SUPERVISORY AND THERAPEUTIC ALLIANCE AMONG CLINICAL PSYCHOLOGY TRAINEES: THE MODERATING ROLE OF EMOTION REGULATION STRATEGIES

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PLAGIARISM

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

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ABSTRACT

Clinical psychology trainees may encounter compelling emotions while conducting sessions with clients even though they are not licensed yet in the period of training. Psychotherapy supervision which is a triadic (supervisor-trainee and therapist-client) process has a crucial role to help trainees to realize emotion regulation processes. There is limited research on the role of emotion regulation strategies in training therefore, a need appears to investigate the role of emotion regulation strategies in clinical psychology trainees. To date, no research investigated the moderating role of emotion regulation strategies (reappraisal and suppression) in supervision and psychotherapy context. Hence, the present study aimed to investigate the moderating role of reappraisal and suppression between the supervisory alliance and therapeutic alliance. Three hypotheses were as follows: 1) supervisory alliance and therapeutic alliance are positively correlated, 2) a higher level of reappraisal strengthens the relationship between supervisory alliance and therapeutic alliance, and 3) a lower level of suppression strengthens the relationship between supervisory alliance and therapeutic alliance. Seventy-eight clinical psychology trainee volunteers who had more than 3 sessions with their clients participated. The Turkish Working Alliance Inventory – Therapist Form, Short Form of Turkish Working Alliance Inventory – Supervisee Form, and Emotion Regulation Questionnaire were used to measure therapeutic alliance, supervisory alliance, and emotion regulation (reappraisal and suppression) respectively. Results indicated that there was a positive correlation between supervisory alliance and therapeutic alliance. There was no significant moderation effect of reappraisal. However, there was a significant moderation effect of suppression. The findings suggest that suppression improved the relationship between supervisory and therapeutic alliance. Results may imply that the adaptiveness

of emotion regulation strategies is not universal, and results underline the importance of looking at the context to decide whether using reappraisal and suppression as an emotion regulation is useful or not. The findings of the present study may contribute to clinical psychology master's programs; in addition to improving students' practical skills, adding courses where trainees can realize their emotion regulation skills can be useful as well.

Keywords: Supervisory Alliance, Therapeutic Alliance, Reappraisal, Suppression

ÖZET

Klinik psikoloji yüksek lisans öğrencileri, eğitim döneminde danışanları ile seansları yürütürken zorlayıcı duygularla karşılaşabilmektedirler. Üçlü bir süreç olan psikoterapi süpervizyonu (süpervizör-terapist ve terapist-danışan), öğrencilerin duygu düzenleme süreçlerini gerçekleştirmelerine yardımcı olmak için önemli bir role sahiptir. Klinik psikoloji yüksek lisans eğitimi sürecinde duygu düzenleme stratejilerinin rolü üzerine sınırlı araştırma vardır. Bu nedenle öğrencilerin danışanlarıyla ve süpervizörleriyle çalışırken kullandıkları duygu düzenleme stratejilerinin rolünü araştırmaya ihtiyaç duyulmaktadır. Bugüne kadar duygu düzenleme stratejilerinin (yeniden değerlendirme ve bastırma) süpervizyon ve psikoterapi süreci bağlamında düzenleyici rolünü araştıran bir araştırma bulunmamaktadır. Bu nedenle, bu çalışma, süpervizyon ittifakı ile terapötik ittifak arasında yeniden değerlendirme ve bastırmanın düzenleyici rolünü araştırmayı amaçlamıştır. Araştırmanın üç hipotezi şu şekildedir: 1) süpervizyon ittifakı ve terapötik ittifak arasında pozitif yönde ilişki vardır, 2) yüksek düzeyde yeniden değerlendirme, süpervizyon ittifakı ve terapötik ittifak arasındaki ilişkiyi güçlendirmektedir ve 3) düşük düzeyde bastırma, süpervizyon ittifakı ve terapötik ittifak arasındaki ilişkiyi güçlendirmektedir. Danışanlarıyla 3'ten fazla seans yapmış olan 78 klinik psikoloji yüksek lisans öğrencisi araştırmaya katılmıştır. Terapötik ittifak, süpervizyon ittifakı ve duygu düzenlemeyi (yeniden değerlendirme ve bastırma) ölçmek için Terapötik İttifak Ölçeği – Terapist Formu, Süpervizyon İttifakı Ölçeği - Terapist Kısa Formu ve Duygu Düzenleme Ölçeği kullanılmıştır. Sonuçlar, süpervizyon ittifakı ile terapötik ittifak arasında pozitif bir ilişki olduğunu göstermiştir. Yeniden değerlendirmenin anlamlı bir düzenleyici etkisi olmadığı bulunmuştur. Bununla birlikte, bastırmanın düzenleyici etkisi olduğu bulunmuştur.

Süpervizyon ittifakı ve terapötik ittifak arasındaki ilişki, bastırma stratejisinin kullanımıyla pozitif yönde güçlenmektedir. Sonuçlar, duygu düzenleme stratejilerinin adaptifliğinin evrensel olmadığının, yeniden değerlendirme ve bastırmanın duygu düzenleme stratejisi olarak kullanılmasının işe yarar olup olmadığına karar vermek için bağlamı değerlendirmenin önemini vurgulamaktadır. Bu çalışmanın bulguları klinik psikoloji yüksek lisans programlarına katkı sağlayabilir; öğrencilerin pratik becerilerini geliştirmenin yanı sıra, duygu düzenleme becerilerini fark edebilecekleri derslerin eklenmesi faydalı olabilir.

Anahtar kelimeler: Süpervizyon İttifakı, Terapötik İttifak, Yeniden Değerlendirme, Bastırma

To My Family

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1. INTRODUCTION

1.1. The Concept of Therapeutic Working Alliance

During the history of psychotherapy research, the therapist and client relationship has been focused on and investigated recurrently. The term alliance, not the term itself but the importance of the therapist-client relationship, had its roots in Freud's writings (Horvath et al., 2011). Freud (1912) had a preliminary attempt to point out the significance of the therapist-client relationship. He introduced the terms transference and countertransference by focusing on the client's attachment with the doctor. He linked the affections of clients for the therapist within the context of the parent relationship (Freud, 1913).

Sterba (1934) also proposed the term ego alliance to identify differences between observing and experiencing ego. Subsequently, the concept was further expanded by Zetzel (1956) who proposed the term therapeutic alliance to explain the client's attachment to the therapist. Zetzel linked therapeutic alliance with rearise child and mother relationship. Zetzel's development of the concept of a therapeutic alliance by considering the therapeutic relationship within the framework of object relations theory is accepted as an important turning point in the history of psychoanalytic psychotherapy (Fine, 1979; Kanzer, 1975). After Sterba (1934) and Zetzel (1956), the term alliance was elaborated by Greenson (1965). Greenson used the term working alliance in the same sense as the therapeutic alliance. Greenson indicated alliance as the client's ability to collaborate on therapy interventions during the therapy process. In addition to this, alliance contained the client's capacity to work in therapy and the affections of clients for the therapist (Greenson, 1965).

Furthermore, Anderson and Anderson (1962) proposed the term therapeutic bond to define rapport and empathy. From this term, Orlinsky and Howard (1975)

indicated three components of alliance that were working alliance, mutual affirmation, and empathic resonance. Bordin (1979) was inspired by this tripartite model that proposed three dimensions of alliance: tasks, goals, and emotional bond. Although, there are various operational definitions for therapeutic alliance in the literature, Bordin's conceptualization was the most commonly used (Gelso & Carter, 1985; Horvath & Greenberg, 1989).

1.1.1. Bordin's Therapeutic Working Alliance Model

The concept of the therapeutic working alliance has its roots in psychoanalytic literature that is further reconceptualized by Bordin (1979) to comprise all psychotherapy approaches. One of the most effective and widely accepted conceptualizations of the therapeutic alliance is introduced by Bordin (1979).

Bordin (1979) sees the therapeutic alliance basically as a whole set of relationships and technically defined the phenomenon in three structures: tasks, goals, and emotional bond. The first dimension, tasks, includes consensus between the therapist and the client in terms of their duties or the application of a particular therapy technique. The second dimension, goals, involves an agreement between the therapist and the client on the goals of the therapy process and anticipated therapy outcomes. The third dimension, emotional bond, refers to the reciprocal relationship that is based on intimacy, trust and acceptance between therapist and client that is helpful to complete tasks and attain the goals (Bordin, 1979).

As can be understood, the perspective proposed by Bordin (1979) is independent from differences in therapy techniques and approaches. The importance of interpersonal relations for effectiveness in all therapy processes is specified. According to Bordin, three dimensions (task, goal, and bond) are interacting mutually and a combination of three dimensions constitutes an alliance between the therapist

and client. The essence of the alliance is based on collaboration between therapist and client on tasks and goals while building an emotional bond (Bordin, 1979).

There are different measurements to evaluate therapeutic alliance, for instance, Therapeutic Alliance Rating Scale (Marmar et al. 1986), Penn Helping Alliance Questionnaire (Luborsky et al. 1985) and Working Alliance Inventory (WAI: Horvath & Greenberg, 1989). In Turkey, WAI is a prominent tool to measure therapeutic alliance due to involving client and therapist aspects that are based on Bordin's conceptualization (Gülüm et al., 2018). In the current study, WAI is used to evaluate therapeutic alliance.

1.1.2. Therapist-related Factors Affecting Therapeutic Working Alliance

Bordin (1979) indicated that the occurrence of the working alliance is "a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of patient and therapist" (p. 253). Both therapists and clients bring personal histories that impact their interpersonal connection in the therapeutic relationship (Bordin, 1979; Orlinsky & Howard, 1986). In the literature, there are studies that investigate therapists' characteristics that influence working alliance.

The therapist's personal characteristics are associated with Bordin's (1979) emotional bond dimension because this dimension involves interpersonal relationships (Orlinsky & Howard, 1986). A study done by Dunkle and Friedlander (1996) found that clients stated a high emotional bond with therapists that are less hostile, more socially supportive, closer, and more comfortable to have intimate relationships. Also, therapists' social interactions and capacity to develop close connection predicts the emotional bond dimension of the therapeutic alliance (Dunkle & Friedlander, 1996). Mallinckrodt and Nelson (1991) specified that the therapists'

experience, skills, and technical knowledge is less likely to be substantial to form an intimate relationship.

On the other hand, therapists' professional characteristics such as technical skills related to Bordin's (1979) goals and task dimensions influence cognitive aspects of the alliance (Orlinsky & Howard, 1986). Although researchers indicated that the experience of the therapist leads them to have more technical skills to enhance working alliance, especially for the goal and task dimensions of the therapeutic alliance (Hillerbrand, 1989; Mallinckrodt & Nelson, 1991), Dunkle and Friedlander (1996) found that the experience of the therapist does not predict the goal and task dimensions of the therapeutic alliance.

Better working alliance is related to therapist characteristics such as being warm, empathic, responsive, taking it kindly (Horvath & Bedi, 2002; Najavits & Strupp, 1994), being flexible and open, behaving respectfully, and facilitating the expression of emotions for clients (Ackerman & Hilsenroth, 2003). In contrast, being strict, neglectful, and making improper self-disclosures, making persistent comments about transference relationships (Ackerman & Hilsenroth, 2003), making immature interpretations, and showing defensive behaviors (Safran et al., 2002) have negative impacts on the alliance. Furthermore, a lower alliance was predicted by the difficulties and stress of therapists (Knekt et al., 2011). Therapists that were securely attached had a higher alliance with clients that were severely disturbed (Schauenburg et al., 2010). Clients' evaluation of alliance is higher when the therapist resembles the caring mother (Hersoug et al., 2009). Therapists' self-doubts about their professional efficacy were positively related to the alliance that was evaluated by the clients early in the therapy process (Nissen-Lie et al., 2010).

According to Safran and Muran (2000), therapist's way of coping with difficulties such as clients rejecting behaviors and hostility strengthens the therapeutic alliance. Also, therapists' capability to deal with ruptures (decrease in the alliance) to repair the therapeutic relationship has an impact on the alliance. Frank and Frank (1991) stated that conducting treatment by considering clients' needs and carrying out treatment in concordance with such needs leads clients to feel that they are understood, and this may increase collaboration on the therapy goals and tasks.

Wolff and Hayes (2009) found that lower alliance was related to therapists' negative emotions toward clients but there was not an association between therapists' overall emotional well-being and alliance. The lack of impact of the therapists' overall well-being on alliance may be because of some therapists' ability to negotiate their inter and intrapersonal distress (Wolff & Hayes, 2009). In addition, Gelso et al. (2002) indicated that therapists' capacity to manage negative countertransference may lead them to conduct deeper sessions and develop a better alliance with their clients as compared to therapists that are acting out their countertransference.

1.2. Supervision in Psychotherapy

Psychotherapy supervision is identified as the professional improvement of novice psychotherapist while more experienced psychotherapist educates novice psychotherapist to enhance the quality of the psychotherapy process between the therapist and client (Bernard & Goodyear, 2014). Milne and Watkins (2014) indicated that to be licensed as a psychotherapist, psychotherapy supervision is a requirement. Supervision in psychotherapy is an education process that is relying on therapist and supervisor interactions and working on the psychotherapy process between the therapist and client (Milne, 2007). In supervision, therapists expand their knowledge

about how to establish and maintain a therapeutic relationship and then transmit it to the therapy context (Searles, 1955).

Bordin (1983) specified eight supervisory goals: mastery of therapists' ability, increasing therapists' comprehension of clients, expanding therapists' awareness about the whole therapy process, developing self-awareness and its influence on the therapy process, handling obstacles, increasing knowledge about theories and concepts, promote to research, and providing a qualified psychotherapy service to clients.

1.2.1. Supervisee and Supervisor Interactions: Supervisory Working Alliance

Beinart (2014) indicated that two terms: supervisory relationship and supervisory working alliance are used in the same sense. The term supervisory working alliance comes from Bordin's (1983) writings. According to Bordin (1983), the supervisory working alliance included the emotional bond between supervisor and supervisee and agreements of both supervisor and supervisee on the goals and tasks of supervision.

The literature on the supervision process specified the significance of the supervisory relationship (Watkins, 2014). Bernard and Goodyear (2014) stated that as in the therapy process, the power of the supervision process depends on the relationship between the supervisee and supervisor. Ramos-Sanchez et al. (2002) claimed that it is nearly unfeasible to carry out productive supervision and conduct the supervisory tasks in the absence of a powerful supervisory relationship. Therefore, the supervisory relationship is perceived as an essential part of effective supervision (Watkins, 2014).

According to Ladany et al. (1999), a strong emotional bond with the supervisor is related to the supervisees' positive impression of the supervisors' characteristics and work, and this can affect the therapists' feeling of comfort in supervision. A strong

emotional bond with the supervisor may lead the therapist to make disclosure easily which is an essential tool for supervision (Mehr, 2011). Therapists' professional growth such as learning new treatment interventions and conformity to clients' emotional needs can be enhanced by having and sustaining a trustful and secure emotional bond with the supervisor (Angus & Kagan, 2007). When ruptures occur in a supervisory alliance, if not managed well, unfavorable results may arise in both the supervision process (Ellis, 2010) and the therapy process (Bambling et al., 2006). Particularly, having problems with interpersonal issues with the supervisor may lead to negative impacts on therapist's growth and supervisory relationship (Ramos-Sanhcez et al. 2002).

Furthermore, several determinants of effectual supervision proposed by Rosenfeld (2010): working on the therapist's personal problems in supervision, effects of supervisors' personal characteristics on therapists' professional development, perception of being respected and understood by the supervisor, trustful supervision context. Those factors are indirectly related to both therapists' and supervisors' abilities how to handle conflicts within supervision (Rosenfeld, 2010).

1.3. Understanding the Parallel Processes in the Frame of Psychotherapy and Supervision Context

The concept of the parallel process was primarily introduced in the psychoanalytic literature as the repetition of the therapeutic relationship in supervision unconsciously (Ekstein & Wallerstein, 1972). The parallel process has its roots in the psychoanalytic concepts of transference and countertransference (McNeill & Worthen, 1989; Morissey & Tribe, 2001). The existence of the parallel process has been supported by other therapy approaches without including unconscious elements (Raichelson et al., 1997; Tracey et al., 2012). Although the concept of the parallel process is based on

psychoanalytic orientation, it has been accepted and studied by other orientations as well (Tracey et al., 2012).

Psychotherapy supervision is a triadic (supervisor-trainee and therapist-client) process during which the supervisor educates the therapist for one or more clients (Tracey et al. 2012). The concept represents the repetition of relational dynamics of the therapeutic dyad (therapist and client) and supervisory dyad (supervisor and supervisee/therapist) unconsciously (McNeill & Worthen, 1989). Bordin (1983) stated that the resemblance of therapists' experiences both in therapy and supervision is natural. Therapists recreate the clients' roles and carry-on therapy issues into the supervision sessions. At the same time, supervisors recreate therapists' roles in therapeutic relations. This happens with the individual who is both supervisee and therapist changing roles from help seeker to expert (Tracey et al., 2012). Many therapists and supervisors view the parallel process as an important tool and a worthful form of communication (McNeill & Worthen, 1989; Morissey & Tribe, 2001).

In the literature, there were various definitions of the parallel process (Tracey et al., 2012) but Raichelson et al. (1997) exhibited that the parallel process was perceived as part of supervision and that did not differ across the theoretical approaches. Many theoreticians recognize the parallel process as emerging in the therapy process and then carried into the supervision context (Searles, 1955). Nevertheless, some theoreticians view the parallel process as bidirectional in that the parallel process not only transported from therapeutic interaction into the supervision but also the supervisee/therapist carries supervision interaction into the therapy context (Clarkson, 1994; Jacobsen, 2007). From this view, Tracey et al. (2012) claimed that proficient supervision can occur while the supervisor enacts the therapist

role that enables a model for the therapist in working with their clients but then adapt this pattern in supervision. Tracey et al. (2012) stated an example of a parallel process: a client who has relational problems comes into therapy. The client needs professional help (clients' submissiveness). The therapist starts to help a client with therapy interventions (therapist dominance). Then clients' perception of the therapists' interventions in the context of the relationship problem with responding to "Yes, but …." sentences. In time, the therapist begins to look at clients' behaviors in a critical way. This pattern progress over time and the therapist carries this issue into supervision since the therapist thinks that nothing is working (supervisees' submissiveness increases in parallel with the client). Then the supervisor's directions about the client start (supervisor dominance) and this time supervisee starts "Yes, but …." sentences. In time, the supervisor begins to look at supervisees' behaviors in a critical way. Thus, supervision interactions start to be a relative repetition of the therapy interactions. Hence, parallel processes might appear in the interpersonal behaviors with more similarity by both individuals in reciprocal roles (expert or help seeker).

In the present study, due to the parallel process in therapeutic and supervision interactions, it is thought that there is a parallel process between the therapeutic alliance and supervisory alliance that includes triadic relationships.

1.4. The Process Model of Emotion Regulation

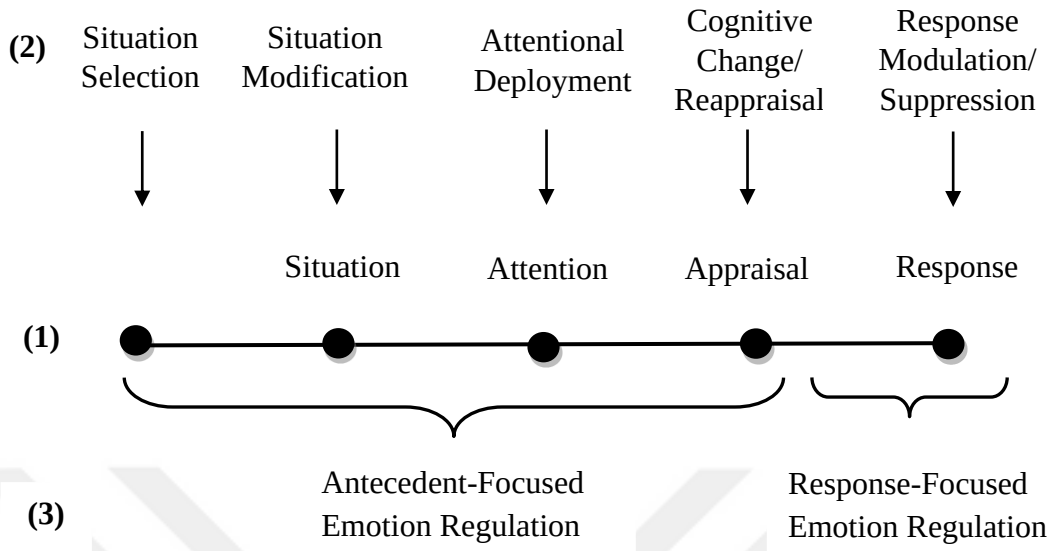
The modern world has distanced us from the many threats that our ancestors faced in the past. This can make it difficult for us to remember that emotions were evolved. Emotions were external actions that comprise a lot of internal alterations that were helpful for humans throughout the history of evolution (Damasio, 1999).

According to the modal model of emotion generation, the formation of emotional response passes through a series of stages: situation, attention, appraisal, and response, as illustrated in Figure 1. The situation can be changed by an emotional response that can be experiential, behavioral, and physiological responses (Gross, 1998b). Emotion generation starts with a psychologically related situation that includes both external surroundings and internal representations. Then, paying attention to and attributing meaning to the situation comes. Situations are attended to and appraised according to an individual's current aims (Moors et al., 2013).

Emotions are different from each other, but most emotions carry various same properties. First, one's personal, social, and cultural goals are important in emotion generation (Scherer et al. 2001). Second, emotions include unique experiential, behavioral, and physiological responses that are subjective (Mauss et al. 2005). These unique components affect response type and intensity, continuance, and frequency of the response when it is activated for a period of time (Davidson, 1998). Emotions are not processes that must be completed. They can change to fit an individual's needs, and this makes emotions regulated (Sheppes & Suri, 2015).

Figure 1

Emotion Generation and Emotion Regulation



Note. (1) The modal model of emotion generation that the formation of emotional response passes through a series of stages: situation, attention, appraisal, and response. (2) The process model of emotion regulation consists of five temporal points: situation selection, situation modification, attentional deployment, cognitive change (reappraisal), and response modulation (suppression). (3) Four of the emotion regulation strategies in the process model were antecedent-focused emotion regulation: situation selection, situation modification, attentional deployment, and cognitive change. One of the emotion regulation strategies in the process model was response-focused emotion regulation which was response modulation (adapted from Gross & Thompson, 2007).

The process model of emotion regulation encompasses both positive and negative emotions that are managed by internal and external processes (Gross & John, 2003). According to this model, emotion regulation can influence the generation and maintenance of emotion as well as the magnitude and frequency of an emotional

response (Gross, 1998a; also see Gross & John, 2003). The process model of emotion regulation (Gross, 1998a) receives its beginning point from the modal model of emotion by identifying each of the major points (situation, attention, appraisal, and response) where the emotion-generative process may be modified. The process model of emotion regulation proposed that there were five temporal points in the process of emotion generation that a person might regulate their emotions. Accordingly, different emotion regulation strategies are identified depending on their temporal location during the emotion generation process (Gross, 1998a). Gross and John (2003) underlined that the generation and regulation of emotions were continuous and dynamic mechanisms. Five points of the process model of emotion regulation were situation selection, situation modification, attentional deployment, cognitive change (reappraisal), and response modulation (suppression) as illustrated in Figure 1.

Situation selection consists of getting close to or staying away from specific locations, objects, or people to regulate emotions (Gross, 1998a). For example, to avoid being exposed to a neighbor's offensive jokes, taking another route to the store or looking for a friend with whom you can cry comfortably. Situation selection is one of the anticipatory strategies of emotion regulation (Aspinwall & Taylor, 1997). Situation selection presumes information on possible properties of avoided situations and emotional responses to these properties (Gross, 1998a). Nevertheless, situations are not simple, instead, they have several layers of emotional content. To decide which situations to avoid and approach, self-knowledge is needed, especially when the emotion regulation results in short-term profit with long-term costs. Even if a shy person avoids being in social environments due to anxiety and provides short-term relief, living a socially isolated life will turn into a long-term cost (Leary, 1986). Situation selection can be useful for cognitive-behavioral therapy interventions such

as increasing pleasurable activities to improve positive states (Jacobson et al., 2001) or to decrease an individual's contact with destructive situations (eg. drug use; Kober & Bolling, 2014).

Situation modification consists of taking actions to alter the external properties of a situation in order to modify its emotional effect (Gross, 1998a) such as reducing the time of the emotional situation to decrease exposure time (Foa & Kozak 1986). Earlier, altering the situation to modify its emotional effect has been considered in the literature on stress and coping as problem-focused coping (Lazarus & Folkman, 1984). Regardless of the situations internal or external state, changing the physical surroundings is intended in the situation modification. As an example of a change in the situation that the teacher gives group assignments to strengthen students' interest and reduce frustration by helping each other (Gross, 2015). The line between situation selection and situation modification is not clear as changing one situation creates an entirely new situation (Gross, 1998a). Another issue is separating emotion regulation from the direct outcome of emotion expression that is not regulated. Social interactions were affected by emotional expressions (Keltner & Kring, 1998). For this reason, emotion regulation actions that are intended to modify the situation must be separated from the emotion expression that was unregulated (Gross, 1999).

Attentional deployment, another emotion regulation strategy in the process model, indicates guiding individuals' attention with the aim of affecting emotional response (Gross, 2015). One form of attentional deployment is trying to change initial information processing, for instance, distracting attention-getting properties of an emotional situation (Sheppes & Gross, 2011). Also, it includes redirecting attention in a particular situation such as redirecting attention from an emotion revealing properties of a part of the situation to neutral properties or completely distracting

attention from the current situation such as dreaming about holiday plans while in a depressive appointment (Gross, 2015). In the contexts that contain negative emotions, distraction prompt the reduction of unpleasant emotion revealing material (Bennett et al., 2007).

Cognitive change refers to altering late semantic-meaning processing, for instance, reappraising the emotional content of a situation with non-emotional features of the situation in order to change its emotional effect (Gross, 2014). Reappraisal is one form of cognitive change that is well-studied. Cognitive change can be applied to both external situations (eg. the boringness of the interview can be appraised as an opportunity to increase knowledge about the industry) and internal situations (eg. excessive heartbeat can be appraised as the body's preparation for speech rather than anxiety; Gross, 2015). Reappraisal decreases the experience of negative emotion compared to no regulation (Gross, 1998b). Even though reappraisal is generally used to diminish negative emotions, it might be used to enhance or diminish both negative and positive emotions (Ochsner & Gross, 2005).

Lastly, response modulation that arises late in the emotion generative process refers to change in experiential, behavioral, or physiological parts of emotional response after the emotion is appear (Gross, 1998a). For instance, drinking alcohol, smoking, and eating food to change an affective state (Khantzian, 1985) or doing physical exercise and breathing deeply to change physiological responses (Thayer & Lane, 2000). This is known as suppression (Gross, 2015). Expressive suppression is one form of response modulation that is well-studied that refers to a continuous attempt to restrain one’s emotion-expressive behavior (Gross, 2015). Most research showed that expressive suppression is effective while decreasing the experience of

positive emotion but not so much while regulating a negative emotion as compared to no regulation (Gross, 1998b; Gross & Levenson, 1993).

The present study focused on the process model's two emotion regulation strategies that are in different temporal locations: reappraisal and suppression. These two different emotion regulation strategies were investigated in psychotherapy and supervision contexts because reappraisal and suppression occur in-process and both psychotherapy and supervision also happen in a process (before, during, and after the sessions). About this point, Prikhidko and Swank (2018) claimed that Gross's (1998b) process model encompasses emotion regulation strategies that counselors can use during and out of sessions with their clients and before, during, and after the supervision meetings. Additionally, the modal model's core properties are apparent in most distinct approaches to emotion (Barrett et al., 2007; Gross, 1998a). The process model of emotion regulation (Gross, 1998a) receives its beginning point from the modal model of emotion. Thus, the present study mainly focused on the process model of emotion regulation strategies.

1.4.1. Reappraisal, Suppression and Related Factors

In general, emotion regulation strategies are categorized as antecedent-focused and response-focused (Gross, 1998b). Antecedent-focused indicates actions we do before the emotional response tendencies fully arise and alter the impact of emotion-generating cues. Four of the emotion regulation strategies in the process model were antecedent-focused emotion regulation: situation selection, situation modification, attentional deployment, and cognitive change. On the other hand, response-focused refers to the emotion regulation attempts after the emotional response has been generated. One of the emotion regulation strategies in the process model was

response-focused emotion regulation which was response modulation (Gross & John, 2003) as illustrated in Figure 1.

Cognitive reappraisal is an antecedent-focused strategy that refers to reinterpreting emotion generating situation to alter its emotional effect. So that means, reappraisal might change the whole succeeding emotion trajectory in an efficient way. Particularly, when reappraisal is used to diminish negative emotion, it should decrease behavioral and experiential parts of negative emotion. Nevertheless, expressive suppression is a response-focused strategy that comes late in the emotion-generating process and mainly changes the behavioral component of the emotional response. Therefore, suppression should be efficient in diminishing the expression of the behavioral part of negative emotion, but this might also diminish positive emotion expression as an unintentional side effect (Gross & John, 2003). Concurrently, suppression might not be useful for decreasing the negative emotion experience due to the accumulation of the not resolved materials. Moreover, as the suppression comes late in the emotion-generating process, it necessitates continuous effort to control emotion response tendencies. These continuous efforts may reduce cognitive resources that can be useful for interactions in the social contexts that involve emotions (Gross & John, 2003). In addition, suppression can create a feeling of inconsistency or incoherence between internal experience and external expression (Rogers, 1951). The feeling of not being honest to oneself and others may lead to thinking negatively about the self and alienating the individual from both the self and others (Gross & John, 2003).

In the literature, many experimental studies investigated results with respect to reappraisal and suppression (see Gross & John, 2003). For example, the group who was asked to suppress their negative emotions while watching a film displayed less

behavioral expression, but they experience negative emotions as much as subjects who only watched the film (Gross & Levenson, 1997; Strack et al., 1988). On the contrary, reappraisal reduced both behavioral expression and experience of negative emotions. At this point, there was an interesting finding emerged that when negative emotions were suppressed, the experience of negative emotions was intact but when positive emotions were suppressed, the experience of positive emotions was decreased (Gross & Levenson, 1997; Strack et al., 1988). In addition, a study shows the cognitive cost of suppression (Richards & Gross, 2000). Results indicated that suppression -but not reappraisal- elicited memory deterioration for social knowledge. These results suggest that there is a cognitive cost of using suppression and this has negative impacts on social relationships as suppressors fail to engage in the necessary information to react properly to others (Richards & Gross, 2000). Moreover, Butler et al.'s (2003) experimental study indicated that using suppression was more stressful than using reappraisal while relating to a partner as understood from the increased blood pressure. These results proposed the negative impacts on the social functioning of using suppression are greater extent than reappraisal (Gross & John, 2003). However, cultural differences may play a role. Culture-specific studies demonstrated different consequences of using suppression. Studies showed that suppression was linked with negative consequences but most of these studies were done in European-American samples that are identified as an individualistic culture where emotional expression is favorable (Butler et al., 2009; Soto et al., 2005). Contrary, East Asian cultures are identified as the collectivistic culture that fosters the suppression of emotional acting to keep away from hurting others and provide relational harmony (Butler et al., 2009; De Leersnyder et al., 2013; Matsumoto et al., 2008; Soto et al., 2005; Wierzbicka, 1994). Studies done in East Asian cultures showed that

suppression was linked with lower levels of negative emotion experience, better social relations, and better physiological response (Butler et al., 2007; Mauss & Butler, 2010; Soto et al., 2011). Thus, these studies demonstrated the adaptive function of suppression in East Asian cultures (Yuan et al., 2014).

Furthermore, to show long-term outcomes and understand the individual differences, studies have been done on cognitive reappraisal and expressive suppression (Gross & John, 2003). Findings on reappraisal indicated that reappraisers arrange situations that are stressful with the help of an optimistic viewpoint, re-explaining things that are stressful for them, and expend efforts to fix bad moods. Also, they experience and manifest more positive and less negative emotions behaviorally and share their positive and negative emotions more with others. They have close connections with friends. In terms of well-being, reappraisers have fewer depressive symptoms, and have higher self-esteem and satisfaction in life (Gross & John, 2003). On the other hand, findings on suppression indicated that suppressors experience themselves as unauthentic due to not showing their true selves, they handle situations that are stressful by covering their internal feelings, and they have confusion about their feelings (Gross & John, 2003). Also, suppressors have less success to fix moods and do not view their feelings in an acceptable way. In addition, they make ruminations about the events that lead to negative emotions. They experience and manifest fewer positive emotions, experience more negative emotions, manifest fewer negative emotions, and hesitate to share both positive and negative emotions with others. They also avoid forming emotionally close relationships. In terms of well-being, suppressors have more depressive symptoms, lower self-esteem, and less satisfaction in life (Gross & John, 2003).

1.5. Emotion Regulation in Psychotherapy and Supervision Context

Clinical psychology trainees may encounter compelling emotions while conducting sessions with clients. These challenging emotions such as fear, guilt and anxiety may emerge before, during, and after sessions (Prikhidko et al., 2020). Testa and Sangganjanavanich (2016) stated that trainees are exposed to emotionally and psychologically stressful things even though they are not licensed yet in the period of training. The transition from trainee to mental health professional is the period that comprises both personal and professional development.

Prikhidko and Swank (2018) mentioned that when working with clients during professional development, both positive and negative emotions arise. In that developmental process, supervision has a crucial role in enabling trainees to apply what they have learned into practice (Bernard & Goodyear, 2014). Vallance (2004) found that a supervisor's emotional support directly influences counselors' work with their clients. Linehan (2015) claimed that emotional arousal may influence trainees' perception of the client due to the difficulties of emotion regulation leading to cognitive distortions. It is crucial for supervisors to be cognizant of how they direct trainees when they confront vulnerabilities and display emotion regulation difficulties to increase the calmness and openness of trainees (Prikhidko et al., 2020).

Prikhidko et al. (2020) stated that when trainees become emotionally charged, they may use emotion regulation strategies and process emotions by sharing them with a colleague or a supervisor. Champe et al. (2013) claimed that supervisees may need help to realize emotion regulation processes and it is supervisors' responsibility to inform trainees about emotion regulation. Prikhidko and Swank (2018) claimed that Gross's (1998b) process model encompasses emotion regulation strategies that counselors can use during and out of sessions with their clients and before, during,

and after the supervision meetings. Newton et al. (2020) indicated that cognitive reappraisal predicts wellness therefore, the training program might contain interventions for improving trainee's cognitive reappraisal in supervision. Champe et al. (2013) stated that supervisors may strengthen cognitive appraisal to the emotional reaction, with the aim of decreasing overwhelming inaccurate appraisals or diminishing ineffectual interpretations. Moreover, evaluating the supervisee's emotional reaction may contribute to aware clues about the cognitive reappraisal and supervisory relationship (Champe et al., 2013).

Prikhidko et al. (2020) indicated that due to the unresolved trauma, trainees may feel negative emotions when they work with a client who has similar traumatic experiences. Emotion regulation may also have a protective function. As Linehan (2015) stated that emotionally vulnerable individuals may freeze. Prikhidko et al. (2020) claimed that this could be related to shock such as when trainees are retraumatized by a client's history and do not know how to cope with trauma and process it. The frozen state may refer trainees' suppressing emotions (Prikhidko et al., 2020). Hofmann (2014) indicated that suppressed emotion paradoxically enhances negative emotion. Therefore, Prikhidko et al. (2020) mentioned that suppressed emotions toward clients and supervisors may lead to inefficacy thus, supervisors may help trainees to be aware of their suppressed emotions.

1.6. The Present Study

Priebe and McCabe (2006) suggested that future studies should put a greater emphasis on therapeutic relationships during training and supervision. Hence, it is necessary to address the relationship between the supervision and therapeutic process carefully. Furthermore, Hill (2013) underlined the importance of emotion regulation in process of counseling.

There is limited research on the role of emotion regulation strategies in training therefore, a need appears to investigate the role of emotion regulation strategies in clinical psychology trainees. Up to date, there is no research that investigated the moderating role of emotion regulation strategies (reappraisal and suppression) in the context of supervision and the psychotherapy process. Therefore, the present study aimed to investigate the moderating role of reappraisal and suppression between the supervisory alliance and therapeutic alliance.

1.6.1. Research Questions

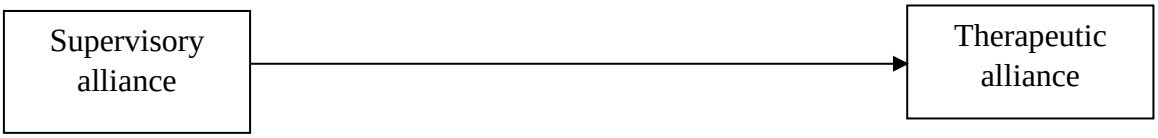
The research questions for the present study are: (1) Is supervisory alliance associated with the therapeutic alliance in clinical psychology trainees? (2) Does reappraisal moderate the relationship between the supervisory alliance and the therapeutic alliance in clinical psychology trainees? (3) Does suppression moderate the relationship between the supervisory alliance and the therapeutic alliance in clinical psychology trainees?

1.6.2. Hypotheses

The research hypotheses for the present study are: (1) increased supervisory alliance will be related to the increased therapeutic alliance, as illustrated in Figure 2 (2) increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the higher level of reappraisal, as illustrated in Figure 3 (3) increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the lower level of suppression, as illustrated in Figure 4.

Figure 2

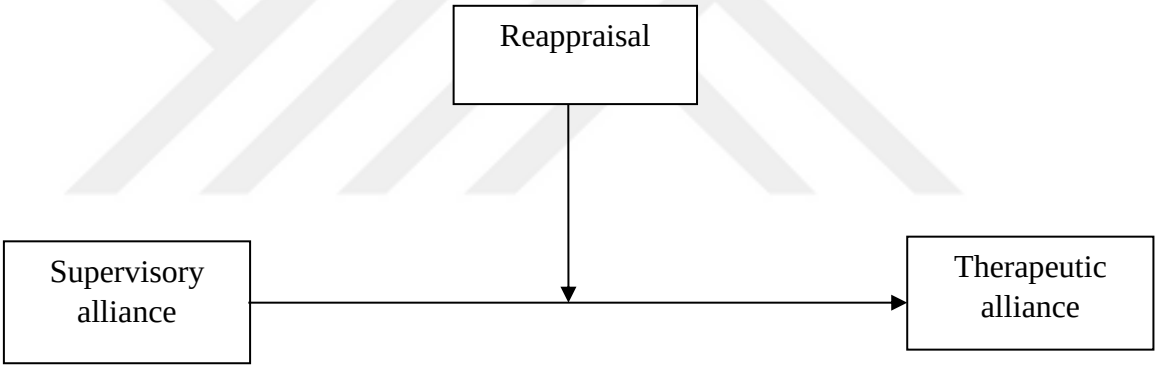
Illustration of Hypothesis 1



Note. The hypothesized relationship between variables that increased supervisory alliance will be related to an increased therapeutic alliance.

Figure 3

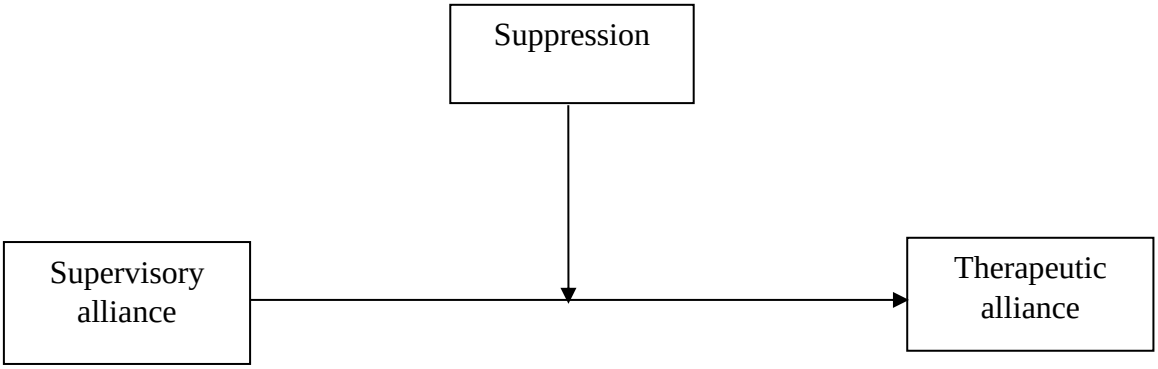
Illustration of Hypothesis 2



Note. The hypothesized relationship between variables that increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the higher level of reappraisal.

Figure 4

Illustration of Hypothesis 3



Note. The hypothesized relationship between variables that increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the lower level of suppression.

2. METHOD

2.1. Participants

In the present study, the convenience sampling method was used to collect data from a sample of clinical psychology trainees in Turkey. Participants were included in the study by sending an informative text about the study to the common mail and WhatsApp groups in the field of psychology and the relevant professors of universities that have clinical psychology programs.

Participants were recruited from clinical psychology trainees who are currently carrying out psychotherapy sessions under individual and/or group supervision. Participants who had less than 3 sessions with their clients were excluded from the study. This specific interval was considered the time interval in which the therapeutic relationship begins to form (Soygüt & Işıklı, 2008). The answers of three participants did not fit the target population due to not completing 3 sessions with their clients yet, as a consequence their answers were not included in the analyses.

Eventually, in the present study, 78 clinical psychology trainee volunteers who had more than 3 sessions with their clients participated. There were 68 females (87.2%) and 10 males (12.8%). Participants' age ranged from 23 to 39 (M = 25.98, SD = 2.89).

One participant did not answer a question about the year of education, three participants did not answer a question about the number of weeks that they have been under supervision, two participants did not answer a question about the number of sessions done under supervision, one participant did not answer a question about the number of sessions with the selected client in an appropriate format (though it was greater than 3). Participants' demographic characteristics are summarized in Table 1.

Table 1

Descriptive Statistics of Participants (N=78)

Variables	*n*	*%*	*Min*	*Max*
Gender				
Male	10	12.8		
Female	68	87.2		
Education Year				
First-year	12	15.4		
Second-year	57	73.1		
Third-year	8	10.3		
The number of total clients			1	15
The number of sessions done in one week			1	15
Therapy Approach of Trainees				
Cognitive behavioral therapy	32	41		
Psychodynamic therapy	32	41		
Other therapy approaches	14	18		
Supervision Type				
Individual supervision	14	17.9		
Group supervision	44	56.4		
Both individual and group supervision	20	25.6		
The number of weeks that trainees have been in supervision			2	96
The number of sessions done under supervision			2	504
The number of sessions with the selected client			3	62
Psychotherapy place with the selected client				
Face-to-face psychotherapy	11	14.1		
Online psychotherapy	57	73.1		
Both face-to-face and online psychotherapy	10	12.8		
Selected Supervisor				
Individual supervisor	27	34.6		
Group supervisor	51	65.4		
The number of supervision meetings done about the selected client			1	32
Supervision Approach				
Cognitive behavioral therapy	32	41		
Psychodynamic therapy	27	34.6		
Other therapy approaches	19	24.4		
Supervision place with the selected supervisor				
Face-to-face supervision	2	2.6		
Online supervision	63	80.8		
Both face-to-face and online supervision	13	16.7		

As it can be seen from Table 1 that most participants were females and in the second year of the clinical psychology master's program. As for the psychotherapy approach, most of the trainees adopted Cognitive Behavioral Therapy and Psychodynamic Therapy approach. The most frequent supervision type was group supervision. Most participants carried out online psychotherapy sessions. The most frequently chosen supervisor was the group supervisor to evaluate supervisory alliance. As for the supervision approach, most of the trainees stated that they were using Cognitive Behavioral Therapy with their supervisor. Frequently, participants carried out online supervision sessions.

2.2. Instruments

It was a survey study. It started with an informed consent form (See Appendix A). The informed consent form consisted of subjects such as the purpose of the study in general, the approximate time it takes to complete the questionnaire, the right to quit the study at any time, voluntary participation in the study, and the limits of confidentiality.

The set of questionnaires is composed of four parts: 1) Demographics and Training-related Information Form (See Appendix B), (2) The Turkish Working Alliance Inventory – Therapist Form (Horvath & Greenberg, 1989; Soygüt & Işıklı, 2008; see Appendix C), (3) Short Form of Turkish Working Alliance Inventory – Supervisee Form (Bahrick, 1990; Gök, 2017; see Appendix D), and (4) Emotion Regulation Questionnaire (Eldeklioğlu & Eroğlu, 2015; Gross & John, 2003; see Appendix E). After the questionnaires were completed, the research ended with the debriefing form (See Appendix F). The purpose of the research is stated in greater detail in the debriefing form. Also, the researcher's contact information was written in the debriefing form in case participants want further information about the study.

2.2.1. Demographics and Training-related Information Form

The demographics and training-related information form are composed of 9 questions. This first section of the questionnaire enabled to gather information about age, gender, year in the clinical psychology master's program, the number of total clients that the participants were following, the number of sessions done in one week, and participants' psychotherapy approach. Next, there were questions about the supervision process that was related to the type of supervision that participants received (individual, group, or both), the number of weeks that participants have been in supervision and the number of sessions done under supervision.

2.2.2. The Turkish Working Alliance Inventory- Therapist Form (WAI-T)

Horvath and Greenberg (1989) developed the Working Alliance Inventory (WAI) relying on Bordin's conceptualization (1983) to evaluate working alliance. Initially, the WAI was developed to measure therapeutic alliance (Horvath & Greenberg, 1989). It is a 7-point Likert-type scale that is composed of 36 items. There were three subscales: goals, tasks, and emotional bond. The scale is composed of two forms: therapist and patient. For the entire scale, the Cronbach's alpha coefficient for patient form is .93 and .87 for therapist form (Horvath & Greenberg, 1989).

Soygüt and Işıklı (2008) were adapted the WAI into Turkish. The scale is composed of 36 items and each item is rated on a 7-point Likert-type that is ranging from "1= never" to "7= always". The scale is composed of three subscales: goals, tasks, and emotional bond. A total score can be calculated in each subscale score. The scale is composed of two forms: therapist and patient. The total score can range from 36 to 252, and higher scores indicate a higher therapeutic alliance. In the Turkish form, the internal consistency for the patient form is .90 and for the therapist form is .96. Internal consistency of subscales for patient form was found .81, .90 and .78

while internal consistency of subscales for therapist form was found .94, .96 and .83 (for goals, tasks, and emotional bond respectively; Soygüt & Işıklı, 2008). In the current study, only The Turkish Working Alliance Inventory – Therapist form (WAI-T) was used to assess therapeutic alliance. In the present study, the internal consistency of the therapist form is .95.

After the participants completed the WAI-T, the following questions were asked: "How many sessions did you have with your client for whom you made the above assessment," and "How do you conduct sessions with your client for whom you made the above assessment (online or in-person)?"

2.2.3. Short Form of Turkish Working Alliance Inventory- Supervisee Form (WAI-S)

Bahrick (1990) adapted Working Alliance Inventory (WAI) to the supervision context with minor modifications in wording, for example, using supervisor and trainee (supervisee) instead of therapist and patient. Gök (2017) constructed a short Turkish form for the trainee (supervisee). In order to prepare a short Turkish form for the supervisee, Gök (2017) considered Hatcher and Gillapsy's (2006) revised short form of WAI and Bahrick's (1990) adaptation of WAI to the supervision context and Soygüt and Işıklı's (2008) Turkish adaptation of WAI.

The short form of the Turkish Working Alliance Inventory – Supervisee Form (WAI-S) is composed of 12 items and each item is rated on a 7-point Likert-type that is ranging from "1= It is not right for me at all" to "7= Absolutely right for me". The scale is composed of three subscales: goals, tasks, and emotional bond. The total score can range from 12 to 84 and higher scores indicate a higher supervisory alliance. Within person reliability of emotional bond, tasks, goals subscales and whole scale

were as follows: .80, .81, .83, .92 respectively. In the present study, the internal consistency of supervisees form is .96.

After the participants completed the WAI-S, the following questions were asked: “For which supervisor (individual or group) did you make the above assessment,” “How many supervision sessions did you have with your supervisor regarding the evaluated client,” “What approach or approaches are you using with your supervisor” and “How do you conduct supervision sessions with your supervisor whom you made the above assessment (online or in-person)?”

2.2.4. Emotion Regulation Questionnaire (ERQ)

The Emotion Regulation Questionnaire (ERQ) was developed by Gross and John (2003) to measure emotion regulation strategies. The scale is composed of 10 items and each item is rated on a 7-point Likert-type that is ranging from “1= strongly disagree” to “7= strongly agree”. The scale is composed of two subscales: cognitive reappraisal and suppression. Scores range between 6 to 42 for the reappraisal subscale and 4 to 28 for the suppression subscale. However, a total score can not be calculated from the scale. The internal consistency for cognitive reappraisal is .79 and for expressive suppression is .73 (Gross & John, 2003).

The scale was adapted into Turkish by Eldeklioğlu and Eroğlu (2015). In the Turkish form, internal consistency for cognitive reappraisal is .78 and for the suppression is .73 and, the test-retest reliability for cognitive reappraisal is .74 and for suppression is .72 (Eldeklioğlu & Eroğlu, 2015). In the present study, the internal consistencies of subscales were as follows: .85 for cognitive reappraisal, .81 for suppression.

2.3. Procedure

The data collection process was started after the approval of the Yeditepe University Social and Human Sciences Ethics Committee (See Appendix G). The process took place in Google Form, which is an online platform. The questionnaires were accessible from March 2021 to January 2022. The convenience sampling method was used to collect data. Informative text about the study that includes the study link was shared via online platforms such as common mail and WhatsApp groups in the field of psychology and the relevant professors of universities.

If the participants wanted to participate in the study, they clicked on the relevant link and connected to the study. They were first asked to read and approve the informed consent form. After approving the informed consent form, they started answering the questionnaire that includes Demographics and Training-related Information Form, The Turkish Working Alliance Inventory – Therapist Form (WAI-T), a short form of the Turkish Working Alliance Inventory – Supervisee Form (WAI-S), and Emotion Regulation Questionnaire (ERQ). It took approximately 10-15 minutes to fill out the questionnaires. After the questionnaires were completed, the research ended with the debriefing form.

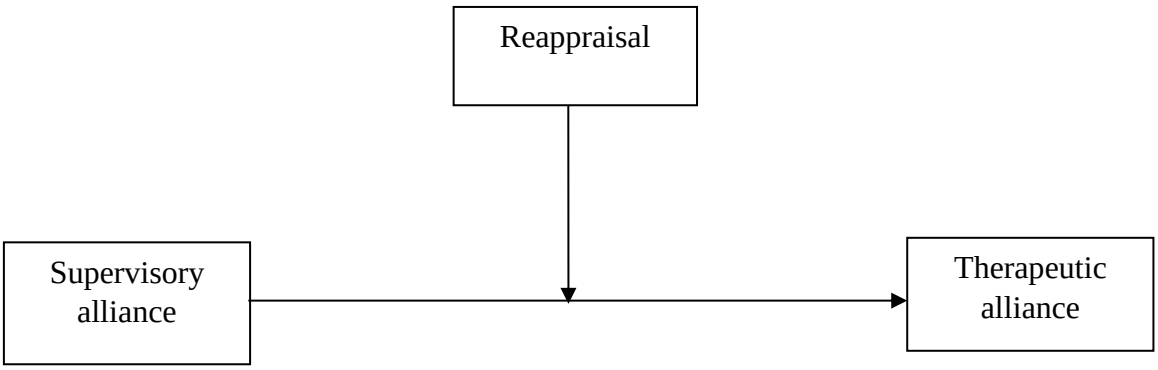
2.4. Data Analysis

In order to examine the moderating role of reappraisal and suppression between the supervisory and therapeutic alliance, moderation analyses were carried out. SPSS version 26 and PROCESS macro (Preacher & Hayes, 2004) model 1 which was a regression-based moderation model were used to conduct moderation analyses, as illustrated in Figures 5, 6, 7, and 8. For normality assumptions, skewness and kurtosis values, and visual inspection were inspected. The log-transformed data were inserted into the analyses when the normality assumption is not supported. Prior to the

moderation analyses, the Pearson correlation coefficient was used to determine the intercorrelations of the variables; supervisory alliance, therapeutic alliance, and emotion regulation strategies (reappraisal and suppression). In order to carry out moderation analyses variables were as follows: supervisory alliance as a predictor, reappraisal and suppression as moderators, and therapeutic alliance as an outcome variable. In the present study, random resampling with 10,000 bootstraps (Hayes, 2017; Preacher & Hayes, 2004) was utilized with a .05 alpha value. As a precaution against bias in estimated standard errors, a heteroscedasticity-consistent approach to estimating standard errors (HC3) and mean-centered variables were used for the model testing procedure. Internal consistency of WAI-T, WAI-S, and ERQ items was analyzed by using Cronbach's alpha coefficient.

Figure 5

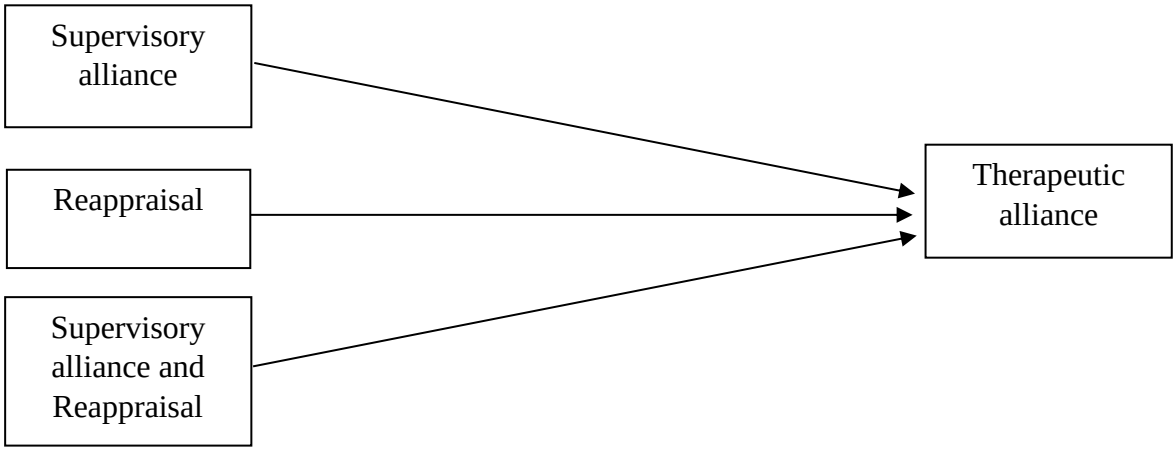
Illustration of the Conceptual Diagram



Note. The conceptual diagram of the moderating role of the reappraisal in the relationship between the supervisory and therapeutic alliance in accordance with the Hayes (2013) PROCESS moderation Model 1.

Figure 6

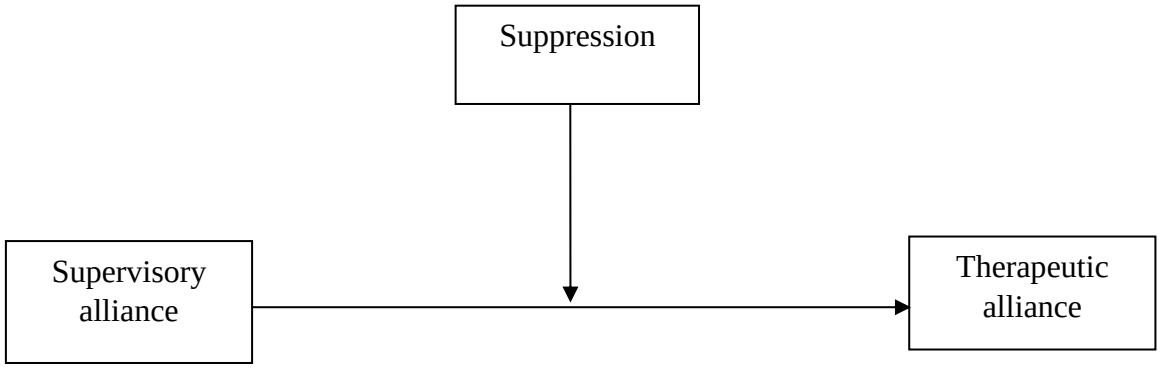
Illustration of the Statistical Diagram



Note. The statistical diagram of the moderating role of the reappraisal in the relationship between the supervisory and therapeutic alliance in accordance with the Hayes (2013) PROCESS moderation Model 1.

Figure 7

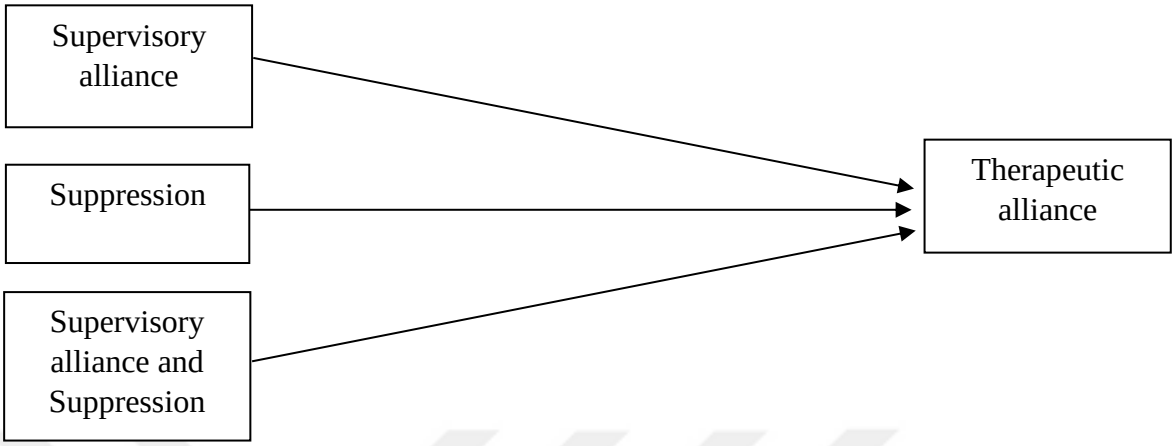
Illustration of the Conceptual Diagram



Note. The conceptual diagram of the moderating role of the suppression in the relationship between the supervisory and therapeutic alliance in accordance with the Hayes (2013) PROCESS moderation Model 1.

Figure 8

Illustration of the Statistical Diagram



Note. The statistical diagram of the moderating role of the suppression in the relationship between the supervisory and therapeutic alliance in accordance with the Hayes (2013) PROCESS moderation Model 1.

3. RESULTS

3.1. Normality Assumptions

In the current study, there were three fundamental variables that were therapeutic alliance measured by The Turkish Working Alliance Inventory – Therapist Form (WAI-T), supervisory alliance measured by Short Form of Turkish Working Alliance Inventory – Supervisee Form (WAI-S), and emotion regulation (reappraisal and suppression) measured by Emotion Regulation Questionnaire (ERQ).

Before correlation analyses, normality assumptions were examined (kurtosis, skewness, and visual inspection). If the skewness and kurtosis values are between -1.5 and +1.5, the distribution can be considered normal (Tabachnick & Fidell, 2013). Skewness and kurtosis values of the variables are presented in Table 2.

Table 2

Normality Assumptions of The Turkish Working Alliance Inventory – Therapist Form, Short Form of the Turkish Working Alliance Inventory – Supervisee Form, and Emotion Regulation Questionnaire Scores

Measure	*M*	*SD*	Skewness	Kurtosis
The Turkish Working Alliance Inventory – Therapist Form	196.05	24.95	- 0.42	0.25
Short Form of Turkish Working Alliance Inventory – Supervisee Form	68.47	13.80	-1.44	1.88
Emotion Regulation Questionnaire Reappraisal Subscale	29.05	6.38	- 0.63	- 0.02
Emotion Regulation Questionnaire Suppression Subscale	11.27	4.95	0.51	- 0.90

The log-transformed data for the short form of the Turkish Working Alliance Inventory – Supervisee Form was utilized in the analyses due to the normality assumption was not supported. After log-transforming the data, normality assumptions were met. Skewness and kurtosis values of log-transformed data for the

Short Form of Turkish Working Alliance Inventory – Supervisee Form were .67 and .51 respectively.

3.2. Intercorrelations between Supervisory Alliance, Therapeutic Alliance, and Emotion Regulation Strategies

Pearson's correlation test was used to test intercorrelations between variables; supervisory alliance, therapeutic alliance, and emotion regulation (reappraisal and suppression) which were summarized in Table 3. As it can be seen from Table 3, there was a statistically significant correlation between supervisory alliance and therapeutic alliance that was in the positive direction, and there was a statistically significant correlation between suppression and therapeutic alliance that was in the negative direction.

Table 3

Intercorrelations of Supervisory Alliance, Therapeutic Alliance, and Emotion Regulation (Reappraisal and Suppression)

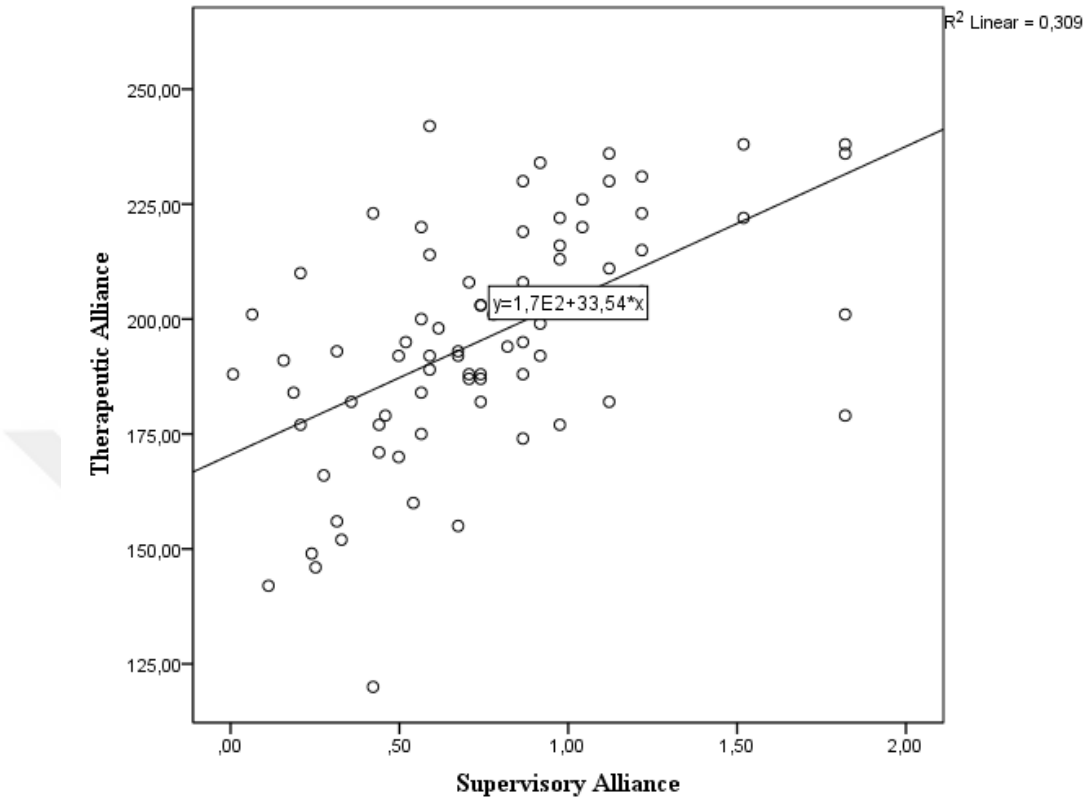
Measure	1	2	3	4
1. Therapeutic Alliance	-			
2. Supervisory Alliance	.56**	-		
3. Reappraisal	.08	.17	-	
4. Suppression	- .41**	- .19	.21	-

* $p < .05$ (2-tailed), ** $p < .01$ (2-tailed)

In the present study, firstly, it was hypothesized that there was a positive correlation between supervisory alliance and therapeutic alliance. Pearson's correlation test results showed that the first hypothesis was supported as shown in Table 3 and illustrated in Figure 9.

Figure 9

Illustration of the Simple Slopes Plot



Note. The positive relationship between supervisory alliance and therapeutic alliance.

3.3. The Moderating Role of the Reappraisal in the Relationship between the Supervisory and Therapeutic Alliance

Moderation analysis was conducted in order to examine the moderating role of reappraisal between the supervisory alliance and therapeutic alliance. In the present study, secondly, it was hypothesized that increased supervisory alliance would be related to the increased therapeutic alliance that was moderated by the higher level of reappraisal. The results of moderation analysis showed that interaction (*XW:* Supervisory Alliance x Reappraisal) was not significant as shown in Table 4, thus the second hypothesis was not supported.

Table 4

Moderation Model Coefficients for Supervisory Alliance Predicting Therapeutic Alliance Conditional on Reappraisal (N=78)

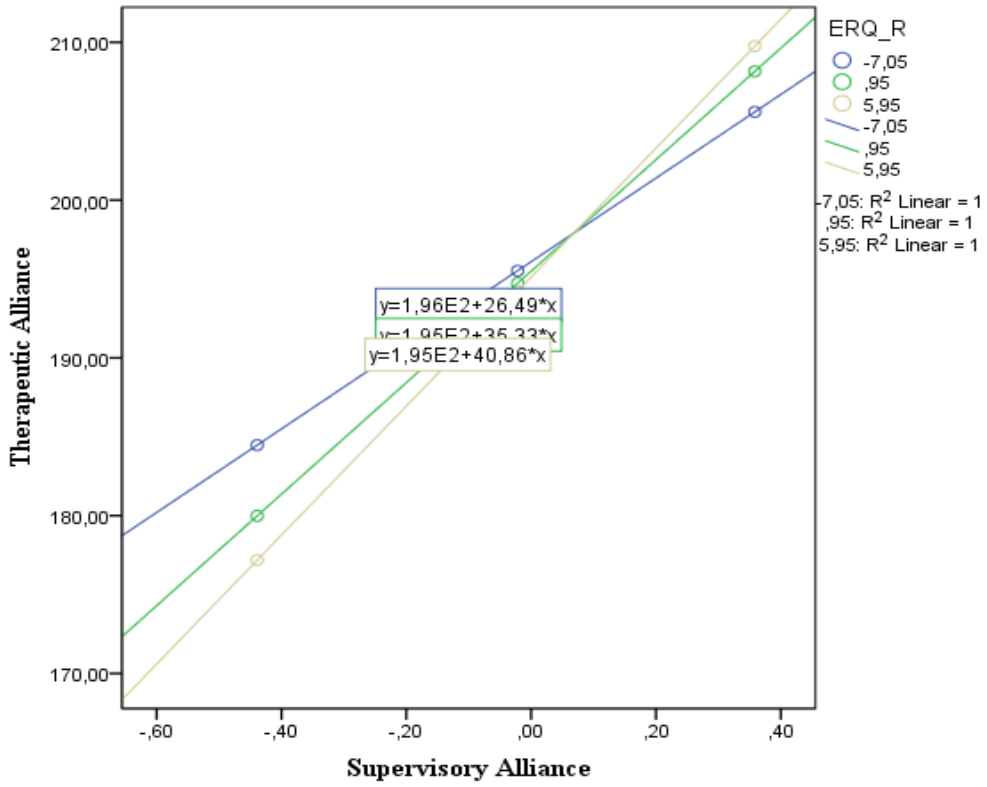
Variable	*B [LLCI, ULCI]*	*SE (HC3)*
Supervisory Alliance	34.28 [17.50, 51.07]***	8.43
Reappraisal	-0.08[-1.12, 0.97]	0.52
Supervisory Alliance*Reappraisal	1.11[-1.77, 3.98]	1.44

** $p < .01$. *** $p < .001$.

The moderation model was expounded significant variance in therapeutic alliance, $R^2 = .33$, F (3,74) = 11.53, $p < .001$. The variables explain 33% of the variance in the therapeutic alliance. The interaction (*XW:* Supervisory Alliance x Reappraisal) was not expounded significant 2% of this variance in therapeutic alliance alone, $F(1, 74) = .59$, $p = .45$. Simple slopes plot, as illustrated in Figure 10, showed that there was no significant moderation effect of reappraisal.

Figure 10

Illustration of the Simple Slopes Plot



Note. The simple slopes plot of the moderation analyses of reappraisal levels (high, medium, and low) between the relationship of supervisory alliance and therapeutic alliance.

3.4. The Moderating Role of the Suppression in the Relationship between the Supervisory and Therapeutic Alliance

Moderation analysis was conducted in order to examine the moderating role of suppression between the supervisory alliance and therapeutic alliance. In the present study, thirdly, it was hypothesized that increased supervisory alliance would be related to the increased therapeutic alliance that was moderated by the lower level of suppression. The results of moderation analyses showed that interaction (*XW:* Supervisory Alliance x Suppression) was significant as shown in Table 5.

According to the findings, suppression improved the relationship between supervisory alliance and therapeutic alliance. Thus, the third hypothesis was not supported.

Table 5

Moderation Model Coefficients for Supervisory Alliance Predicting Therapeutic Alliance Conditional on Suppression (N=78)

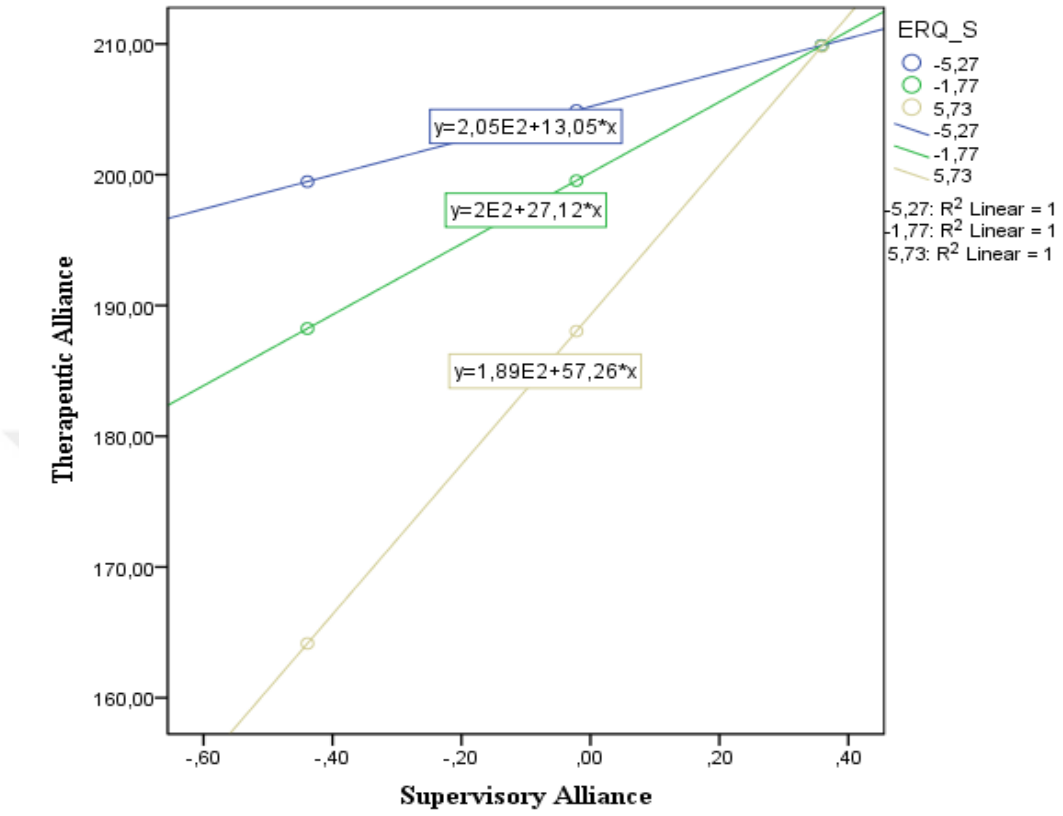
Variable	*B [LLCI, ULCI]*	*SE (HC3)*
Supervisory Alliance	34.23 [23.28, 45.18]***	5.49
Suppression	-1.45 [-2.35, -0.54]**	0.45
Supervisory Alliance*Suppression	4.02[1.12, 6.92]**	1.45

** $p < .01$. *** $p < .001$.

The moderation model was expounded significant variance in therapeutic alliance, $R^2 = .50$, F (3,74) = 23.40, $p < .001$. The interaction (*XW:* Supervisory Alliance x Suppression) was expounded as significant 8.8% of this variance in therapeutic alliance alone, $F(1, 74) = 7.64$, $p = .007$. Significant moderation effect was investigated with a simple slopes plot, as illustrated in Figure 11, which exhibited that the high suppressor group ($B_{high} = 57.26$, *LLCI/ULCI* $\neq 0$, $p < .001$) had a stronger positive relationship between supervisory alliance and therapeutic alliance in comparison to medium suppressor group ($B_{medium} = 27.12$, *LLCI/ULCI* $\neq 0$, $p < .001$) and to low suppressor group where no significant relationship between supervisory alliance and therapeutic alliance was observed ($B_{low} = 13.05$, *LLCI/ULCI* $= 0$, $p = .190$).

Figure 11

Illustration of the Simple Slopes Plot



Note. The simple slopes plot of the moderation analyses of suppression levels (high, medium, and low) between the relationship of supervisory alliance and therapeutic alliance.

4. DISCUSSION

In the present study, it was aimed to investigate the moderating role of reappraisal and suppression between the supervisory alliance and therapeutic alliance. There is limited research on the role of emotion regulation strategies in training therefore, a need appears to investigate the role of emotion regulation strategies in clinical psychology trainees in the contexts of psychotherapy and supervision.

Firstly, it was hypothesized that increased supervisory alliance would be related to an increased therapeutic alliance. Results indicated that the first hypothesis was supported. Secondly, it was hypothesized that increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the higher level of reappraisal. Thirdly, it was hypothesized that increased supervisory alliance will be related to an increased therapeutic alliance that is moderated by the lower level of suppression. Results indicated that the second and third hypotheses were not supported.

In the following section, our findings are discussed in accordance with the literature. It might be important to discuss the usage of reappraisal and suppression by considering different impacts on both positive and negative emotions, and behavioral manifestations and experiential parts of the emotions. Practical implications and limitations of the present study, and suggestions for future studies are provided.

4.1. The Positive Relationship between Supervisory Alliance and Therapeutic Alliance

Psychotherapy supervision is a triadic process (supervisor-trainee and therapist-client) during which the supervisor educates the therapist for one or more clients (Tracey et al., 2012). Ekstein and Wallerstein (1972) stated the unconscious repetition of the therapeutic relationship in supervision. In the present study, due to

the parallel process in therapeutic and supervision interactions, it is thought that there would be a parallel process between the supervisory alliance and therapeutic alliance that includes triadic relationships. Therefore, in the light of literature, it was hypothesized that increased supervisory alliance will be related to an increased therapeutic alliance. Findings indicated that there was a positive relationship between supervisory alliance and therapeutic alliance which corresponded with the literature. DePue et al. (2016) found that scores on supervisory relationships improve the therapeutic alliance. Coutinho et al. (2014) indicated that a strong therapeutic relationship can be understood by counselors' strong bond with supervisor. Also, the present study's findings are parallel with Ganske et al.'s (2015) research findings that supervisees' experience of working alliance with clients is associated with their experience of working alliance with supervisors. DePue et al. (2016) indicated that Ganske et al.'s (2015) finding is providing an explanation that the relationship with the supervisor may have a function in parallel process for trainees. Findings in the literature specified the importance of the professional role modeling of supervisors for trainees (Bernard & Goodyear, 2014; DePue et al., 2016). When trainees feel they are in a supportive environment and they are understood by their supervisor (high supervisory alliance) they may feel more confident in their work with their clients (high therapeutic alliance) because a high supervisory alliance may provide trainees feel more prepared while working with clients (Bernard & Goodyear, 2014; DePue et al., 2016).

4.2. The Moderating Role of the Reappraisal in the Relationship between the Supervisory and Therapeutic Alliance

Clinical psychology trainees experience a period that transition to mental health expertise by doing psychotherapy sessions within the scope of supervision.

Testa and Sangganjanavanich (2016) stated that trainees are exposed to emotionally and psychologically stressful things even though they are not licensed yet in the period of training. Studies on reappraisal indicated that reappraisers re-explain situations that are stressful for them (Gross & John, 2003). Therefore, in the light of literature, it was hypothesized that a higher level of reappraisal moderated the relationship between supervisory alliance and therapeutic alliance. Contrary to expectations, results indicated that there was no significant moderation effect of reappraisal.

First, if we focus on the impacts of using reappraisal on both positive and negative emotions it can be stated based on literature that when reappraisal is used to diminish negative emotions, it should decrease behavioral and experiential parts of negative emotions. In addition, reappraisers experience and manifest more positive emotions (Gross & John, 2003). This may show us that reappraisal is an adaptive emotion regulation strategy because of increasing positive emotions and decreasing negative emotions in both behavioral and experiential parts but McRae (2016) indicated that although reappraisal is generally more adaptive than other strategies, under certain circumstances using reappraisal may not be the most adaptive option. Moreover, the adaptiveness of emotion regulation strategies is not universal (McRae, 2016).

A study showed that when compared with the reappraisal, distraction might be a more adaptive strategy. Particularly, distraction, which is an earlier emotion regulation strategy, may be more effective if the appropriate time to use reappraisal is severely limited (Sheppes & Meiran, 2007; Sheppes & Gross, 2011). Ochsner and Gross (2005) stated that considerable time may be required for reappraisal to generate possible reinterpretations, select one of these interpretations, implement the selected

reinterpretation, and check for its success. Hence, it may be challenging for clinical psychology trainees to generate possible reappraisals as they were at the beginning of the professional experience and may not really manage the required time for reappraisal. In addition, trying to reappraise is more effortful when emotional intensity is high (Silvers et al., 2014) which may diminish one's self-efficacy perceptions about using emotion regulation strategies (McRae, 2016). Skovholt and Rønnestad (2003) stated that the uncertainty of the psychotherapy process may reveal intense emotions in the novice therapist. Based on these statements from the literature, it can be thought that trainees may encounter emotionally intense situations (e.g., clients' traumatic experiences) for this reason they may hesitate to use reappraisal as it is more effortful. Also, to perceive themselves as more efficient, trainees may not have used reappraisal.

Moreover, using reappraisal is less likely to be effective when one's cognitive resources are restricted (Bunge & Weight, 2007) such as when exposed to additional cognitive requirements (Ward & Mann, 2000). In the light of literature, it may not become effective to use reappraisal for trainees because they might have limited cognitive resources due to managing all psychotherapy processes (listening to clients carefully, asking to-the-point questions to understand deeply, taking notes, etc.) at the beginning of the professional experience. Although reappraisal is largely seen as an adaptive strategy, recent years' nuanced findings showed that context changes the success and adaptive nature of the reappraisal (McRae, 2016).

It should be noted that, in the present study, it was not measured whether the trainees reappraise the emotions that originated from their own life experiences or does trainees reappraise the emotions that are client related. It might be more adaptive for trainees to use reappraisal to regulate emotions that originated from their own life

experiences to silence their own agenda. This may lead them to focus more on clients' issues and clients may feel more understood and as a result, therapeutic relationships may enhance. On the other hand, using reappraisal might not be adaptive to regulate client-related emotions due to overlooking countertransference that may include positive or negative emotions toward clients that are important to work on. As mentioned before, in the present study, no tool was used to show the differences between the two: emotions that originated from trainees' own life experiences or emotions that are client related. This distinction can be vital while assessing the role of emotion regulation strategies.

4.3. The Moderating Role of the Suppression in the Relationship between the Supervisory and Therapeutic Alliance

Literature indicated the impacts of using suppression. For instance, a study found negative impacts of using suppression on social relationships as suppressors fail to engage in the necessary information to react properly to others (Richards & Gross, 2000). As the suppression comes late in the emotion-generating process, it necessitates continuous effort to control emotion response tendencies. Eventually, these continuous efforts may reduce cognitive resources that can be useful for interactions in the social contexts that involve emotions (Gross & John, 2003). Both psychotherapy and supervision include social interactions therefore, it was hypothesized that a lower level of suppression moderated the relationship between supervisory alliance and therapeutic alliance. Results indicated that there was a significant moderation effect of suppression. Suppression improved the relationship between supervisory alliance and therapeutic alliance. Although there was a significant moderation effect, the third hypothesis was not supported.

Research in the literature indicated that suppression might have adaptive outcomes (Gross, 1998b). Also, processing emotions is an ongoing cycle which can change to fit an individual's needs and an urge for emotion regulation may arise (Sheppes & Suri, 2015). If we consider results from these points, trainees may use suppression in an adaptive way with the aim of conducting efficient psychotherapy sessions. Trainees have their own life experiences that they may feel happy or sad but in the professional context, trainees should silence their own agenda to focus on clients' issues. With respect to this, most research showed that expressive suppression is effective while decreasing the experience of positive emotion (Gross, 1998b; Gross & Levenson, 1993) and this might also diminish the behavioral part of positive emotion (Gross & John, 2003). Also, Gross and John (2003) indicated that suppression should be efficient in diminishing the expression of the behavioral part of negative emotion. Therefore, it may be useful to use suppression in order to get ready to listen to clients' issues. For instance, before the therapy, if the therapist feels happy and the client comes to therapy sadly and explains upsetting events, or if the therapist feels sad and the client comes to therapy happy and explains pleasant events, in order to be attuned and get in touch with to clients' feelings in an empathetic way, therapists' usage of suppression might be effective for the psychotherapy process. Also in the same way, while carrying on client's issues (e.g., traumatic experiences) into the supervision context showing emotionally attuned work with the client might be crucial to have a supervisory alliance. Thus, maybe the therapist's suppression of their own emotions prior to entering the therapy may not be maladaptive but suppressing therapy-induced emotions may be maladaptive because this might prevent the therapist to work with the supervisor on blind spots, defenses, and countertransference to the clients. Research in this area indicated that therapists'

capacity to manage negative countertransference may lead them to conduct deeper sessions and develop a better alliance with their clients as compared to therapists that are acting out their countertransference (Gelso et al., 2002).

Gross and John (2003) indicated that suppression should be efficient in diminishing the expression of the behavioral part of negative emotion, but when negative emotions were suppressed, the experience of negative emotions was intact (Gross & Levenson, 1997; Strack et al., 1988). It may be adaptive for therapists to use suppression to regulate their negative emotions because while the client is talking about negative experiences, it might be important for the therapeutic relationship that the therapist exhibits a more neutral behavior while listening to these negatives. Instead, sharing clients' emotions and experiencing negative issues from a professional perspective can strengthen the therapeutic relationship. Accordingly, it might be important to decide whether using suppression as an emotion regulation is useful or not, it might be helpful to look at the context.

Culture-specific studies demonstrated cultural differences also play a role in using suppression. Studies showed that suppression was linked with negative consequences but most of these studies were done in European-American samples that are identified as individualistic cultures where emotional expression is favorable (Butler et al., 2009; Soto et al., 2005). On the other hand, studies demonstrated the adaptive function of suppression in East Asian cultures (Yuan et al., 2014) such as using suppression in emotional acting to keep away from hurting others and provide relational harmony (Butler et al., 2009; De Leersnyder et al., 2013; Matsumoto et al. 2008; Soto et al., 2005; Wierzbicka, 1994). Also, studies done in East Asian cultures showed that suppression was linked with lower levels of negative emotion experience,

better social relations, and better physiological response (Butler et al., 2007; Mauss & Butler, 2010; Soto et al., 2011).

4.4. Limitations of the Present Study and Suggestions for Future Studies

The present study has some limitations despite efforts to take the necessary steps. Firstly, there are limitations that include issues with the sample. In the present study, 78 clinical psychology trainees participated. Although bootstrapping analysis which is an acceptable method to use in small samples (Scholz, 2007; also see Hayes, 2017), it would be better to have a larger sample size. Moreover, the study included 10 male and 68 female clinical psychology trainees thus, the number of male participants is quite less than the number of female participants. This gap between the number of female and male participants may be since females are more inclined to apply for clinical psychology graduate programs (Fowler et al., 2018). This might also mean that most clinical psychologists are females. Hence, it might not be a major problem in terms of external validity. Also, in the present study, the convenience sampling method was used to collect data. In order to increase the representativeness of the study, e-mails were sent to the department professors that were from many private and public universities in Turkey, but these are limited to the participants we can reach.

Secondly, some limitations include issues with the data collection. In the present study, self-report measures were used to collect data. Although self-report is one of the most powerful tools to measure subjective topics such as attitude and emotion (Gerald & George, 2010), data can be collected from other aspects as well. In addition, the current study only examined the trainees' perspective. Therefore, future studies can use both qualitative and quantitative measures and conduct a longitudinal study with follow-up measures that also include supervisor and client perspectives.

Since the relationship includes a dynamic process, if data is collected from the trainee, client, and supervisor at certain session intervals, the relationship process can be understood more deeply.

Thirdly, there is limited research on the role of emotion regulation strategies in training therefore, in the present study, two emotion regulation strategies were investigated in the therapy and supervision context to expand understanding of the related topic. Gross (1998a) indicated that there might be substantial variation in emotion regulation processes in different emotions. Therefore, future studies may identify specific emotions and examine emotion regulation strategies with identified emotions in the context of therapy and supervision. Also, future studies may consider the role of distraction, which is an earlier emotion regulation strategy, that might be more effective when the required time to use reappraisal is severely limited (Sheppes & Meiran, 2007; Sheppes & Gross, 2011). Also, in the present study, no tool was used to understand the differences between emotions that are client-related and trainees' own emotions. Thus, it might be important to differentiate between the two. In addition, it might be essential to understand conscious and unconscious processes of regulating emotions. Future studies may diversify emotion regulation strategies, including conscious and unconscious processes, to compare their differences.

Fourthly, in the present study, the most frequently chosen supervisor was the group supervisor to evaluate supervisory alliance. While trainees establish a one-to-one relationship with their client, a relationship is established with the supervisor in the presence of other people. Other people may affect the emotion regulation strategies used in the relationship with the supervisor. Future studies can divide participants into two groups: trainees that are receiving individual supervision or group supervision, and it can be investigated whether there is a difference in emotion

regulation strategies used between the two groups. In addition, other studies may focus on group dynamics to expand our knowledge of how the existence of others influences individuals. At this point, future studies may focus on the dynamics of both group therapies and group supervision.

Fifthly, most participants carried out online psychotherapy and supervision sessions because the data was collected during the pandemic process. Sucala et al. (2013) indicated that clinicians stated less confidence in their ability to establish an alliance in E-therapy when compared with face-to-face therapy. Although the current study presents a unique perspective, it might be difficult to generalize research findings to other conditions. Future studies may examine alliances under different conditions.

4.5. Conclusion and Practical Implications

In conclusion, the present study was conducted with clinical psychology trainees that aimed to expand the understanding of the supervisory and therapeutic alliance in training by considering the moderating role of reappraisal and suppression. It was found that there is a positive relationship between supervisory alliance and therapeutic alliance which may suggest there is a parallel process between the supervisory alliance and therapeutic alliance that includes triadic relationships. Also, results indicated that there was no significant moderation effect of reappraisal but there was a significant moderation effect of suppression. Suppression improved the relationship between supervisory alliance and therapeutic alliance. Results may imply that the adaptiveness of emotion regulation strategies is not universal. Although reappraisal is generally more adaptive than other strategies, under certain circumstances using reappraisal may not be the most adaptive option. Also, the results

underline the importance of looking at the context to decide whether using reappraisal and suppression as an emotion regulation is useful or not.

The present study also underlines the cruciality of therapists' emotional functioning and the influence of their emotions on the therapeutic work and supervision context. The findings of the present study may contribute to clinical psychology master's programs which is the period that trainees experience the transition to mental health expertise. Barlow et al. (2017) stated that identification, toleration, and regulation of emotions are therapeutic skills. Hence, in addition to improving students' practical skills, adding courses to the master's programs (e.g., mindfulness) where clinical psychology trainees can realize their emotion regulation skills can be useful as well.

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APPENDICIES

Appendix A: Informed Consent

Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

Bu araştırma Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı bünyesinde Dr. Öğretim Üyesi Ayşe Berna Sarı Arasıl danışmanlığında Tuğçe Yıldız tarafından bir tez çalışması kapsamında yürütülmektedir. Çalışmada süpervizyon kapsamında danışan gören klinik psikoloji yüksek lisans öğrencilerinin tutumlarına ilişkin bilgi edinilmesi amaçlanmaktadır. Katılımınızla sizler de ilgili literatüre katkıda bulunmamıza yardımcı olacaksınız. Çalışmada demografik bilgiler, klinik psikoloji eğitiminiz, süpervizyon süreciniz, yürüttüğünüz terapi süreci ve duygu durumlarınıza yönelik anket soruları bulunmaktadır. Çalışmanın yaklaşık olarak 10-15 dakika süreceği öngörülmektedir. Anket sorularının katılımcılarda olumsuz etkiler yaratacağına dair bir veri rapor edilmemiştir. Ancak çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmayı bırakma hakkına da sahipsiniz. Araştırmanın amacına ulaşması için sizden beklenen, bütün soruları eksiksiz ve size en uygun gelen cevapları işaretleyecek şekilde doldurmanızdır.

Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Bu formu okuyup onaylamanız araştırmaya katılmayı kabul ettiğiniz anlamına gelmektedir. Ancak yukarıda da belirtildiği gibi çalışmadan istediğiniz anda ayrılma hakkına sahipsiniz. Bu çalışmadan edinilecek bilgiler tamamen bilimsel araştırma amacıyla kullanılacaktır, kimlik bilgileriniz istenmeyecek ve verdiğiniz bütün kişisel bilgiler gizli tutulacaktır.

Eğer araştırmanın amacı ile ilgili verilen bu bilgiler dışında daha fazla bilgiye edinmek veya araştırma sonuçlarına ulaşmak isterseniz araştırmacının e-posta adresine mail atabilirsiniz.

Yukarıda yer alan bilgileri okudum ve katılmam istenen çalışmanın amacını ve gerekliliklerini anladım. Çalışmaya gönüllü olarak katılmayı kabul ediyorum.

Appendix B: Demographics and Training-related Information Form

1. Yaşınız:

2. Cinsiyetiniz:
   - Kadın
   - Erkek
   - Diğer

3. Klinik psikoloji yüksek lisans eğitiminizin kaçıncı senesindesiniz?
   - ----------

4. Şu anda toplam kaç danışan takibi yapıyorsunuz?
   - ----------

5. Bir haftada ortalama kaç seans yapıyorsunuz?
   - ----------

6. Hangi terapi yaklaşımını kendinize daha yakın hissediyorsunuz?
   - Adlerian Psikoterapi
   - Bilişsel Davranışçı Terapiler
   - Birey Merkezli
   - Davranışçı Terapiler
   - EMDR
   - Gestalt Terapi
   - İlişkisel Terapi
   - Jungian Psikoterapi
   - Psikodinamik Psikoterapi
   - Psikanaliz
   - Varoluşçu
   - Şema Terapi
   - Diğer ---------- (lütfen belirtiniz)

7. Süpervizyonu ne şekilde alıyorsunuz?
   - Bireysel Süpervizyon
   - Grup Süpervizyonu
   - Hem bireysel hem de grup süpervizyonu

8. Kaç haftadır süpervizyon alıyorsunuz?
   - ----------

9. Şimdiye kadar süpervizyon altında toplam kaç seans yaptınız?
   - ----------

Appendix C: The Turkish Working Alliance Inventory – Therapist Form

Lütfen aşağıdaki ifadeleri **en az 3 seans** yaptığınız, **herhangi 1 danışanınızla** gerçekleştirdiğiniz **tüm seansları düşünerek** doldurunuz.

		1. Hiçbir zaman	**2. Çok seyrek**	**3. Seyrek**	**4. Bazen**	**5. Sık sık**	**6. Çok sık**	**7. Her zaman**
1.	Hastamla kendimi rahat hissetmiyorum.							
2.	Hastam ve ben, sorunlarının düzelmesi için terapide neler yapması gerektiği konusunda aynı şekilde düşünüyoruz.							
3.	Bu görüşmelerin sonucunda ne olacağı konusunda endişelerim var.							
4.	Hastam ve ben, terapide yaptıklarımızın işe yaradığına inanıyoruz.							
5.	Hastamı anladığımı düşünüyorum.							
6.	Hastam ve ben, onun terapiden neler beklediği konusunda hemfikiriz.							
7.	Hastam terapide yaptıklarımızı kafa karıştırıcı buluyor.							
8.	Hastamın bana yakın hissettiğine inanıyorum.							
9.	Hastam için görüşmelerimizin amacını netleştirmeye ihtiyacım var.							
10.	Terapiden ne elde etmesi gerektiği konusunda hastamla aynı fikirde değiliz.							
11.	Hastamla zamanı etkin kullanmadığımıza inanıyorum.							

12.	Terapide neye ulaşmak istediğimiz konusunda şüphelerim var.							
13.	Hastamın terapide üzerine düşenlerin ne olduğunu bildiğine eminim.							
14.	Bu görüşmelerin amaçları hastam için önemli.							
15.	Terapide yaptıklarımızın, hastamın sorunlarıyla ilişkili olmadığını düşünüyorum.							
16.	Terapide yaptıklarımızın, hastamın istediği değişikliklere ulaşmada ona yardımcı olacağını hissediyorum.							
17.	Hastamın iyiliğini gerçekten düşünüyorum.							
18.	Görüşmelerde hastamdan ne beklediğimi biliyorum.							
19.	Hastam ve ben birbirimize saygı duyuyoruz.							
20.	Hastama gösterdiğim duygularımda tam olarak dürüst olmadığımı hissediyorum.							
21.	Hastama yardım edebileceğime inanıyorum.							
22	Hastam ve ben, ortak hedeflerimize doğru ilerliyoruz.							
23.	Hastamı takdir ediyorum.							
24.	Hastam için neyin üzerinde durmamızın daha önemli olacağı konusunda hemfikiriz.							
25.	Hastam bu görüşmelerin sonunda neler yaparak değişebileceğini daha iyi anladı.							
26.	Hastam ve ben birbirimize güveniyoruz.							
27.	Hastam ve ben sorunlarının neler olduğu konusunda farklı düşünüyoruz.							
28.	İlişkimiz hastam için çok önemli.							
29.	Hastamın, eğer yanlış şeyler söyler ya da yaparsa, benim terapiye							

	devam etmeyeceğime dair korkuları var.							
30.	Görüşmelerin amaçlarını belirleme konusunda hastam ve ben iş birliği içindeyiz.							
31.	Hastam terapide yapmasını istediğim şeylerden dolayı yerinde saydığını hissediyor.							
32.	Ne tür değişikliklerin onun yararına olacağı konusunda anlaşmaya vardık.							
33.	Terapide yaptıklarımız hastama anlamlı gelmiyor.							
34.	Hastam terapinin sonucunda neye ulaşacağını bilmiyor.							
35.	Hastam sorununu ele alma yollarımızın doğru olduğuna inanıyor.							
36.	Onaylamadığım şeyler yapsa da hastama olan saygım devam eder.							

- Yukarıdaki değerlendirmeyi yaptığınız danışanınızla toplam kaç seans yaptınız?
  - ----------

- Yukarıdaki değerlendirmeyi yaptığınız danışanınızla görüşmeleri nasıl yapıyorsunuz?
  - Yüz yüze
  - Çevrimiçi
  - Hem yüz yüze hem de çevrimiçi

❖ Lütfen bir sonraki ölçeği yukarıdaki değerlendirmeyi yaptığınız danışanınızı götürdüğünüz **1 süpervizörünüzü** düşünerek yanıtlayınız.

Appendix D: Short Form of Turkish Working Alliance Inventory – Supervisee Form

Lütfen aşağıdaki ifadeleri bir önceki ölçeği doldururken **seçtiğiniz 1 danışanınızı götürdüğünüz süpervizörünüzle** yaptığınız **tüm görüşmelerinizi** düşünerek doldurunuz.

		1. Benim için hiç doğru değil	**2. Benim için doğru değil**	**3. Benim için biraz doğru değil**	**4. Kararsızım**	**5. Benim için biraz doğru**	**6. Benim için doğru**	**7. Benim için kesinlikle doğru**
1.	Süpervizörüm ve ben, ortak hedeflerimize doğru ilerliyoruz.							
2.	Süpervizyonda yaptıklarım, sorunlarımla ilgili yeni bir bakış açısı kazandırıyor.							
3.	Süpervizörümün kendisini bana yakın hissettiğine inanıyorum.							
4.	Benim için neyin üzerinde durmamızın daha önemli olacağı konusunda hemfikiriz.							
5.	Süpervizyonda yaptıklarımın, istediğim değişiklikleri elde etmemde bana yardımcı olacağını hissediyorum.							
6.	Süpervizörüm ve ben birbirimize saygı duyuyoruz.							
7.	Süpervizörüm ve ben, hedef belirlerken iş birliği içerisindeyiz.							
8.	Süpervizyon ile neler yaparak değişeceğimi daha iyi anladım.							
9.	Süpervizörümün beni takdir ettiğini hissediyorum.							

10.	Ne tür değişikliklerin benim yararıma olacağı konusunda anlaşmaya vardık.							
11.	Süpervizyonda sorunları ele alma yollarımızın doğru olduğuna inanıyorum.							
12.	Onun onaylamadığı şeyler yaptığımda da süpervizörümün beni önemsediğini hissediyorum.							

- Değerlendirmeyi yaptığınız süpervizörünüz aşağıdakilerden hangisi?
    - Bireysel Süpervizörüm
    - Grup Süpervizörüm

- Yukarıda değerlendirmeyi yaptığınız süpervizörünüzle seçtiğiniz 1 danışanınızla ilgili toplam kaç görüşme yaptınız?
    - ----------
- Süpervizörünüzle hangi yaklaşımı veya yaklaşımları kullanıyorsunuz?
    - Adlerian Psikoterapi
    - Bilişsel Davranışçı Terapiler
    - Birey Merkezli
    - Davranışçı Terapiler
    - EMDR
    - Gestalt Terapi
    - İlişkisel Terapi
    - Jungian Psikoterapi
    - Psikodinamik Psikoterapi
    - Psikanaliz
    - Varoluşçu
    - Şema Terapi
    - Diğer ---------- (lütfen belirtiniz)

- Yukarıda değerlendirmeyi yaptığınız süpervizörünüzle görüşmeleri nasıl yapıyorsunuz?
    - Yüz yüze
    - Çevrimiçi
    - Hem yüz yüze hem de çevrimiçi

Appendix E: Emotion Regulation Questionnaire

Size duygusal yaşamınızla özellikle de duygularınızı nasıl kontrol ettiğiniz (yani düzenlediğiniz ve yönettiğiniz) ile ilgili sorular sormak istiyoruz. Aşağıdaki sorular duygusal yaşantınızın iki farklı yönünü kapsamaktadır. Birisi duygusal deneyiminiz ya da içinizde ne hissettiğinizdir. Diğeri duygusal ifadeniz ya da konuşma, el kol hareketleri yapma ve davranma şeklinizde duygularınızı nasıl gösterdiğinizdir. Aşağıdaki soruların bazıları size benzer görünebilir fakat önemli açılardan farklıdırlar. Her bir madde için, lütfen aşağıdaki ölçeği kullanarak cevap veriniz. Her bir ifadenin sizi ne ölçüde tanımladığını aşağıdaki 7 aralıklı ölçek üzerinde değerlendiriniz.

		1. Kesinlikle aynı fikirde değilim	**2.**	**3.**	**4. Kararsızım**	**5.**	**6.**	**7. Kesinlikle aynı fikirdeyim**
1.	Daha olumlu duygular hissetmek istediğimde (keyif veya eğlence gibi) düşündüğüm şeyi değiştiririm.							
2.	Duygularımı kendime saklarım.							
3.	Daha az olumsuz duygu hissetmek istediğimde (üzüntü ve öfke gibi) düşünüyor olduğum şeyi değiştiririm.							
4.	Olumlu duygular hissettiğimde onları ifade etmemeye özen gösteririm.							
5.	Stresli bir durumla karşılaştığımda sakin kalmama yardım edecek biçimde düşünmeye çalışırım.							
6.	Duygularımı onları açıklamayarak kontrol ederim.							

7.	Daha fazla olumlu duygu hissetmek istediğimde, içinde bulunduğum durum hakkındaki düşünme biçimimi değiştiririm.							
8.	Duygularımı içinde bulunduğum durumla ilgili düşünme biçimimi değiştirerek kontrol ederim.							
9.	Olumsuz duygular hissediyorsam kesinlikle onları ifade etmem.							
10.	Daha az olumsuz duygu hissetmek istediğimde durumla ilgili düşünme biçimimi değiştiririm.							

Appendix F: Debriefing Form

Katılım Sonrası Bilgilendirme Formu

Klinik psikoloji yüksek lisans öğrencileri, süpervizyon kapsamında danışan takibi yaparak ruh sağlığı uzmanlığına geçiş yaptıkları bir dönem deneyimlemektedirler. Öğrenciler danışan takibi yaptıkları bu süreçte birçok olumlu ve olumsuz duyguyla karşılaşmaktadır. Kişisel ve mesleki gelişimin gerçekleştiği bu süreçte süpervizörün rolünün önemi saptanmıştır. Psikoterapi süpervizyonu, süpervizörün terapisti bir veya daha fazla danışanla çalışmasında yeterliliğini geliştirdiği, terapötik durumlarla başa çıkmada bilgi ve deneyim kazanmasında yardımcı olduğu terapist-danışan, süpervizör-terapist ilişkilerini içeren üçlü bir süreçtir. Katılmış olduğunuz araştırmada süpervizörle olan ittifak ile terapötik ittifak arasındaki ilişkiyi duygu düzenleme stratejilerinin düzenleyici rolünün incelenmesi amaçlanmaktadır. Bu amaçla sizden terapötik ittifak, süpervizyon ittifakı ve duygu düzenleme stratejilerine yönelik anketler doldurmanız istenmiştir.

Kişisel bilgileriniz ve test sonuçları bilimsel ve mesleki etik ilkeleri çerçevesinde korunacak, anket sonuçları toplu olarak yorumlanıp yalnızca bilimsel yayın amacıyla toplu bilgiler halinde paylaşılacaktır. Çalışma hakkında daha fazla bilgi almak isterseniz araştırmacıya aşağıdaki e- posta adresinden ulaşabilirsiniz.

Katılımınız için teşekkür ederiz.

Appendix G: Yeditepe University Social and Human Sciences Ethical Committee

T.C.
YEDİTEPE ÜNİVERSİTESİ REKTÖRLÜĞÜ

27.05.2021

Sayı : E.50532705-302.01.01-107
Konu : Tuğçe Yıldız Kurul Onayı

İLGİLİ MAKAMA

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji Öğrencisi Tuğçe Yıldız'ın "Supervisory and therapeutic alliance among clinical psychology trainees: The moderating role of emotion regulation strategies" başlıklı araştırma önerisinin beşeri bilimler etik standartlarına uygunluğuna ilişkin Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurul Onayı ekte sunulmuştur.

Gerekli iznin verilmesi hususunu bilgilerinize arz ve rica ederim.

İmza
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