.

Benefits for clients. The most commonly identified benefit to clients was the ability of two therapists to model behaviors for their clients. A further advantage was that clients can feel they have their own advocate when there are multiple therapists. The utility of having "two sets of eyes and ears" was mentioned as beneficial to clients, especially for less experienced therapists. A final benefit was that therapists each brought their own strengths and experience providing a greater array of possibilities to enrich the clients' experiences in therapy.

Costs to clients. The primary theme arising from this discussion was the negative cost to clients of having therapists who did not cooperate. A primary disadvantage for clients was when their therapists had either personalities or styles that clashed and let this surface in the sessions. The result of therapists not working together was seen as unfocused therapy that was not helpful for clients. When not working together, therapists found they distracted each other and contributed to less effective therapy. As one therapist stated "It's important for both members of the team to be on the same page." Therapists also identified that at times when co-therapy teams did not work together effectively they found themselves mirroring the client system rather than mentoring the client system.

Incorporating supervision input. One of the challenges most therapists identified of co-therapy relationships is that each trainee may be getting input from a different supervisor. Therapists highlighted this challenge as requiring co-therapists to resolve the potentially conflicting directives to arrive at a unified plan for the sessions. A particularly difficult aspect of this challenge was that therapists sometimes had difficulty conveying their supervisor's input to their co-therapist. The advantage stated was that this forced therapists to be more clear in their understanding of supervisor input. Another challenge was learning to work with multiple levels of the therapeutic system, including client, therapist, and supervisor. Finally, the therapists expressed that their supervisors had high expectations of the therapist's ability to work out potential conflicts and that this at times added to therapist stress.

Experience level combinations. Therapists reported they found themselves spending more time in content-level planning when the co-therapy team consisted of equally experienced therapists (homogenous pairings), compared to more process level planning with unequal co-

therapists (heterogeneous pairings). Equally experienced co-therapists were less worried about "stepping on their co-therapist's toes," while more experienced therapists expressed reluctance to give control of the sessions to less experienced co-therapists. Being paired with a more experienced therapist was described as forcing the less experienced therapist to be more assertive in planning and conducting sessions. Equal pairings were more likely to emphasize supporting each other.

Supervisor's perspectives on pairings. Supervisors described pairing of co-therapists as helpful for both therapists and clients when teams were strategically chosen for a variety of reasons. A strength of using co-therapy was the ability to match the experience level of the team with the difficulty of the case potentially exposing therapists to a greater breadth and range of cases. Furthermore, the supervisors identified as a benefit for the development of the therapists the requirement of learning to balance input and negotiate strategies for sessions with another therapist. The increased complexity of the system when multiple therapists and supervisors are used was seen as strengthening the systemic understanding of the therapist trainees. Another benefit to the pairing of therapists was the ability of the trainees to help each other develop greater therapeutic skills. One of the therapeutic skills enhanced was the ability to more effectively address the complexity of family systems. The supervisors related choosing pairings of therapists for the potential developmental benefits to one or both therapists (i.e., a therapist uncertain of working with children paired with a therapist more capable of working with children in therapy). Supervisors identified as a challenge the tendency of less experienced therapists to "disappear" during sessions with more experienced and dominant co-therapists. This often became beneficial in therapist development since it highlighted early the need for a more passive therapist to find effective ways to increase their involvement.

DISCUSSION

This study addressed two research questions: "Do different pairings of co-therapists affect client outcomes?" and "Is co-therapy a viable option for a training program?" A mix of quantitative and qualitative methodology generally indicated that outcomes for co-therapy are no

better or worse than outcomes for individual therapy and that co-therapy can be a valuable option for training.

Do different pairings of co-therapists affect client outcomes? In general, this question yielded an answer of "no." Teams of two inexperienced student therapists yielded no worse overall outcomes than teams with more experienced student therapists. In fact, when comparing only student co-therapy team results, teams of inexperienced therapists had somewhat lower rates of dropouts and higher rates of continuers compared to teams with more experienced student therapists. The rates of clients who successfully completed goals were not significantly different for any of the student co-therapy teams or individual student therapists. There was no indication that the use of different pairings of co-therapists or the use of individual therapists had any affect on client outcomes and, therefore, clients were not at risk from treatment by less experienced co-therapists. In fact, a trend in the data indicated that clients continued in therapy longer and had a lower dropout rate for less experienced co-therapy teams.

Is co-therapy a viable option for a training program? This study indicates there are many benefits and few costs to using co-therapy teams as part of a clinical training program. The benefits included sharing responsibilities, more opportunities when there are few cases available, and clinical opportunities that arise from the flexibility of having two therapists. While in a non-training setting the cost of paying two therapists to do one case would be a concern, this is not a concern in a training setting. Further support for the use of co-therapy is the finding of no significant difference in client outcomes between individual and co-therapy. There may actually be benefit to having inexperienced student therapists working in co-therapy teams. This is best demonstrated by results indicating that inexperienced teams have lower dropout rates and higher continuer rates. Another benefit of pairing low experienced student therapists with faculty therapists allows for a struggling student therapist to experience successful completion of a case. Furthermore, pairing more experienced with less experienced student therapists allows the more experienced therapist to practice leadership skills in coordinating the efforts of the co-therapy team. The more experienced co-therapist must also articulate the dynamics of both the client system and the co-therapy system. As a genera-

tive process this articulation of system dynamics facilitates growth of both therapists.

Recommendations

Future research can explore the impact of co-therapy teams on additional client outcomes. Examples of additional client outcomes meriting study include degree of client change, client satisfaction with therapy, and long term maintenance of therapeutic changes. A second recommendation is to use larger samples from multiple sites. Multiple sites would allow for reduction of potential bias arising from the use of a single site.

Future research can explore the impact of co-therapy teams on additional client outcomes. Examples of additional client outcome meriting study include degree of client change, client satisfaction with therapy, and long-term maintenance of therapeutic change. A second recommendation is to use larger samples from multiple sites. Multiple sites would allow for reduction of potential bias arising from the use of a single site.

Additionally, more research needs to look at therapist variables such as gender that potentially moderate therapy outcomes. For the teams of faculty therapists with student co-therapists, issues of gender and power are potentially problematic. The mix of male faculty therapist with female student therapist is likely to have the same imbalance of power as has been found in supervision literature between male supervisors and female supervisors. This pairing is generally seen as more problematic because of the dual impact of gender inequities and the imbalance of power (Turner & Fine, 1997). In a study of the impact of co-therapy arrangements, this imbalance would likely empower the male faculty therapist while disempowering the female student therapist. This study did not control for the dual impact of gender and experience in faculty-student pairings. Thus future studies should examine the possible power differential in experienced male/inexperienced female as well as experienced female/inexperienced male pairings.

Co-therapy can be beneficial as an addition to the training process for an educational setting with therapists ranging from no clinical experience to those nearing the end of their training. Supervisors can use variations in co-therapy teams to help students to develop skills, to have a larger caseload sooner, to learn to interact closely with another therapist, to encourage creativity among therapists, and to allow thera-

pists the opportunity to model for clients effective relationships. While therapists also need to demonstrate the ability to be the sole therapist for cases, co-therapy can have many benefits as an adjunct to the experience of being an individual therapist.

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