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## The growth and development of novice family counselors theory to practice

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*William & Mary - School of Education*

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THE GROWTH AND DEVELOPMENT OF NOVICE FAMILY COUNSELORS  
THEORY TO PRACTICE

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A Dissertation

Presented to

The Faculty of the School of Education  
The College of William & Mary in Virginia

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In Partial Fulfillment

Of the Requirements for the Degree of  
Doctor of Philosophy

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by

Denyse B. Doerries

June, 1999

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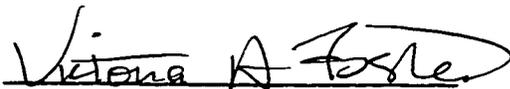
THE GROWTH AND DEVELOPMENT OF NOVICE FAMILY COUNSELORS:  
THEORY TO PRACTICE

by

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## **ABSTRACT**

### **GROWTH AND DEVELOPMENT OF NOVICE FAMILY COUNSELORS: THEORY TO PRACTICE**

The purpose of this study was to provide an in-depth description of the development of novice family counselors as they progressed through a nine month internship in a counseling graduate program. Six novice family counselors provided videotapes of their counseling sessions with "real life" families as well as written responses to questions concerning their conceptualizations, perceptions and therapeutic interventions. Qualitative methods were used to describe, analyze and interpret the novice counselors' growth and development over time. The counselors began the year with relatively strong generic person-centered counseling skills. They added a greater number of structuring and restructuring strategies, increased the dialogue between family members, attended more closely to the parental subsystem and generally became more aware of the need to focus on patterns of interactions. The course of the counselor's development was influenced by the interaction of the following factors: the nature of the family's problems, the number of sessions with the family, the counselor's ability to connect with the family, the amount of instruction and supervision the counselor received, the counselor's personal approach, the nature of the referrals, as well as the counselor's prior experience with theories of individual counseling.

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## Chapter One

### Introduction

#### Statement of the Problem

Although outcome research in family therapy has proven its efficacy (Avis & Sprenkle, 1990; Gurman, Kniskern & Pinsof, 1986; Shadish, Ragsdale, Glaser & Montgomery, 1995), the results of research on the training of novice family counselors have been more equivocal (Anderson, 1992; Avis & Sprenkle, 1990; Kniskern & Gurman, 1988; Liddle, 1991). Both graduate and post graduate training in family therapy have demonstrated improvement in the trainees' conceptual skills (Greenberg & Neimyer, 1986; Pulleybank & Shapiro, 1986; Tucker & Pinsof, 1984). However, it is less clear that training improves the application of these skills to therapeutic interventions because few studies assessed these skills in actual family therapy settings (Anderson, 1992; Avis & Sprenkle, 1990). Because the research in family therapy training has focused on the acquisition of conceptual knowledge and training sequences, little information has been discovered about how or if change occurs in the "doing" of family therapy by novice family counselors as a result of their training (Anderson, 1992; Avis & Sprenkle, 1990; Friedlander, Wildman, Heatherington & Skowron, 1994). There has been an absence of rich, descriptive data in the family therapy literature which examines the actual experience of being trained as a family

therapist (Skovholt & Ronnestad, 1992). Given the proliferation of graduate school programs in family therapy (Anderson, 1992; Gurman & Kniskern, 1992; Piercy & Sprenkle, 1984), there is a pressing need to examine the development of novice family counselors in order to describe the growth and change which occurs over the course of their training (Liddle, 1991).

### Introduction

The growth of family counseling within the clinical community has been extraordinary (Gurman & Kniskern, 1992; Home, Dagley & Webster, 1993). It has now become firmly entrenched in the psychotherapy professions of counseling, psychology, social work, psychiatry and other mental health professions (Gurman & Kniskern, 1992). It boasts one of the fastest growth rate of adherents in the mental health community (Home, Dagley & Webster, 1993; Nichols, 1996). Since the inception of family therapy as a separate, distinct theory and practice in 1952, training typically occurred through non-degree programs such as clinical workshops, supervised practice, or as a post graduate experience (Broderick & Schrader, 1991). More recently, because of the requirements for certification established by the American Association for Marriage and Family Therapy (AAMFT) in 1979, and the advent of a standard examination for in marital and family therapy in 1989, it appears that only those professionals who have graduated from a university based family therapy program will be able to be licensed as family therapists (Christensen, Brown, Rickert & Turner, 1989; Gurman & Kniskern, 1992; Touliatos, Lindholm & Nichols, 1997). Because of this trend and its popularity, there has been a

proliferation of two year master's degree programs in family counseling which attempt to provide the essential courses and experiences for family counselors (O'Sullivan & Gilbert, 1989). However, there continues to be a need to more clearly define the essential courses and distinct clinical experiences necessary for the development and training of competent family counselors (Gurman & Kniskern, 1992).

Traditionally, the role of counselor requires the integration of both cognitive and affective skills, usually with regard to an client's presenting problem (Blocher, 1983). Family counselors have an even more complex task because the focus changes from the individual to the interactions between and among individuals within a family. Family counselors must make a conceptual shift from thinking about individuals to thinking about systems (Home, Dagley, & Webster, 1993). Historically, family therapy trainers have been concerned with being able to prepare students to integrate the perceptual-conceptual aspects of therapy with the therapeutic aspects. The perceptual-conceptual skills refer to thinking about therapy and the therapeutic skills are related to conducting the counseling (Tomm & Wright, 1979; West, Bubenzer, Pinsoneault & Holeman 1993). Attempts to match the perceptual-conceptual skills with therapeutic intervention skills through a course curriculum were made by Tomm & Wright (1979) with limited success. The issue of making meaning out of complex interactional data and integrating specific findings into therapeutic strategies has been a family counseling training issue which demands continued examination.

Family

counseling, itself, has been found to be an effective intervention with a wide

range of child related problems (Gurman, Kniskern, & Pinsof, 1986; Shadish, Ragsdale, Glaser, & Montgomery, 1995). Gurman, et al., (1986) found that 71% of childhood and adolescent behavior problems showed improvement when treated through family counseling. Yet, the field continues to struggle to identify key ingredients for the practice of successful family counseling and the training needed for such (Figley & Nelson, 1990). Efficacy research has evaluated the effectiveness of family counseling but has not reliably described the events that make up the process of family counseling (Pinsof, 1981). Change in the conceptual skills of counselors is difficult to assess particularly with regard to the interaction between conceptual skills and therapeutic skills (Pinsof, 1981). The actual development of the novice family counselors with regard to their application of conceptual, perceptual and therapeutic skills as they participate in the therapy process has been suggested as an area which has potential for investigation through an experiential approach (Liddle & Saba, 1982).

### Family Systems Theory

“Family is the primary context of human experience from cradle to grave (Mikesell, Lusteran & McDaniel, 1995, p.xiii). Until the 1950s psychological theories of human development and counseling were primarily concerned with the individual (Gale & Long, 1996). Psychoanalysis was the preferred therapy applied by clinicians and it was dominated primarily by psychiatry (Gale & Long, 1996). Psychoanalysis was mainly concerned with individual psychodynamics and how it related to emotional and mental disorders (Shields, Wynne, McDaniel & Gawinski, 1994). World War II created a need for therapies which were more

effective in a shorter period of time and an opportunity for practitioners of other disciplines to address mental health needs (Gale & Long, 1996). After World War II, as society became more complex given the advances in technology and industry, an awareness of a need for more multifaceted and complex theories of human development emerged (Mikesell, Lusteran & McDaniel, 1995).

Counseling theories that assumed the source of the problem lay within the individual (intrapsychic theories) gave little mention to the reciprocal nature of the person and their environment. Such intrapsychic models that focus on the development of the individual in isolation from their context were limited in their contribution to the understanding of the nature of human development with regard to the effect of the inter-relationships between the person and his/her context or environment (Bronfenbrenner, 1995). When examining the issues related to children's development, the importance of understanding the influences of environments, the effects of the child's attributes on these environments and the reciprocal nature of these relationships is even more apparent (Atkinson, Heath & Chenail, 1991; Bronfenbrenner, 1995; Fine, 1992). The adoption of a multilevel, multisystems approach more effectively addresses the complex problems of the real world (Henggeler, Schoenwald, & Pickrel, 1995). Family systems theory offers a different way of explaining, describing and locating problems as well as a different focus of treatment (Anderson, 1994).

### Family Systems

#### Therapy

Family counseling emerged as an alternative to the traditional individual focused paradigms for thinking about the

development and treatment of problems of children, adolescents, and adult schizophrenics (Atkinson, Heath & Chenail, 1991). Family counseling as an intervention model takes an interpersonal perspective as opposed to an intrapsychic perspective. It views and treats individuals and events within their societal, environmental and familial context (Liddle & Saba, 1982). The emphasis is on strengths, interaction patterns and structures. These methods are often referred to as family systems counseling/ therapy (Becvar & Becvar, 1988). Rather than exploring the why or origin of the behavior within the individual, the counselor attends to the patterns of interaction currently occurring within a family (Liddle & Saba, 1982). This paradigm provides a useful tool for helping counselors see the patterns, processes, and transactions of the family (Becvar & Becvar, 1988; Nichols & Schwartz, 1995). The family systems paradigm broadens the counselors' view to attend to the nature and role of individuals in their primary relationships. Emphasis is on empowering people and developing their competencies rather than on delineating psychopathology (Waters & Lawrence, 1993). Family systems theory presents a non-linear, dynamic, complex thinking style that is the basis for understanding and development of treatment strategies ( Liddle & Saba, 1982; Becvar & Becvar, 1988). Systemic thinking is a way of conceptualizing a problem which uses circular thinking to evaluate patterns of interactions within a system and between systems (Goldenberg & Goldenberg, 1996).

Not only did family systems counseling introduce a conceptual paradigm shift, but it also implemented a revolutionary way to train therapists (Anderson,

1994). The use of one way mirrors and videotape techniques, afforded more opportunities for observation of the therapy process and significantly influenced the theory, practice and training in psychotherapy (Anderson, 1994). An often overlooked part of family counseling has been the willingness of its practitioners to have their work observed by supervisors, trainees and workshop audiences, a distinct departure from the practice of traditional, individually oriented therapies (Shields, Wynne, McDaniel, & Gawinski, 1994).

#### Research in Family Counseling Training Programs

As family therapy theory developed concepts and models of intervention, more attention was focused on research in training and preparation of family therapists (Avis & Sprenkle, 1990; Liddle, 1991). The integration of theory and clinical practice comes together in the training provided to the students of family counseling. Over the past 20 years the research on training novice family counselors examined the content of course work, number of skills acquired and concepts mastered (Anderson, 1992; Avis & Sprenkle, 1990; Liddle, 1991; Liddle & Saba, 1982). The focus of this research was on more clearly defining and delineating concepts and theoretical approaches rather than the integration and application of concepts and therapeutic skills within the therapeutic environment (Avis & Sprenkle, 1990; Liddle, 1991). Acquisition of skills is an important training component, but once learned they must be applied systematically and intentionally which involves the counselor's thought processes or conceptualizations (Fuqua, Johnson, Anderson & Newman, 1984).

In a comparative review of the literature on training and supervision, Liddle and Halpin (1978) noted that of 100 studies, most were theoretical or descriptive studies of training programs. Very few of these studies were related to the evaluation of the training programs or to the description of skills that were actually learned through the programs. Clinical impressions and self reports were the major source of information in these studies ( Liddle & Halpin, 1978). Avis and Sprenkle (1990) found that in 15 studies on training of novice family therapists that were not included in the original Liddle and Halpin (1978) study, six focused on the development of instruments which could evaluate the outcome of training programs by distinguishing experienced from inexperienced family therapists and nine evaluated training programs mainly through self report or trainer reports. Of these 15 studies, two are of particular interest because of their investigation into the perceptual-conceptual aspects of training.

These two studies evaluated the training of family counselors by measuring the cognitive acquisition of the perceptual and conceptual knowledge of the novice counselors (Greenberg & Neimeyer, 1982; Pulleybank & Sharpapiro, 1986). These studies also attempted to assess the therapeutic skills of the novice counselors but found problems with inadequate measurement instruments and poorly defined skills. These studies concluded that conceptual development and therapeutic skills did not necessarily follow the same course and cannot be assumed to be one and the same. These skills, therefore, need to be evaluated separately and in interaction with each other but not assumed to be equivalent (Anderson, 1992; Liddle, 1991). That a novice family counselor has

learned to conceptualize family problems in a systemic way does not predict how he/she will integrate this into therapeutic interventions with families. Further, measuring the quality of conceptualizations and their application to counseling is a daunting problem (Anderson, 1992; Avis & Sprenkle, 1990; Gurman & Kniskern, 1992; Liddle, 1991) .

Another difficulty noted in research on the impact of training on novice therapists was that the counseling context in which the skills are practiced is in constant change and, therefore, does not provide a standard stimulus (families) against which to measure improvement (Avis & Sprinkle, 1990). Observing, recording, and describing actual behaviors of novice counselors is very labor intensive and time consuming. Thus, the research on the training of novice family counselors has, for the most part, maintained a focus on quantifying the content of training rather than examining what occurs in the therapy room (Avis & Sprenkle, 1990, Friedlander, Wildman, Heatherington & Skowron, 1994).

An important question concerning the training of family counselors then is whether the academic program or curriculum actually meets the training needs of novice family counselors (Horne, Dagley & Webster, 1993). In order to promote competency, training in family counseling should emphasize conceptual development, skill development, and the integration of the both when being applied in the therapeutic setting (L'Abate & Collondier, 1987). Because of the increased conceptual complexity required in order to implement a systems approach to counseling, the training of beginning family counselors ideally should occur within a framework that promotes the integration of conceptual

development and skills acquisition (Fuqua, et al., 1984; Liddle & Saba, 1982). The context or curriculum within which training of family counselors occurs should address the processes needed to promote the development of complex conceptualizations. Such a curriculum would be consistent with a trend in social sciences which attempts to understand human behavior through a cognitive perspective (Morran, Kurpius, Brack & Brack, 1995).

Literature in conceptual development generally looks at either how conceptual levels or developmental levels of counselors affects a variety of variables related to counselor performance or how to teach specific conceptual skills (Cummings, Hallberg, Martin, Slemon & Hiebert, 1990; Holloway & Wampold, 1986; Morran, Kurpius, Brack & Rozecki, 1994). These studies suggest a need to consider how specific instructional strategies can enhance conceptual development. Cognitive-behavioral theorists suggest the direct teaching of cognitive processes, particularly those processes such as hypothesis formation which seem more easily changed than other more stable conceptual processes (Fuqua, Johnson, Anderson & Newman, 1984). A curriculum designed to directly teach such skills as hypothesis formation would be one avenue to address the issue of enhancing conceptual complexity (Morran, Kurpius, Brack & Rozecki, 1994).

A different alternative is presented by cognitive developmental theories. Cognitive developmental theorists assume that psychological growth does not happen automatically, but can be stimulated given an adequate learning environment (Sprinthall, 1978). Rather than strategies to change specific

conceptual skills, cognitive developmental theorists examine the development of complex conceptual thinking. Researchers have found that a person's developmental stage predicts how they will function in complex helping roles such as counseling (Sprinthall & Thies-Sprinthall, 1983). Studies have found that by using a cognitive developmental curriculum, conceptual complexity can be increased in adults such as school counselors (Peace, 1995) and teachers (Reiman & Thies-Sprinthall, 1993). Training programs not only need to address the process and content of family counseling but the context within which the learning occurs (Avis & Sprenkle, 1990; Reiman & Thies-Sprinthall, 1993).

#### Rationale for the Study

Much of the research in the preparation of family counselors has focused on the perceptual-conceptual components to be included in course work, models of supervision, evaluation tools to help delineate experienced from inexperienced counselors and basic skills needed for novice counselors (Figley & Nelson, 1990; Heath, 1982; Liddle, Breunlin, Schwartz & Constantine, 1984; Pulleybank & Shapiro, 1986; Tomm & Wright, 1979). Because of the research in family therapy concepts and theoretical underpinnings, as well as the increased interest in becoming trained as a family counselor as evidenced by the dramatic growth of the International Association of Marriage and Family Counselors (Home, Dagley & Webster, 1993), a number of family therapy training models have been created (Christensen, Brown, Rickert & Turner, 1989; Smith, 1993). There are now two standardized programs endorsed by professional associations, the Council for Accreditation of Counseling and Related Education Programs (CACREP) and

the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) ( Smith, 1993). These programs have established the number and type of courses to be taken and the concepts which need to be taught as well as the amount of supervision and counseling activities required to meet their respective certification requirements (O'Sullivan & Gilbert, 1989; Touliatos, Lindhom & Nichols, 1996). However, the number of training and education programs that meet these standards are still limited and family therapy training within counselor education programs is still in the early stages of development (Home, Dagley, & Webster, 1993). There is an obvious need for further examination of the development of novice family counselors in order to provide trainers with important information with regard to the application of skills and concepts in a therapeutic setting.

Problems in the inclusion of training family counselors in counselor education programs range from the challenge of making the conceptual shift from individual to systems thinking (Home, Dagley, & Webster, 1993) to theoretical questions regarding the form and content of family counseling training from proponents of constructivism, feminism, and cultural diversity (Smith, 1993). Challenges have also come from researchers who report that only fragmentary knowledge exists with regard to what family therapists do that leads to client improvement (Avis & Sprenkle, 1990).

Studies by Figley & Nelson (1989,1990) note that the family therapy literature provides some guidance for teachers of family counseling with regard to necessary skills for novice counselors but caution that these skills tend to be

theoretically based. These authors also note that because family therapy differs in both form and content from other counseling models, there is a pressing need to identify skills specific to family counseling. The theoretical structure for the training programs has been established, but questions continue concerning what skills and experiences are needed to become a competent family counselor (Figley & Nelson, 1990).

In order to validate generic counselor training programs it was necessary to study student acquisition of skills, which was found to be associated with positive counseling outcomes (Avis & Sprinkle, 1990). However, family counseling theory and research needs to go beyond the study of skill acquisition and examine how acquired skills and conceptualizations interact in the novice family counselor's development (Anderson, 1992, Friedlander, Wildman, Heatherington & Skowron, 1994). The literature on training family counselors has given little attention to the "lived" experience of being trained as a novice family counselor (Keller, Protinsky, Lichtman & Allen, 1996).

#### Personal Statement

As a family counselor and clinical supervisor, I have had both the experience of being trained as and training novice family counselors. My experiences have led me to believe it is a challenging process at both a professional and personal level. I believe that competent family counselors use all parts of themselves in integrating the perceptual-conceptual skills with their personal/emotional histories to create therapeutic interventions similar in form yet uniquely different depending on who they are as a person. The whole is

always greater than the sum of its parts. Therefore, observation of the novice family counselor's development over time in real life counseling sessions would provide much needed information on a complex, difficult to measure process.

### Purpose of the Study

The purpose of this study was to document the growth and development of novice family counselors who were trained in a university internship in structural family counseling. The family counseling internship was part of a counselor education program in which the cognitive developmental framework was an integral part of the curriculum. How the novice interns applied perceptual-conceptual processes to develop systemic hypotheses and establish a therapeutic alliance with the family was explored through observation of videotaped counseling sessions and through the interns' and instructors' responses to reflective questions. With this purpose in mind, the following questions were investigated through a qualitative design:

1. What do the interaction patterns of the novice family counselor look like and do these interaction patterns change over the period of the internship?
2. How do novice family counselors conceptualize family problems? Does this change over time?
3. What do the structuring and re-structuring skills of the novice counselor look like in counseling sessions? Do these change over time?
4. In what ways does the kind of interaction between the novice counselor and the family influence the counselor's behaviors and conceptualizations ?

This study provides rich, contextual information for trainers as well as novice therapists with regard to the assimilation of skills and concepts of family counseling and their application in counseling sessions. Factors which interacted with the learning process were also examined.

### Methodology

It is interesting to note that in the history of family counseling most of the major insights and theoretical models were created through informal, exploratory research (Moon, Dillon & Sprinkle, 1990). Early pioneers such as Minuchin and Haley engaged in up-close interviews and observations of families and applied their data to develop insights and a theoretical model which has since been verified through both empirical studies and by professional practitioners. A qualitative design is thus consistent with the philosophical underpinnings of family therapy in general.

The qualitative design of this study allowed for the experiences of the novice family counselors, their actions and interactions with families, to be documented. This study was a descriptive one which examined the verbal and non-verbal interactions of novice counselors, as they worked toward developing perceptual-conceptual and therapeutic skills during family counseling sessions. The novice family counselors were enrolled in a two semester family counseling internship class in a graduate program in counseling at Pine Tree College. The *primary data collection methods* were videotaped observations of the novice family counselors during therapy sessions with families and written responses of the counselors to reflective questions both before and after the counseling

session. The novice counselors were asked to respond to questions which reflected their conceptualizations of the family problems, their systemic hypothesis about the interactional patterns in the family, the strengths of the family and their goals and intervention strategies for the family. The instructors of their internship class were also asked for written responses to reflective questions concerning the development of these novice family counselors.

Observation has been used as a strategy to study the clinical supervision process in family counseling (Keller, Protinsky, Lichtman & Allen, 1996). That team of researchers used videotapes to examine the themes which emerged during the supervision between clinical supervisors and supervisee's (Keller, et al., 1996). This study of the development of novice family counselors used observation of the videotapes of the interns (novice family counselors) which were presented to the internship class. At least twice a semester each intern presented a family counseling case on which they needed assistance. The novice family counselor presented the case orally to the internship class, gave a written case summary, showed a clip of the videotape, and then discussed alternative strategies and conceptualizations with the instructor and peers in the class. The videotapes and case summaries were used as part of the data collected for this research. In addition, responses to the reflective questions included contextual information such as date, time of day, location of the counseling session, and kind of day the intern had prior to the session.

### Participants

The participants included six graduate students enrolled in the master's and doctoral programs in counseling at PineTree College who were enrolled in the family counseling two semester internship. All of these graduate students participated in a family counseling internship at the Family Counseling Center of Pine Tree College. The Family Counseling Center is a regional counseling program which receives from the public schools referrals of families whose children are exhibiting problems in school. The family counseling services are provided at no cost to the families but all members of the family are expected to attend the sessions and they must be willing to be videotaped for purposes of supervision, training and research. As a standard procedure prior to any counseling, the families sign an informed consent form.

In addition, the two instructors of the family counseling internship classes and seven professional family counselors from the community were asked to participate. Both instructors were also involved in the development of this proposal and had input into the design of the study. A group of seven experienced professional family counselors from an advanced clinical supervision group provided by a private community agency were asked to volunteer for participation in a Delphi study and focus group. These experienced family counselors all had been practicing in their profession for over 10 years. The focus group was asked to list the skills that they believed were the most important ones that novice family counselors need to learn during their internship. This list of skills were used to inform the data analysis. A volunteer from this group shared an example of his/her videotaped family counseling

sessions at the end of the study to provide the researcher with a realistic idea of what the experienced counselors meant by certain skills and techniques.

Two master family therapists were also interviewed because of their intimate involvement with Salvador Minuchin, the father of family therapy (Nichols & Schwartz, 1995). Each of these master therapists worked with Minuchin at different times during the development of family therapy and thus were able to provide important contextual information as to the history of structural family therapy.

It should be noted, that in this study “counseling” and “therapy” (psychotherapy) were considered interchangeable terms. Psychotherapy is “a primarily verbal means of helping troubled individuals change their thoughts, feelings, and behavior to reduce stress and to achieve greater life satisfaction” (Davidson & Neale, 1994, p.9). Counseling is “a series of direct contacts with the individual which aims to offer him assistance in changing his attitudes and behavior” (Rogers, 1942, p.3). The distinction between counseling and therapy has often been in reference to the intensity of the interaction. However as Carl Rogers so aptly stated, “while there may be some reason for this distinction, it is also plain that the most intensive and successful counseling is indistinguishable from intensive and successful psychotherapy (Rogers, 1942. p. 4).

### Data Analysis

A constant comparative analysis provided for a continuous and simultaneous collection and processing of data. From the initial analysis of observations, hypotheses concerning themes and categories were created but

were continuously refined throughout the process of data collection (Lincoln & Guba, 1985). As observations were constantly compared to previous observations and data, new hypotheses, themes and categories were created. Observational analysis of counselors' behaviors, both verbal and non-verbal was based on categories of structural family therapy skills derived from the research of Figley and Nelson (1990) and the responses from the focus group of experienced counselors. The Flanders Scale adapted for counselors by Fowler and Devivo (1988) was also used to categorize more generic counseling skills. In addition, discourse analysis that evaluated the themes of the dominant culture such as control, power, racial and ethnic diversity were part of the analysis (Hare-Mustin, 1994).

### Credibility

A doctoral student who studied the clinical supervision process by actually attending internship classes was asked to participate in this study as an informant. Two peer debriefers also participated. One of the debriefers was an expert in the area of videotape supervision and gave another perspective on the analysis of the videotapes. The second peer debriefer was not involved in any way with family counseling but functioned as a sounding board for the researcher's thoughts and ideas. Documentation of these discussions was done through a reflective journal.

Triangulation of the material in this study, which added trustworthiness to the data analysis, was achieved through the videotapes, the responses of the interns and the response of the instructors to the reflective questions.

### Bias Statement

My perceptions of the process of becoming a structural family therapist were shaped by my post graduate and graduate school experiences in preparing to be a family counselor as well as teaching and supervising beginning family counselors. For the past 12 years I have been actively involved in not only my own training but in establishing a training program for beginning family counselors. Last year my doctoral internship was devoted to creating and implementing a teaching curriculum for novice family counselors as well as providing clinical supervision for beginning family counselors. I brought with me both the experience of learning family therapy in different contexts and also teaching structural family therapy. These experiences sensitized me to the personal and professional challenges that beginning structural family counselors must confront.

Although my experiences assisted me in interpreting and understanding the development of the novice family counselors, they also intensified my reaction to beginning counselors missing or failing to react to the pain of the families or potential signs of dangerous situations in the families. Given the sensitive nature of viewing the very intimate session of families and counselors struggling with difficult problems, my experiences gave me a heightened awareness of the complex issues that make the well being and protection of the family a primary focus within a training setting.

I firmly believe that family counseling requires at least five to seven years to learn and continued clinical supervision is necessary in order to provide this

kind of counseling. The learning process never ends and, therefore, the training program must provide the student counselors with a perspective that they are a work in progress.

### Limitations

It is recognized that the design of this study focused on a very limited, narrowly defined sample of novice family counselors that does not allow the results to be generalizable to the general population. Because this study occurred at one college training program which only deals with families with children who have school related problems, the results were focused on the experiences of the novice counselors in this setting with a specific population of families. The videotapes provided data on the development of the novice counselor's skills, as they dealt with different families not necessarily the same families over time. Because the novice counselors were not interviewed in this study, a holistic view of the learning was not possible and will remain perhaps for future research. It is expected that the readers of the study will use their own experiences and common sense in applying this data to other training programs or families.

### Definitions

**Boundary :** Invisible line of demarcation in a family which may be defined, strengthened loosened or changed as a result of structural family therapy (Piercy & Wetchler, 1996).

**Circularity:** Refers to the interactional nature of families. An individual's behavior is a part of a sequence of behaviors of a family. The counselors' hypotheses also develop through an interactional relationship with the family (Piercy & Wetchler, 1996).

**Circular Causality:** A contextual, cyclic view of behavior as opposed to a linear, cause and effect explanation of behavior (Piercy & Wetchler, 1996).

**Coalition:** A covert alliance between two family members against a third (Piercy & Wetchler, 1996).

**Conceptual Skills:** Organization and content of counselors thoughts. The manner in which the counselors views the observations; i.e., through a structural lens (Pulleybank & Shapiro, 1986).

**Constant Comparative:** A method of data analysis which uses a constant process of categorization, sorting and resorting, coding and recoding of data for emergent categories of meaning (Rafuls & Moon, 1996).

**Counseling :** For purposes of this study the terms counseling and therapy refer to the same processes. Counseling/therapy is primarily a verbal means of helping troubled people change their thoughts, feelings, and behavior to

reduce distress and achieve greater life satisfaction (Davidson & Neale, 1994).

**Cybernetics:** The science of communication and control in man and machines. It conceptualizes how patterns of organization or systems maintain stability and control through levels of feedback (Gale & Long, 1996). Cybernetics studies the flow of information through feedback loops (Gale & Long, 1996).

**Delphi method:** This method is based on the philosophy that more opinions are better than one opinion (Dalkey, Rourke, Lewis & Synder, 1972). It is a procedure designed to sample a group of knowledgeable persons in order to create a consensus of opinion on a specific subject (Fish & Busby, 1996).

**Discourse analysis:** A post modernist strategy that explores how forms of communication actively create the way we understand the social world (Bozic, Leadbetter & Stringer, 1998).

**Disengaged family:** An extreme pattern of family organization in which members are so separate they seem oblivious to the effects of their actions on each other (Piercy & Wetchler, 1996).

**Enactment:** The acting out of a dysfunctional transactional pattern within the family therapy session, and encouraged by the therapist ( Piercy & Wetchler, 1996).

**Enmeshed family:** An extreme pattern of family organization in which family members are so tightly locked that autonomy is impossible (Piercy & Wetchler, 1996).

**Epistemology:** The science or theory of methods of knowledge or answers the question "What is knowing" (Gale & Long, 1996).

**Family:** Those who consider themselves to be a family (Sprenkle & Wilkie, 1996).

**Family Life Cycle:** The developmental progression of the family unit through transitional periods which often require rules to be rewritten in order for the family to remain functional ( Sprenkle & Wilkie, 1996).

**General Systems Theory:** Set of assumptions that can be applied to all systems: the system is more than the sum of its parts; patterns of relationship within the system are important; organisms both seek and resist change (Schwartz & Nichols, 1995).

**Hierarchy:** A boundary that differentiates the leader of an organization from the other members. The parents are higher in the hierarchy in a family than the children (Piercy & Wetchler, 1996).

**Hypothesizing:** Hypothesizing refers to the therapist developing systemic theories about a family's behavior (Piercy & Wetchler, 1996).

**Isomorphism:** Situations in which the structure of a larger system is similar to or replicates a family's structure (Piercy & Wetchler, 1996).

**Joining:** An accommodating maneuver in which the therapist establishes rapport with the family and temporarily becomes part of the family system (Piercy & Wetchler, 1996).

**Linear Causality:** The etiology of problems is assumed to be based on prior events in their past. It is predicated on the Newtonian concept of unidirectionality which describes the movement of non-living forces (Nichols & Schwartz, 1995).

**Perceptual Skills:** Manner in which the counselor interprets and categorizes observations (Pulleybank & Shapiro, 1986).

**Reframing:** Use of language to give new meaning to a situation. The alteration of meaning gives a possibility of change (Piercy & Wetchler, 1996).

**Restructuring:** Any therapeutic intervention that confronts and challenges a family and facilitates structural change (Piercy & Wetchler, 1996).

**Rules:** Rules are repeated communication patterns that serve to stabilize family relationships (Gale & Long, 1996).

**Strategic family therapy:** Strategic family therapy is based on the assumption that behavior occurs as a part of a sequence of ongoing, interactional events and can only be understood in context. Symptoms are embedded in these sequences of interaction and are developed and maintained by ineffective solutions. Reality is created by the family (Fish, 1989).

**Structure:** Invisible set of functional demands that organize the way families interact (Becvar & Becvar, 1988).

**Structural family therapy:** An active, problem solving approach to a dysfunctional family context. It emphasizes organizational issues (Piercy & Wetchler, 1996). It is based on the theoretical assumptions that families are evolving, hierarchical organizations with rules, or transactional patterns, for interacting across and between subsystems (Fish, 1989).

**Subsystems:** Units within a family based on characteristics such as sex, age or interest (Piercy & Wetchler, 1996).

**System:** A system is a complex of interactional components (Gale & Long, 1996).

**Systems (systemic) thinking:** A framework for viewing unrelated phenomena and understanding how together they represent interrelated components of a larger system (Goldenberg & Goldenberg, 1996). The whole is different from the sum of its parts is a systems approach. A system is put together in such a way that whatever affects one part of it affects other parts (Nichols & Everett, 1986).

**Therapeutic paradox:** An intervention which entails a seemingly illogical intervention which uses maneuvers that seem to contradict the goals of therapy to bring about change such as prescribing the symptom or restraining change (Piercy & Wetchler, 1996).

**Therapeutic Skills:** All intervention techniques employed by counselors (Piercy & Wetchler, 1996).

**Training:** A process by which individuals learn to become counselors and acquire specific family counseling education. It refers to comprehensive

teaching of family counseling concepts and techniques (Sprenkle & Wilkie, 1996).

### Structural Family Therapy Concepts

*Structure:* According to structural family therapy, the family is a dynamic organism which maintains a delicate balance among its members. The family environment exhibits varying degrees of openness and flexibility as the needs of the family change over time and in response to environmental circumstances (Nichols & Schwartz, 1995). All families develop interaction patterns among their members that typically become the standards for family behavior. The term structure refers to these recurring interaction patterns. Family structure describes how family members relate to one another, what activities members engage in, and which roles each member plays in the context of family life (Nichols & Schwartz, 1995).

*Subsystems:* According to structural family therapy, each family member belongs to one or more subsystems. Subsystems are composed of family members who join together to perform various family functions. The primary subsystems are the spousal subsystem, the parental subsystem, and the sibling subsystem. The concepts that define subsystem relationships include boundary, alignment, and power.

*Boundaries:* The boundaries of a subsystem are the rules that determine who participates in the subsystem and how (Minuchin & Fishman, 1981). These rules may be implicit or explicit and dictate the amount and kind of contact that is

permitted between family members. Boundaries define the roles each family member plays with other members and with the world. Boundaries are described as ranging from rigid to diffuse, and these terms reflect the relationships both between subsystems and within them. In healthy families, there must be appropriate interpersonal boundaries between generations. Rigid boundaries are characterized by relatively little involvement among family members or subsystems. Such boundaries are described by the term “disengagement”. Disengaged individuals/subsystems act autonomously. If carried to an extreme, relationships between the disengaged individual/subsystem and the other family members are only minimally sustained. Parental subsystem disengagement, for example, would leave children to resolve their own issues most of the time with little emotional support from the parents. Parent support to children would become evident only in times of extreme crises (Becvar & Becvar, 1988; Nichols & Schwartz, 1995). When boundaries are clear, the relationships among family members are nurturant, expressive, and foster autonomy. Rules are firm, but flexible. Clear boundaries shift to accommodate the changing needs of family members—either by offering greater freedom or by increasing attention. Families that maintain clear boundaries are typically capable of adjusting to normal as well as unexpected changes that occur throughout the family life cycle (Minuchin & Fishman, 1981; Nichols & Schwartz, 1995). Clear boundaries enable all family members to know what behaviors and relationships are permitted among the family members.

*Alignment.* Alignments occur when family members join or oppose one another to avoid conflict and/or alleviate stress. Some alignments are healthy and appropriate, such as close relationships between siblings or between an adult and an older child who assists in carrying out family responsibilities. Some alignments represent ineffective ways of coping with relationship issues in the family (Goldenberg & Goldenberg, 1996).

*Power.* Power refers to both the authority in the family (the decision makers, and who has the responsibility for carrying out the decision (Goldenberg & Goldenberg, 1996). Power refers to the relative influence of each family member. Power is typically organized within a generational hierarchy. Power is also often organized by gender, reflecting and incorporating any social context of gender inequity in which the family exists.

In summary, structure refers to the recurring, predictable interaction patterns that develop between family members. Subsystems refer to the organizations between and among family members which enable the family to perform various family functions. Boundaries outline the ways in which family members may interact with each other. Alignment indicates how family members join together or oppose each other in responding to family issues. Power decides who will prevail in disagreements and whether decisions will be carried out. Within structural family therapy no single family configuration is considered ideal. Effective family function relates, not to specific configurations, but to (a) interaction patterns that enable clear communication, (b) boundaries and alignments that respect autonomy but foster closeness, and (c) clear rules and

beliefs that guide the behavior of family members but can adapt to the changing needs of individuals within the family.

## Chapter two

### Literature Review

The previous chapter identified issues relative to the training of family counselors. It was noted that much of the research has been theoretical with limited observational research that describes the experiences of novice family counselors. Chapter two will explore the history and development of family systems theory and therapy, particularly structural family therapy; family therapy training; the basic instructional frameworks for enhancing the integration of the conceptual, perceptual and therapeutic skills; and the interconnections between family systems therapy and qualitative research. Structural family therapy theory and therapeutic strategies will be emphasized, since the counseling interns who are participating in this study are involved in learning this particular school of therapy. Further, although the history of family therapy and theory are being discussed separately in this literature review, they are tightly entwined and clear boundaries between them are not readily apparent either in practice and in the research. The terms “therapy” and “counseling” are used in this study to mean the same processes. The term therapy is used in the discussion of the theory while the students are referred to as counseling interns.

As part of this literature review, two interviews were conducted with individuals who could enhance the meaning and provide a richer understanding of the history of structural family therapy. The first interview was with Dr. Steve Greenstein, a family therapist, who worked with Salvador Minuchin from 1969-

1973 and was active in the development of the theory of structural family therapy (Nichols & Schwartz, 1995). The second interview was with Dr. Michael Nichols, a professor, who studied with Minuchin from 1972-1974 and became, through his writings, a chronicler of structural family therapy. Although information from the interviews was woven into the literature review, a brief summary is provided to give a more personal context for the understanding the progress of family therapy. (See Appendix A)

### History of Family Therapy

#### Family Systems Theory

Although the clinical ground work for family systems theory was laid by the work of a number of psychiatrists and psychologists such as John Bell, Nathan Ackerman, John Bowlby, and Harry Stack Sullivan, the theory was developed by researchers who were not necessarily interested in family therapy nor were all of them trained as clinicians (Broderick & Schrader, 1991). In 1953 Gregory Bateson recruited Jay Haley, who studied communication and fantasy, John Weakland, a chemical engineer who also studied anthropology, and William Fry, who was interested in humor, to research levels of communication in both humans and animals (Nichols & Schwartz, 1995). In 1954 Bateson received a grant from the Macy Foundation to study patterns of communication patterns in people with schizophrenia. Don Jackson, a psychiatrist, also joined the group. Jackson had been trained by Harry Stack Sullivan and brought an interpersonal dimension of psychotherapy to the communication research. This group became known as the Palo Alto Group (Nichols & Schwartz, 1995) (see Figure 1. for a

time line at end of chapter 2).

Initially, this group of researchers interviewed hospitalized schizophrenics and did not actually observe their interactions with their families or other people. From this information the researchers developed a theory of communication which explained the nature and origin of schizophrenia (Broderick & Schrader, 1991). The researchers theorized that the schizophrenic behavior served a cybernetic function of maintaining homeostasis in the family (Nichols & Schwartz, 1995). They hypothesized that the etiology of schizophrenia was a result of the double bind interaction patterns which occurred between mothers and their children (Nichols & Schwartz, 1995). After developing this hypothesis, the researchers proceeded to collect data by observing mother-child interactions. Because of their observations, the researchers became readily aware of the pain in these families and that awareness transformed their roles as observers to therapists or participant-observers which altered the nature of their research (Nichols & Schwartz, 1995). Intervening in the lives of the families being studied, also highlighted a distinction between Bateson, who was researching communication processes and developed a highly theoretical analysis, and the other team members who were more interested in studying therapy (Broderick & Schrader, 1991; Nichols & Schwartz, 1995). Bateson eventually left the group and returned to the research on communication patterns of porpoises ( Broderick & Schrader, 1991).

The blossoming of family systems therapy, actually followed the development of the theory and was secondary to the theory (Nichols & Schwartz,

1995). However, in order for the theory to develop, clinical experiences had to be valued over dogma since a family orientation was a direct departure from the intrapsychic orientation and dogma of psychoanalysis (Nichols & Schwarz, 1995). Family systems theory and therapy evolved from the integration and collaboration of theorists and clinicians with some help from serendipity (Greenstein, Interview, 1998). Because of this collaboration and its rich multidisciplinary heritage, family systems theory became instrumental in expanding the perspectives of the traditional mental health disciplines (Shields, McDaniel, Wynne, & Gawinski, 1994). Although the theoretical basis for this paradigm shift is typically attributed to the application of systems theory to human relationships, the focus on interpersonal relationships rather than intrapsychic concerns was also an important distinguishing feature (Shields, et al., 1994). Family systems theory created a new paradigm for studying and intervening in the interface between interpersonal relationships and human distress (Hardy, 1994).

Family systems theory is an amalgamation of theories and perspectives from disciplines both inside and outside the field of mental health. Family systems theory evolved from multiple disciplines including anthropology, sociology, education, psychology, and psychiatry as well as from a number of different individuals working separately and jointly within the therapeutic community (Nichols, 1984; Nichols & Schwartz, 1995). Because the study of family interactions was such a complex area, individual researchers focused on specific parts of family processes which resulted in the emergence of different branches or schools of family therapy

(Nichols, 1996). These schools each had their own terms and procedures and their own charismatic leaders, but all shared the belief in systems thinking and the focus on patterns of interactions. Each of these schools of family therapy/theory demanded loyalty which resulted in specialization and polarization, typical of evolving theories (Nichols & Schwartz, 1995; D'Amato & Rothlisber, 1997). Polarization seemed to be a necessary part of the development of the theory in order to clarify and define terms and hypothesis (Greenstein, Interview 1998; Nichols, Interview, 1998). However, the original theorists of family therapy did not believe their theory was the one truth (Greenstein, Interview, 1998; Nichols, Interview, 1998; Liddle, 1991). Each of the many clinicians and researchers contributed important pieces to the puzzle of family interactions (Nichols, 1996). Without the shared underpinning of systems theory, which was used as a metaphor for family interactions, the integration of these pieces into a common language and framework through which family patterns could be understood would not have been possible (Nichols & Schwartz, 1995).

A number of theoretical metaphors were borrowed and parts of them combined predominantly from engineering, (the theory of cybernetics), from biology, (general systems theory), and from anthropology (functionalism) to create a theoretical model (Broderick & Schrader, 1991). The theory of cybernetics was reinterpreted by Gregory Bateson, an anthropologist and student of evolution, animal behavior, and ecology, to describe human communication processes (Gale & Long, 1996; Nichols & Schwartz, 1995). This

theory was used to examine the structure, patterns of organization, and control of communication processes through feedback cycles (Goldenberg & Goldenberg, 1996). Cybernetics, which applied a mechanistic view of interaction, represented a whole new way to conceptualize human problems and required a new set of premises and methods for collecting and interpreting information (Gale & Long, 1996).

The basic assumptions of general systems theory (GST) developed by von Bertalanffy, a biologist, became tenets of the family systems theory but are often attributed to cybernetics (Nichols & Schwartz, 1995, Goldenberg & Goldenberg, 1996). The most prominent assumptions from GST that influenced family systems theory were that a system is more than the sum of its parts and patterns of relationships within systems are important to study (Nichols & Schwartz, 1995).

Functionalism, an approach borrowed from anthropology, described behavior as having a social function rather than merely an evolutionary function (Nichols & Schwartz, 1995). This concept was interpreted as meaning that dysfunctional behaviors have a function within the family system. Both functionalism and general systems theory introduced the idea that reality exists but the reality we know can never be truly objective because it is filtered through our own particular perspective.

Functionalism also introduced the participant-observer method of research to the field which became an important component of family therapy research.

Observing and listening to the stories of families thus were important parts of the family therapy movement (Nichols & Schwartz, 1995).

The evolution and development of a theory cannot be separated from the historical, social and

cultural contexts of the time (Broderick & Schrader, 1981; Gale & Long, 1996; Nichols & Schwartz, 1995). According to Greenstein (Interview, 1998) the therapists of the 60's and 70's became such devotees of systems thinking they believed it would transform the mental health field because it was a way of life, not just a technique in therapy. This first generation of family therapists believed systems thinking was revolutionary and behaved as if systems thinking was like a religion. The sense that this theory was creating a powerful shift in the mental health field may also have been reinforced by the 60's revolutionary spirit supporting even further the growth of alternative approaches to healing human problems (Greenstein, Interview, 1998).

As recently as 1987

the authors L'Abate and Jurkovic were concerned that family systems theory proponents created a cult and actually hindered the usefulness of the theory. L'Abate and Collondier (1987) referred to family systems or systems thinking as a "metatheory" because of its abstractness and vagueness while the schools or models of family therapy as theories because of their more focused concepts which were more easily measured and evaluated. The complexity of studying and theorizing about family interactions, the various disciplines which studied these interactions, geography, historical contextual factors as well as the charismatic personalities all contributed to the creation of the variety of models of family therapy (Greenstein, Interview, 1998). Intrapsychic to Interpersonal: The

Evolution to Systemic Approaches

Although therapists did not begin to treat families as the client until in the 1950s, there were a number of early harbingers or precursors to the family systems therapy movement (Broderick and

Schrader, 1991). Interpersonally oriented psychiatrists such as Harry Stack Sullivan, who despite being psychoanalytically trained, began to focus on interactions within the therapy sessions. These psychiatrists trusted their own experiences in therapy over the teachings of psychoanalysis (Broderick & Schrader, 1991). Working with families as the focus of the problem was a distinct departure from the psychoanalytic tradition which assumed that psychiatric problems developed from unhealthy earlier relationships in the family and could only be ameliorated at a distance from the family. Traditional psychoanalytic theory even admonished therapists to avoid working with the families because it would compromise their work with the individuals (Broderick & Schrader, 1991). Because these initial movements toward relational therapy were outside the predominant psychiatric model of therapy, they lacked a theoretical foundation as well as a body of scholarship to assist the development of this movement (Broderick & Schrader, 1991; Nichols & Schwartz, 1995).

Clinical research with families actually began to appear as early as the 1920s. In 1921, an article by the psychoanalytically trained psychiatrist, Flugell, titled the "Psychoanalytic Study of the Family", was published followed by the writings of two other psychiatrists, "Unity of the Family" by Ackerman in 1938 and "Study and Reduction of Group Tension in the Family" by Bowlby in 1949 (Broderick & Schrader, 1991). Moreno's work in the 1930's and 1940's with groups of married couples and unrelated persons also influenced the thinking of psychiatrists of the times (Broderick & Schrader, 1991). Treating families as if they were unrelated individuals in group counseling

continued to occur into the 1960s (Greenstein, Interview, 1998).

Although there were some articles as mentioned above, few articles were actually published in traditional journals until 1961, when the journal *Family Process* was created. There was no central professional journal to provide a forum for the critique or exchange of ideas in family therapy (Broderick & Schrader, 1991). The years from 1952-1961 are referred to as the founding decade of the family therapy movement because of the creation of a journal as well as the collaboration between researchers/clinicians, which resulted in the first handbook on family therapy (Broderick and Schrader, 1991).

The 1950-60s also began an era in which a number of different research institutes emerged which studied specific aspects of the application of systems theory to family functioning. During this era the researcher/clinician was one and the same (Nichols & Everett, 1986). The research was process oriented, evaluating what was happening in the therapy (Gurman & Kniskern, 1981, 1992). The Palo Alto group, one of the most influential, subdivided itself based on differing research and therapy interests. Bateson, the intellectual theorist, became disenchanted with the psychiatrists' lack of awareness about their role in social control of patients and left (Guttman, 1991; Schwartz & Nichols, 1995). The legacy of the Palo Alto group was the unresolved issues of the role of power, control, and causality which continue to be debated at both a theoretical and therapeutic level (Guttman, 1991; Libow, Raskin, & Caust, 1982).

The 50s also saw parallel research in other areas of family interaction performed by Whitaker (1958) in

symbolic experiential family therapy, Wynne(1958) in the personality as a subsystem of the family, Lidz (1956) in the influence of fathers, and Bowen (1956) in a theory of family systems that included the differentiation of the self from the family of origin (Broderick & Schrader, 1991; Goldenberg & Goldenberg, 1996; Guttman, 1991; Nichols & Schwartz, 1995). However, in the 1960s-1970s the split between researcher and clinician grew as clinicians became more intent on treating families, developing therapeutic techniques and less focused on documenting what was happening (Guttman, 1991). It was in the late 1970's that research into the effectiveness of family therapy emerged. This research introduced a competitiveness between the schools of family therapy and an even greater division between clinicians and researchers (Gurman & Kniskern, 1981,1992; Nichols & Everett, 1986). Piercy and Sprenkle (1990) suggested that there continues to be a need to return to process research to provide contextual data and to discover the relationships among variables which influence the outcomes of family therapy. These authors recommended a need for both qualitative and quantitative research in order to more clearly explore interaction effects between problems and treatments which would support integrative approaches to research as well as therapy (Piercy & Sprenkle, 1990).

### The Structural Family Therapy Model

By the 1970s and into the 1980s a number of distinct schools or models of family therapy had developed with their own techniques and interventions. In 1967 Haley moved from the Mental Research Institute (MRI) in California to the Philadelphia Child Guidance Clinic to work with Minuchin. This began a creative,

fruitful partnership from which developed structural-strategic family therapies, the most frequently used frameworks for the conceptualization of family therapy (Becvar & Becvar, 1988; Greenstein, Interview, 1998; Nichols & Schwartz, 1995). In addition to Haley and Minuchin, other theorists/therapists Braulio Montalvo, Harry Aponte, Marianne Walters, Charles Fishman and Stephen Greenstein contributed to the development of structural family therapy (Becvar & Becvar, 1988).

Minuchin surrounded himself with creative, dynamic clinicians who collaborated to envision the structure and processes of structural family therapy (Becvar & Becvar, 1988; Nichols & Schwartz, 1995). Although Minuchin was aware of the differences between himself and Haley, he still invited Haley to come work with him (Greenstein, Interview, 1998). Haley's interests were in digital communication patterns while Minuchin was much more interested in the processes occurring in the family which maintained its dysfunction (Greenstein, Interview, 1998). Minuchin stands out for his openness to the ideas and works of others (Greenstein, Interview, 1998).

Greenstein (Interview, 1998) described the differences among the clinicians as only adding to the richness of the discussions at the Philadelphia Clinic (Greenstein, Interview, 1998). According to Greenstein, structural family therapy evolved through the interchange of the day-to-day experiences of the clinicians, and the dynamic supervision of Minuchin and Haley. This supervision employed the use of one way mirrors for live supervision and eventually the use of videotape equipment to provide ongoing feedback to the therapists. From this

group of clinicians, referred to as the first generation of family therapists, who worked under Minuchin's and Haley's tutelage in the 1960-70's the pattern of divisions arose again based on personality and theoretical differences (Broderick & Schrader, 1991; Greenstein, Interview, 1998). Haley's work became a brand of strategic family therapy and focused on power and control, while Minuchin's was known as structural family therapy because of its focus on the organization and hierarchy in families.

The differences in actual therapeutic interventions are not so distinct but are a matter of emphasis (Piercy & Wetchler, 1996). Structural family therapy became popular because it provided a clear, concrete conceptual map about what productive family functioning should look like. It gave therapists the tools for seeing the patterns, processes and transactions of the family as a system (Becvar & Becvar, 1988). Structural family therapy attends to the here and now through focusing on the in-session behaviors and creating enactments of the problem while strategic explores current out of session sequences of behavior and makes use of out of session assignments to disrupt these sequences (Piercy & Wetchler, 1996). Both structural and strategic family therapy assess hierarchy, boundaries, subsystems, coalitions and emotional distance between subsystems but use this information in different ways.

The main clinical techniques in structural family therapy focus on spatial, physical and emotional parameters in the family through joining, boundary making, restructuring, unbalancing in sessions while strategic use techniques such as reframing, prescribing therapeutic tasks, prescribing the symptoms, and

restraining change (Piercy & Wetchler, 1996). In reality, many of these techniques are shared by both structural and strategic family therapists because.

Greenstein (Interview, 1998) reported the only way he could delineate the difference between these two brands of therapy was by discussing the differences in the personality characteristics of Haley and Minuchin. A clearer difference between the structural and strategic approaches can be seen by comparing the role of the therapist. Structural family therapists take an active role in intervening in the family in a respectful but firm manner to create boundaries, support the hierarchy and restructure the family. The therapist needs to know what he or she wants to have happen (Liddle, 1991). Changing the way family members relate to each other requires the therapist to take leadership within the therapy room to make things happen. Problem solving is not the goal of structural family therapy as it is with the strategic approach. The goal of structural family therapy is to create a structure in the family which will allow the family to problem solve in a more flexible and productive manner (Becvar & Becvar, 1988; Liddle, 1991). The job of the therapist is to create change in the therapy room. The responsibility for change lies on the therapist's shoulders.

The creative process of growth and subdivision continued to evolve as various aspects of this complex field developed specializations and denominations (Guttman, 1991). "Zealotry" was a word which was applied to the clinicians of that time (Greenstein, 1998, Interview; Nichols & Schwartz, 1995). The proponents of structural family therapy saw themselves as distinctly different both conceptually and clinically from other models of family therapy as well as

more individualistically oriented models of therapy (Shields, Wynne, McDaniel & Gawinski, 1994). The fervor which characterized the family system therapies was a response to the individually oriented psychoanalytic approach as well as the revolutionary 1960's. During the time when the facets of structural family therapy were being honed, the researcher/therapists were also picketing in the streets of Philadelphia to show support for racial integration and anti-war sentiments (Greenstein, interview, 1998). Emphasis on systemic thinking was placed above all else in their approach and training (Greenstein, Interview, 1998).

### Contemporary Issues in Family Systems Theory and Therapy

Viewing the development of family systems theory from today's perspective, there are a number of interesting factors. Given the importance of the influence of the context of the historical/ political period within which it was developed (1950's-60's), it cannot be assumed that the theory was meant to stagnate but to grow with new input from future generations of family therapists. (Framo, 1979; Greenstein, Interview, 1998). Social, political and environmental changes all affect family interactions and require theories to be updated and methodology altered (Ribordy, 1988).

Challenges have come to family therapy from feminist counselors who assert that issues of power, equality, problem definition and sex roles have not been properly addressed (Enns, 1988). Rather than defining problems as due to difficulties in the interaction patterns these counselors suggested that a broader view of problem definition, which includes the social context, needs to be taken (Enns, 1988). The general systems concept of circular causality, in which no

specific situation or person is considered the cause of a problem, became an issue when applied to family violence (Hare-Mustin, 1987; Taggart, 1985; Enns, 1988). Unequal social power and sex role socialization were seen as the sources and causes of many women's problems which are not accounted for by structural family therapy (Enns, 1988; Fish, 1989). Hare-Mustin (1987) also argued that family counselors have not adequately examined the consequences of the socialization practices which hinder the development of women.

Other contributions to understanding the context within which family stress develops and influences relational conflicts come from consideration of the family life cycle as well as the influence of ethnicity and culture on families (Carter and McGoldrick, 1980). Thus, the need to be informed by women's views of family functioning as well as multi-cultural input was missing in the original theory development and remained for future generations of family therapists to explore (Greenstein, Interview, 1998; Nichols, Interview, 1998). Contributions from multi-cultural perspectives, developmental perspectives, and social constructivists are informing the growth of the family systems therapies and theories (Liddle, 1991).

Some theorists believe that family therapy is entering an era of integration (Liddle, 1991; Nichols, 1996). The 1990's was described by Goldenberg and Goldenberg (1996) as a time of integration and eclecticism. The focus is on the application of concepts rather than additional development and refinement of basic theoretical principles (Goldenberg & Goldenberg, 1996). Professionals are being trained more broadly and borrowing strategies from various schools of family therapy (Broderick & Schrader, 1991). In a comparative study of the

change process in family therapy, it was noted that even the strategies of two of the master therapists, Minuchin and Whitaker, known for their theoretical differences, were remarkably similar (Friedlander, Wildman, Heatherington & Skowron, 1994). Another step toward integration can be seen in the extension of the concept of the individual in relationship which has been expanded to include relationship to oneself, to others and to ones' environmental world (Anderson, 1994). However, the number of new emergent models such as "solution focused", "collaborative-conversational", "deconstruction", "psychoeducational" and "internal family systems" suggests that the field may still be subdividing which further complicates the integration of the field. (Nichols & Schwartz, 1994).

### Professional Identity and Training Issues in Family Therapy

#### Professional Issues

The development of family therapy training, from its beginnings, was an interdisciplinary endeavor and originated outside academic institutions as did the theory (Lebow, 1987; Nichols & Schwartz, 1995). Prior to the 1960's individuals were trained in family therapy through programs in psychiatry, clinical psychology, social work or psychiatric nursing (Nichols & Schwartz, 1995). In 1965 The Ackerman Institute for Family Therapy was founded and offered training in systemic family therapy and in the 1970's the Philadelphia Child Guidance Clinic became one of the leading centers of family therapy, specifically structural (Minuchin) and strategic (Haley) (Nichols & Schwartz, 1995). These and other institutes provided both the conceptual instruction and supervision of family therapists across disciplines. Issues concerning which discipline,

psychology, social work, counseling, psychiatry, was the best source of training were not seen as important as the discovery of a new paradigm.

The professionalization of the field of family therapy began in the early 70's through the emergence of academic training institutions and organizations such as the American Association of Marriage and Family Therapists (AAMFT) (Liddle, Breunlin & Schwartz, 1988). The first generation of therapists did not see family therapy as a separate profession but rather a way of thinking and seeing the world and, therefore, resisted professionalization (Greenstein, 1998, Interview). Training was not addressed because these family therapists were explorers who expanded frontiers and trained themselves through trial and error (Liddle, Breunlin, & Schwartz, 1988). Essentially their model of training was one of apprenticeship. Although training through an apprenticeship model was always a primary goal of the creators of family therapy, it was not their top priority (Liddle, 1988; Nichols, Interview, 1998; Touliatos, Lindholm & Nichols, 1997).

The emergence of academic programs of family therapy seemed antithetical to the development of creative therapy and theory development to the first generation of therapists (Greenstein, Interview, 1998; Nichols, Interview, 1998). They were concerned that their revolutionary ideas would be reduced to mere techniques. These therapists perceived each approach as making specific philosophical statements about the nature of families and the nature of reality (Guttman, 1991). There was resistance to professionalization or making family

therapy a separate discipline rather than a specialization within an already established discipline.

The first legislation to regulate the quality of the professionals doing marriage and family therapy, was enacted by California in 1963 which formally recognized and regulated the profession. This legislation established that a master's degree in a behavioral science from an accredited college and two years of supervised experience was necessary to become a marriage and family therapist (O'Sullivan & Gilbert, 1989). Programs in psychology, social work, and counseling established specializations within their already existing programs to accommodate the standards and a new degree, in marriage and family therapy was created (O'Sullivan & Gilbert, 1989). Family institutes which were separate from the academic settings also continued to provide post graduate training and supervision in marriage and family counseling (Lebow, 1987).

Problems in training existed no matter what setting in which it occurred. The setting in which training in family therapy occurred influenced the process and outcome of the training (Liddle, Breulin & Schwartz, 1988). These authors reported training that defined family therapy as a separate profession was different than training that occurred within already established disciplines. The purpose of the training, the amount of time devoted to the training, the exposure to systems thinking and the amount of clinical work with real families differs depended upon the slant of the program (Liddle, Breulin & Schwartz, 1988).

Academic training programs which included a specialization within an already existing counseling or psychology program varied with regard to the

number of didactic courses on systems theory, amount of clinical supervision and practical experiences available to the students (Liddle, Breulin & Schwartz, 1988). Further, graduate programs within disciplines of psychology or counseling tended to be deeply entrenched in the ideology of individualism which created a challenge for the students and faculty who were specializing in family counseling (Ribordy, 1987).

Students who received their degrees from a marriage and family graduate program struggled with different issues. Within marriage and family programs, there was a lack of agreement about the basic foundation courses needed, in addition to courses in systemic thinking, in order to create well versed mental health professionals (O'Sullivan & Gilbert, 1989). Admissions requirements to the marriage and family graduate programs often lacked rigor and continued evaluation of the students throughout their training rarely occurred (O'Sullivan & Gilbert, 1989).

In 1988 California modified its law to include both doctoral or masters' degree professions with one of several acceptable titles from accredited schools to apply for licensure as a marriage and family therapist. These titles included: marriage, family and child counseling; marital and family therapy; psychology; clinical psychology, counseling psychology; counseling with an emphasis in marriage, family and child counseling; and social work with an emphasis in clinical social work (O'Sullivan & Gilbert, 1989). This time the legislation defined not only the kinds of course work needed but also recommended that the person of the therapist be trained as well.

The degree to which counselors identified themselves as clinicians who used a systemic approach versus a marriage and family professional changed as the field became more regulated. In 1968 a survey of the members of the American Association of Marriage Counselors (the AAMFT today) found that 75% of them did not see themselves as belonging to a new or unique profession. By 1987, 86% of the members of AAMFT saw themselves as in a unique clinical profession (Sprenkle, 1988). This paralleled both regulatory legislation and growth in graduate programs. The number of programs offering degrees in marriage and family counseling went from 7 in 1979 to 28 in 1987 (Sprenkle, 1988). The issue of whether family therapy training should occur as a specialization either within a training program in a mental health discipline or as a post graduate specialization versus within a degree program specific to marriage and family therapy still exists. It is interesting to note that as of 1987, few of the prominent family therapy thinkers were teaching in the degree granting institutions (Sprenkle, 1988). Most of these therapists continued to work in free standing institutes. However, despite the reluctance to see family therapy as a separate profession and their reluctance to become part of graduate faculty, issues of training became a challenge and continues to be debated.

The debate about training is exemplified today in two articles which discuss the issue of the marginalization of family therapy. The pros and cons of becoming a separate profession were discussed in an article by Shields, Wynne, McDaniel and Gawinski (1994). These authors reported that some of the positive aspects of being a distinct profession and not just a part of a philosophy or

subsumed under another discipline are the greater internal strength and clear professional identity. However, the negative side is the increased marginalization, intellectual isolation and restricted opportunities for collaboration and research. These authors asserted that the original multidisciplinary nature of the early pioneers enriched and expanded the perspectives of researchers and clinicians. However, with the increase in family therapy journals there has been a decrease in family therapy articles in other disciplinary journals (Shields, et al., 1994). These authors also report a lack of attention in the training of family therapists in the broader area of becoming a mental health practitioner which entails learning to communicate and coordinate services as well as use integrative approaches. This lack of training as a mental health practitioner is consistent with the early development of family therapy which separated itself from the individualistic paradigms of therapy.

A response to the Shield, et. al.(1994) article was given in an article by Hardy (1994). He reframed the professionalization of family therapists as part of the developmental process of family therapy and necessary for the training of qualified family therapists. In order to become a profession an occupation must not only have a technical base, but have exclusive jurisdiction and link the skills and jurisdiction in training (Hardy, 1994). Both Shields, et al. (1994) and Hardy (1994) expressed concern about the training of family therapists; however, Hardy did not see exposure to other mental health issues such as individual assessments, psychopharmacology, or DSM-IV as being relevant for family therapists. Although Hardy (1994) supported a move toward greater

specialization in the training of family therapy, there continues today to be great heterogeneity in the training of family therapists.

### Training Issues

The test of a clinical theory is that people can be trained in it and its effectiveness is not just the result of a dynamic personality or charisma of the founders (Grunebaum, 1988). A theoretical framework for training in family therapy has been very slow in its development because of the complexity of the behaviors to be learned (Avis & Sprenkle, 1990). As mentioned earlier, the initial attempt at training family therapists was an apprenticeship model with an emphasis on the supervised clinical experience (Touliatos, Lindholm and Nichols, 1997). The early training of family therapists was dominated by the clinical wizardry of the charismatic originals such as Whitaker, Minuchin, and Bowen rather than by clear curricula and objectives (Greenstein, Interview 1998; Liddle, Breunlin & Schwartz, 1988; Nichols, Interview, 1998). Changing this training pattern happened more as a result of the interaction of academic programs and accreditation standards in marital and family therapy, rather than as result of theoretical research in family therapy training (Touliatos, Lindholm & Nichols, 1997). Even the early legislation regarding the practice of marital and family therapy followed the apprenticeship pattern by requiring a plethora of degrees rather than requiring content specific to the field of marriage and family therapy (Touliatos, Lindholm & Nichols, 1997). The establishment of the Marital and Family Therapy Regulatory Boards (AMFTRB) in 1987 and its regulatory

examination in marital and family therapy in 1989 set a new pattern in motion (Touliatos, Lindholm & Nichols, 1997).

Although the academic programs became standardized with regard to content and course work (Smith, 1993), research examining the learning and acquisition of skills of novice family counselors continued to be limited and has lagged behind the research in other arenas of family therapy (Avis & Sprenkle, 1990; Greenstein, Interview, 1998; Liddle, Breunlin & Schwartz, 1988; Liddle & Halpin, 1978). Although the very innovative use of one way mirrors and live supervision, a hallmark of family therapy, exposed the discrepancy between concepts and actual behavior in session, little attention was actually directed toward research in training because the creators of family therapy believed that integration would occur as a result of doing therapy. There was a view that traditional research methodology did not address the complex issues in family therapy (Liddle, Breunlin, & Schwartz, 1988; Wynne, 1988). Theories of training were limited to the isomorphic or similar structure to the nature of training and therapy (Liddle, Breunlin & Schwartz, 1988). Thus, the first attempt at training structural family therapists was through teaching techniques and assuming the theory integration would follow. As different schools of family therapy developed, three basic models of training emerged; an experiential one in which development of the relational skills of the therapist was emphasized; the competency based model which focused on teaching specific skills; and the integrated model which focused on teaching conceptual, behavioral and relational skills (Liddle, Breunlin & Schwartz, 1988; Tucker & Pinsof, 1984).

### Research in Training of Family Therapists

In a review of the research on the training of family therapists it was noted that there was actually little evidence to support the effectiveness of training (Kniskern & Gurman, 1988). These authors noted that research in training was not an important part of the family therapy. Although the creation of family therapy was intertwined with clinical observational and case study research, the increase in empirical outcome research created a significant division between clinicians and researchers (Gurman & Kniskern, 1992). By emphasizing the global efficiency of family therapy treatment rather than how interpersonal change actually comes about in context, little was discovered about how change occurs in either therapy or the training of family therapists (Friedlander, Wildman, Heatherington & Skowron, 1994). The focus in research was on outcomes rather than the processes necessary to develop effective family therapists. Although there was some research with instruments developed for the purpose of evaluating family therapy training, there was still little research that linked training with therapeutic outcome (Kniskern & Gurman, 1988). In order to understand what we do know about training in family therapy we need to look at both the research on the essential elements of successful family therapy as well as the research on the process or skills and qualities of the therapists which contribute to positive outcomes in family therapy.

In a Delphi study which asked experienced academic clinicians to identify variables they believed to be predictive of successful family therapy outcomes, five categories of variables emerged (Scott, Edwards and Russell, 1997). These five categories were therapist's variables, client variables, therapist-client relationship variables, therapy process variables and context variables. This study found that the therapist variables could be grouped into four categories; personal qualities of the therapist; therapist executive skills; therapist relationship skills; and therapist perceptual-conceptual skills (Scott, Edwards and Russell, 1997). The authors concluded that it was important that therapists not only possess personal maturity and character but be able to execute the tasks of therapy, be able to recognize interactional patterns of behavior and be able to create a positive relationship with the client. Within the process variables, the ability of the therapists to emphasize the families' strengths as well as the ability to work productively by being actively engaged in the therapy process were considered the key factors to successful outcomes. Within the context variables, providing a supportive environment for the therapist was paramount. Finally, the primary variable related to the client was their willingness and commitment to work on the relational system (Scott, Edwards & Russell, 1997).

There is some evidence that the results of the Delphi study are supported by both outcome research and research evaluating the effects of training on novice family counselors. In a comparative review of research on therapist variables, three characteristics of therapists were found to relate to positive outcomes in family therapy (Kniskern & Gurman, 1988). These variables

included the therapist's experience level in family therapy, the therapist's structuring skills and the therapists relational skills. Another study found that more experienced family therapists were more active and used a wider range of interventions than the novice therapists (Pinsof, 1981). This finding was also supported by a hallmark study by Tucher and Pinsof (1984) which evaluated students at the end of their first year in a two year post graduate family therapy training program. This was the first study, that evaluated the effect of training on novice therapists which used performance measures other than self report and trainer impressions to evaluate a training program. These authors found that after one year of training beginning family therapists increased their skills in thinking systematically, increased their activity level during the sessions (that is, they used a wider range of interventions) and were more specific with these interventions. These increases in behaviors were measured through the use of a pre and post test of conceptual knowledge and observation of a simulated Interview. Other characteristics of novice family counselors which were found to effect the outcome of the therapy were relationship skills and structural skills (Alexander & Barton, 1976). These authors operationalized relationship skills as a combination of warmth, humor, directiveness, self-confidence, supportiveness and non-blaming behavior. This seminal study found through observation of real life counseling sessions, that although the relationships skills were important to the success of the family therapy, actual improvement in the family depended upon the therapist's structural skills. Relationship and structuring skill scores accounted for 59.65% of the variance in therapy outcome (Alexander & Barton,

1976). This study which involved delinquent adolescents and their families found that the most important structural skills included clear directives to modify communication patterns in the family, reinforcing the families' acceptance behaviors rather than punishing behaviors which involved reducing blaming and focus on past behaviors, reinforcing the families' strengths as well as reinforcing an appropriate, clear hierarchy in the family (Alexander & Barton, 1976).

Much of the research on the study of the change processes which result in positive outcomes focused on the speech acts of the therapists but out of the context of the therapeutic relationship (Friedlander, Wildman, Heatherington & Skowron, 1994). These authors (Friedlander, et al., 1994) did a comparative review on what is known about the change process from a contextual perspective. They found the following speech patterns to be indicative of positive outcomes. The therapist gives more supportive statements, particularly during the initial phases of therapy, than challenging statements. In the early stages, therapists are affirming, supporting, nurturing and understanding and become more challenging toward the middle phase of therapy. The issues of support and challenge in the change process was essential. The more supportive the statements of the therapist the more likely the clients continued in therapy. The less supportive the speech acts of the therapist the more likely there would be premature termination (Alexander, Barton, Selievo & Parson, 1976). Further, more families complete therapy when the therapist participates more actively by executing structuring skills.

Research has also found that the nature of structuring skills and their interaction with the families were of particular import to the success of family therapy (Friedlander, et al., 1994). This study found that the structuring skills did not necessarily need to be direct commands but rather could be indirect such as reframing, punctuating strengths and creating boundaries. Further there was evidence that male and female clients responded differently to restructuring strategies. Males responded better to reframing while females to reflecting. The therapist needed to interrupt dysfunctional communication patterns in order to have not only successful outcomes but to have families who completed the therapy (Friedlander, et al., 1994).

Other structuring strategies that successful family therapists used were maintaining the focus on the parental subsystem, aligning with the parental unit, allowing for more talking between family members than between the therapist and family members, and providing fewer interpretive statements (Friedlander, et al., 1994). Given all these attributes of successful family therapists, the one that is predominant in the literature which is predictive of successful outcomes is the ability of the therapist to establish a positive relationship with the family (Alexander & Baron, 1976; Friedlander et. al., 1994).

### Family Counseling Training Skills

#### Curriculum and supervision.

Research has noted that the more skills the counselor acquires the more successful the family outcome tends to be (Avis & Sprenkle, 1990) . However, which specific skills are needed and the circumstances that facilitate learning are

less clear. The aggregate of behaviors and personal characteristics which result in successful family therapy outcomes presented in the literature suggests that the training of family therapists is a daunting task. It has been noted by Blocher (1983) that the role requirements of counselors (individual orientation) combines both the acquisition of discrete cognitive and affective skills as well as the integration of these skills into a complex relationship to promote healthy development of clients (Blocher, 1983).

In an attempt to prioritize the most important skills needed by beginning counselors, Figley and Nelson (1989) surveyed experienced counselors about the most important skills needed by counselors regardless of orientation in order to be effective. These authors reported the following list of interpersonal helping skills as being mentioned most frequently in the literature: empathy, questioning, genuineness, respect, attending, reflection of feelings, confrontation, concreteness and immediacy. Although these skills have been found to have positive benefits for clients in therapy, few training programs measure the mastery level of their students in these areas (Figley & Nelson, 1989).

It appears that family therapy differs in both content and form from other therapeutic approaches (Figley & Nelson, 1990). Because of this difference, family counselors have an even more complex task because of the need to broaden their scope from an individual orientation to a group or a system orientation. In order to be effective, family counselors must be able to integrate information from multiple sources, conceptualize family communication patterns and family rules, take multiple perspectives and choose appropriate intervention

plans from multiple sources (Liddle & Saba, 1982). The family therapist must experience the family's world view and perspective but not become inducted into the dysfunctional pattern. Direct skills such as altering conversational sequences and blocking dysfunctional patterns as well as indirect skills as reframing problems are distinctly different from the generic counseling skills needed for individual therapy (Figley & Nelson, 1990).

In order to delineate these differences more clearly, a list of the most important skills needed by beginning family therapists was solicited from academic trainers and educators (Figley & Nelson, 1990). Feedback from over 208 experienced family therapists was solicited and resulted in a list of over 100 skills which could be grouped into three broad categories, conceptual, perceptual and behavioral. This Delphi study found that most of the structural family therapy skills were operationalized as behaviors in therapy rather than personality characteristics of the therapist which is more typical of generic counseling descriptors. The authors concluded that family therapy continues to struggle to identify key ingredients for the practice of successful family therapy and the training needed for such (Figley & Nelson, 1990).

Evaluating the effectiveness of training family counselors has been hindered by a number of methodological and epistemological issues. The effectiveness of traditional research methodology on the outcomes of family therapy and family therapy training has been questioned (Greenberg & Neimeyer, 1986; Gurman, 1981; Pinsof, 1989). The absence of adequate control groups, inadequate measurement tools for both in therapy behavior of the

therapist and client, methods to evaluate learning and application of skills of beginning therapists, reduction of complex interactions to isolated behaviors, lack of specification and description of training programs and their trainers, and ignoring the change process are some of the concerns (Avis & Sprenkle, 1990; Breunlin, Schwartz, Krause & Selby, 1983; Breunlin, Schwartz, Krause, Kochalka & Liddle, 1991; Byles, Bishop & Horn, 1983; Friedlander, et. al., 1994; Greenberg & Neimeyer, 1986; Gurman & Kniskern, 1986,1991, 1992; Piercy, Laird & Mohammed, 1983; Puetz & Dyke, 1989; Perlesz, Stolk & Firestone, 1990;Stolk & Perlesz, 1990;Tucker & Pinsoff, 1984). Family therapy training is a complex task and the evaluation of the process and outcomes of the training continues to be challenging (Avis & Sprenkle, 1990).

Over the years a number of researchers have attempted to define and measure the skills necessary in the training of family therapists. One definition described the purpose of structural family therapy training as being a way to provide a conceptual template that enables a beginning therapist to understand and intervene in family dynamics (Greenberg & Neimeyer, 1986). In a theoretical paper by Tomm & Wright (1979) a sequence of skills used in their training program for family therapists was described and defined. This paper described the need to address in training the therapists' perceptual skills, or the ability to make accurate observations, conceptual skills. which refers to the process of attributing meaning to these observations, and executive skills which included both the therapists' affective responses and overt interventions in the therapy room.

One of the first studies which evaluated the effects of a 14 month agency training program found an increase in the selection of treatment strategies and as well as a small change in perceptual skills but questioned the lack of sufficient instruments to detect and measure changes in the trainees as well as the lack of a control group (Byles, Bishop & Horn, 1983). In another study based on the work of Tomm and Wright (1979), Greenberg & Neimeyer (1986) divided what they considered the necessary skills into conceptual and executive skills and assessed the acquisition of these skills as a result of a fourteen week structural family therapy training seminar. The conceptual skills were defined as the organization of the therapist's thoughts while executive skills were the interventions utilized (Greenberg & Neimeyer, 1986). Up until this study, the evaluation of structural family therapy training was based on "post hoc" self report data of the participants. This study evaluated two groups of graduate students, one group from a counseling psychology program enrolled in the family therapy seminar and the other group from a counselor education program not enrolled in the seminar. Both groups were assessed on their conceptual skills and on their responses to simulated videotapes to evaluate their executive skills. The authors reported that those students who had the least amount of prior experience with family therapy improved the most in conceptual skills and that participation in the training did not seem to increase the number of executive interventions listed by the trainees except in the area of structural realignment.

A study which also evaluated a structural family therapy training program through both paper and pencil rating scales and videotaped simulated Interviews

was done by Pulleyblank & Shapiro (1986). The skills presented were grouped into observational, conceptual and therapeutic. Over the nine months of the training there was some indication that there was a sequence to the learning of the beginning family therapists from conceptual understanding to planning skills to intervention skills or therapeutic skills. However, after nine months of family therapy training, although there was significant progress made in conceptual understanding and case planning, progress was not as evident in therapeutic or intervention skills. The authors reported that part of the problem was in the newly developed measurement instruments and disagreements by the raters about what behaviors constituted an appropriate intervention at a particular moment. Another interesting point in this study was that experienced therapists rated themselves the lowest in the beginning but actually improved the most in training (Pulleybank & Shapiro, 1986).

Another group of researchers attempted to evaluate the effects of a two year non-academic training program found that the trainees' rated themselves as significantly improved after the second year of training but this was not corroborated by observational data (Perlesz, Stolk & Firestone, 1990). Although the results did support gains in skill acquisition in perceptual, conceptual and executive skills as a group, the executive skills or therapeutic interventions were not observed to have changed to the degree that the conceptual/perceptual skills did. The raters in this study did agree with the trainees initial evaluation of their therapeutic skills but did not agree with the trainees over the course of the two year program. This discrepancy between the counselors self report of

improvement in therapeutic skills and actual observer reports is consistent with other studies in this area (Avis & Sprenkle, 1990)

Based on these studies it is evident that there continues to be a question about the effectiveness of training particularly on therapeutic interventions and the optimal sequence for learning conceptual and executive skills. Application and transfer from the conceptual to executive or doing in family therapy continues to be a challenge (Avis & Sprenkle, 1990; Perlesz, Stolk & Firestone, 1990). The absence of documentation for the effectiveness of academically based family therapy programs continues to be a serious problem given the increase in standardization requirements and proliferation of programs (Anderson, 1992). A comparative review of the literature in training family counselors found few studies which actually evaluated training outcomes with regard to student acquisition of skills (Avis & Sprenkle, 1990). The authors concluded from their review of the literature that "training can produce an increase in trainee's cognitive and intervention skills, although the latter is less certain because "intervention skills have never been measured in actual therapy sessions" (Avis & Sprenkle, 1990, p. 260). They also found that cognitive and therapeutic skills do not necessarily develop concurrently and that the sequencing of training activities may be a significant variable in how the trainees acquire the family therapy skills. The authors concluded that family therapy training research is in its beginning stage and has great importance to the field of family therapy. Questions still remain as to what training is effective when, for whom, under what conditions and for what kind of presenting problems of

families (Avis & Sprenkle, 1990). As a result of their review of the literature Liddle and Halpin (1978) suggested three areas for future research: level of trainer functioning, level of trainee functioning and therapy outcome. Evaluating the effectiveness of training only on therapeutic outcomes was not considered adequate. Other aspects of the trainer-trainee interactions need to be evaluated for impact upon learning and performance of the trainees. Thus, there are two levels of outcome which continue to need to be explored, the effectiveness of training on the trainee and its impact on the success of family therapy (Stolk & Perlesz, 1990).

#### Factors Predicting Learning Skills

Researchers have found that the beginning family therapy student's personal characteristics such as conjugal family experience, prior knowledge of family theory and experience doing individual therapy coupled with the severity level of the family cases accounted for a large percent of the variance in learning to do family therapy (Breunlin, Schwartz, Krause, Kochalka, Puetz & Dyke, 1989). This study evaluated 170 students from a number of different structural-strategic training programs pre and post training on the Family Therapy Assessment Exercise (Breunlin, et al., 1989). The Family Therapy Assessment Exercise (FTAE) is a simulated videotape of a family counseling session. The students are asked to respond to questions on a 34 item multiple choice test. The FTAE was developed to measure the acquisition of skills within the structural/strategic model in three areas, perceptual (observational), conceptual and therapeutic. The study found that conjugal family experiences or having

extensive experiences relating to spouses and children, significantly predicted family therapy learning. This study also found that prior experience doing individual therapy positively effects conceptual but not therapeutic learning. Because the FTAE had a ceiling effect for experienced counselors, it was not possible to determine if prior experience with family therapy had a significant effect on the acquisition of skills. This study also found that program variables such as the severity of the family's problems overwhelmed novice family counselors and negatively impacted their learning of the skills. These variables affected conceptual and therapeutic skills differently with conjugal family experience affecting therapeutic skills more than conceptual skills and the prior experience doing individual therapy positively effecting therapeutic skills.

The effect of the amount of counseling experience of counselors on learning structural family therapy was also explored in the research of Greenberg and Neimeyer (1986). These authors found that the more experienced therapists, particularly those trained in an individually oriented theory, developed more complex conceptualizations at an earlier point in the training than those therapists with limited experience. The experienced therapists reported less confusion and more integration of the concepts of structural family therapy.

The role of amount of academic training on the trainee's therapeutic skills was examined by Stolk and Perlesz (1990) and Spielberg (1980). The findings of these studies present interesting data with regard to the effect of graduate training for the counselor. The study by Spielberg (1980) found that the fourth year psychology doctoral students produced fewer facilitative responses than the

second and third year students. Spielberg (1980) attributed this decrease in facilitative responses to the fact that graduate training programs are most efficient in teaching cognitively oriented information and assume that the student some how will be able to translate these concepts into therapeutic action. He hypothesized that graduate education may be associated with relatively small but significant changes in facilitative responses. Spielberg's data suggest not only the need for experiential learning with real life clients, but also a need for close clinical supervision from supervisors who are themselves competent helpful practitioners.

The research by Stolk and Perlesz (1990) evaluated the effect of graduate training on the report of family satisfaction with family therapists. The families in this study preferred the first year students over the second year students. These authors reported that after the first year of training there appeared to be a deskilling process when the family therapists were more focused on planning strategies to change family patterns and gave less attention to affect and feelings of the family members and gave fewer facilitative responses. There appeared to be a time in which facilitative counseling skills were seemingly placed on hold while the trainee worked on specific family therapy techniques. Stolk and Perlesz (1990) attribute this to perhaps a developmental stage in the process of learning family therapy skills in which the trainee becomes more comfortable with working with families and is more focused on the development of skills such as becoming more active and directive.

Other researchers also reported that for both

experienced and inexperienced therapists a temporary decline in both performance and conceptualizations was evident when first introduced to structural family therapy (Greenberg & Neimeyer, 1986). The experienced therapists were able to recover and advance more quickly than the less experienced. Perhaps the experienced counselor by already having the generic counseling skills is better able to focus on integrating the structural skills (Greenberg & Neimeyer, 1986).

In a more recent study that examined further the effect of life experiences such as conjugal family experience, significant life events, professional employment, and maturity (based on age) of the novice therapist on learning evidence was found which questions the validity of their importance to training (Lyman, Storm & York, 1995). This study found that maturation and professional employment are not predictive of therapeutic outcomes. However, a number of variables such as beginning skill level and difficulty of cases were not controlled for in this study. Further research was suggested in this area in order to evaluate this long held belief that experience and maturity effect the learning of family therapy.

The teaching of family therapy skills, relationship skills and structural skills was further elaborated by the work of Mohammed and Piercy (1983). These authors defined the important structural skills as: the therapist's ability to stop chaotic interactions; to use short, specific, clear communication; to ask open ended questions; to structure interactions among family members (creating enactments); to define the purpose of the session and to lay down the ground

rules for the process. Relationship skills were judged as: the ability of the beginning therapist to give hope to the family; demonstrate warmth; validate the existence of a problem; use humor; have a comfortable pace; empathize with family members and confirm the family members' experiences of an event (Mohammed & Piercy, 1983). These authors found that teaching the beginning family therapists first through observation and feedback and then by presenting and practicing a skill based curriculum increased mastery of the material. Their conclusions were not strongly supported by their data.

Training in structural family therapy within an academic setting refers to both the conceptual course work as well as clinical supervision to assist the student in the transfer of abstract knowledge into therapeutic strategies (Liddle, Breunlin & Schwartz, 1988). One of the hallmarks of training in structural family therapy is the use of either live supervision and videotaped supervision. In a recent survey of counselor education programs it was reported that the most widely used modality of supervision was videotape, with audiotape and live supervision almost used as frequently (Carlozzi, Romans, Boswell, Ferguson & Whisenhunt, 1997). When these same directors of counseling programs were asked which modality they felt was the most effective, live supervision was chosen followed by cotherapy and videotape review (Carlozzi, et al., 1997).

These results are similar to a study by Bubenzer, West and Gold (1991) which found that 69 percent of the counselor education programs preferred to use live supervision. In a survey of approved marriage and family supervisors, Nichols, Nichols and Hardy (1990) found that 25 percent actually used live

supervision which was four times the number found in a 1976 survey. These supervisors were not necessarily a part of an academic training program which explains the difference in numbers. Given that live and videotaped review are the methods of choice, it is curious that there is little research evaluating its effect on the learning patterns of novice family therapists. In a comparison study by Fenell, Hovestadt and Harvey (1983) of live versus delayed supervision, no significant differences were found in the performance of the trainees. However, the size of the sample in this study was quite small (6 in each group) and the skill learning was judge by a simulated experience rather than a real life interview.

One of the purposes of live supervision and videotaped supervision is to assist the learner in experiencing the family's perspective while remaining outside of the dysfunctional pattern (Greshenson & Cohen, 1978). Integrating the content and process of the therapy is aided by an objective supervisor who can provide feedback to the therapist in a constructive, supportive manner (Greshenson & Cohen, 1978). The supervisory process is also used as a way to focus on the personal development of the trainee either through the challenges of specific cases or through support of self exploration. Family therapy challenges counselors to use their personal selves effectively within the professional relationship (Aponte, 1994). However, the supervision experience can be a challenging exercise for the beginning family therapist who may have performance anxiety because of the new skills being mastered let alone the fact of being observed by a supervisor as well as fellow classmates. Stage fright, evaluation concerns and panicked learning were reported by Greshenson &

Carter as their reactions (1978) to the supervision process. These authors described three stages that they experienced during their supervision training: stage 1. was one of anxiety and resistance to the supervision, stage 2. was emotional involvement in the supervision which seemed to result in greater conceptual understanding and stage 3. therapeutic strategies were initiated.

A more recent study by Williams, Judge, Hill & Hoffman (1997) which combined both quantitative and qualitative methods of evaluation, found that novice therapists typically experienced feelings of anxiety, frustration, inadequacy and distraction which at times interfered with their ability to provide maximally effective counseling. These novices were being supervised in the more traditional individual therapy with supervisors who did not require videotaping. Given the complexity of family therapy training and the use of videotaped presentations, it can only be assumed that the experience of family therapy training for novice family therapists is challenging both on a personal as well as a conceptual level.

In a phenomenological investigation of "good " supervision events from the perspective of the novice counselors it was found that the quality of the supervisory relationship was cited as the most crucial and pivotal component for the supervisees' learning (Worthen & McNeil, 1996). The authors interviewed four women and four men from three counseling psychology doctoral programs. The participants discussed their dislike of the overt evaluation quality of some supervisory relationships. The interns already were questioning their competency and an evaluative stance by the supervisor only added to their sense of

inadequacy. This sense of inadequacy set the stage for the supervisory relationship. The interns reported that if the supervisor was empathetic, nonjudgmental and affirmed their learning then the supervisory experience was defined as productive and good ( Worthen & McNeil, 1996).

In another study which looked at the perceptions of the supervisor and supervisee, it was found that although the supervisors thought they changed their behavior depending on the developmental needs of the supervisees, the supervisees did not perceive the change (Krause & Allen, 1988). It was found that the supervisees preferred a collegial relationship with their supervisor with a focus on the trainee's personal development (Krause & Allen, 1988).

A study which employed observation of clinical supervision between supervisors of family therapy and their supervisees (novice family counselors) and follow up in-depth interviews with the participants found three themes that emerged from the data analysis (Keller, Protinsky, Lichtman & Allen, 1996). First it appeared that clinical supervision is seen by both the supervisor and supervisee as a way to impart knowledge by helping to clarify conceptualizations. It also was seen as a way to increase self understanding on the part of the supervisee. The supervisees reported that supervision raised an awareness of their strengths and what might be inhibiting the fuller expression of these strengths as a therapist. The third theme was related to the hierarchical nature of supervision and its relationship to supervisee growth. An unanticipated result of this qualitative study was that the nature of the hierarchical relationship

between the supervisor and supervisee changed and became more multi-directional as a response to the supervisors being observed.

Clinical supervision has always been an integral part of the training for family therapists (Liddle & Saba, 1982). Although there are many theoretical articles written about the techniques of supervision (Berger & Dammann, 1982; Coppersmith, 1980; Liddle, Breunlin, Schwartz, & Constantine, 1984; Rickert & Turner, 1978) the responses to supervision (West, Bubenzer, & Zarski, 1989) and the advantages and disadvantages to various types of supervision (McDaniel, Weber, & McKeever, 1983) there is little research which examines its effects on the learning of novice family counselors. However, the studies suggest a need in clinical supervision, live or videotaped, to balance the amount of support provided by the supervisor and the degree of challenge to the novice family therapist. Anxiety, frustration and feelings of inadequacy were found to interfere with learning and performing within the counseling setting.

Effective training of novice family counselors is a complex process which results from an interaction between the program design, the instructors (supervisors), the trainees, the families and even the observations of the training by researchers. Training involves both the academic course work as well as the supervision of therapeutic work in order to teach the integration of the conceptual, perceptual, and therapeutic skills necessary to be a competent family therapist (Kniskern & Gurman, 1988). It is clear from the work of researchers that a one semester didactic course in family counseling is not enough for students to learn to create systemic hypotheses or to change

conceptualizations of problems from an individual focus to a systems focus and to translate the conceptual/perceptual knowledge into therapeutic interventions in the therapy room (Christensen, D., Brown, J. H., Rickert, V. & Turner, J., 1993; Liddle & Saba, 1982).

The range of the number and type of courses varies with the nature of the academic program, whether it is a degree in marriage and family counseling or a specialization within another discipline. However, since family therapy training continues to occur within other disciplines such as counseling programs at a masters degree level, Christensen, Brown, Rickert & Turner (1989) suggested at least a three course, interdisciplinary sequence. The first course would be Family Systems Process and cover family system functioning and the family life cycle. The second course, Family Assessment: Concepts and Skills would focus on the therapist's assessment skills and finally the third course, which should be taken concurrently with the students' practicum, would be Supervised Clinical Seminar. This model is consistent with degree programs in marital and family counseling which typically require four courses directed toward understanding families (Touliatos, Lindholm & Nichols, 1997). The interdisciplinary model would not only be consistent with the history of family therapy but also provide programs that have limited funding and faculty broader course offerings and greater expertise in their personnel (Christensen, et al., 1989; Horne, Dagley & Webster, 1993).

#### Cognitive Development-Construct

The beginning family counselor's cognitive shift from an intrapsychic, individualistic epistemology of human behavior which views problems as residing

within an individual to an interpersonal model in which symptoms are seen as a manifestation of relationship dysfunctions has been found to create a sense of disequilibrium in the counselor trainee as measured by reports of students in family counseling courses (Liddle & Saba, 1982). This dissonance can result in an environment for change in the conceptual structures of the family counselors. A change from simple to more complex levels of cognitive organization and hypotheses concerning family dynamics and functioning has been found to be an integral part of the learning process (Greenberg & Neimeyer, 1986). Abandoning intrapersonal theories of behavior can result in major transformations in the counselors' organizational and conceptual thinking which can have an impact in both the trainee's personal and professional life (Liddle & Saba, 1982). It is also interesting to note that the research has not demonstrated that experienced counselors maintain this higher level of conceptual thinking (Liddle & Saba, 1982). Perhaps these changes are not permanent or the experience of working in counseling environments which are based on individualistic, intrapsychic models of pathology limits the experienced counselors' perspectives. Context may determine counseling orientations.

Training programs typically begin students with a practicum course in which basic counseling skills are taught (Cumming, Hallberg, Martin, Slemon & Hiebert, 1990). Within the area of training, counselors' case conceptualization and the domain of cognitive skills training or enhancement is closely allied (Nelson & Neufeldt, 1998). However, given the complexity of family therapy training, skill development alone does not provide counselors with the necessary

knowledge to conceptualize the family interactions and develop systemic hypotheses (Christensen, Brown, Rickert & Turner, 1989). Because of the skill requirements and degree of personal and conceptual flexibility needed by counselors, researchers and educators in counselor training have asserted that the development of cognitive processes should be an integral component of counselor preparation (Morran, Kurpius, Brack & Brack, 1995). Teaching students in a way which enhances their cognitive development has been recommended by Lovell and McAuliffe (1997) and is predicated in the literature on conceptual level and its relation to counseling ability (Holloway & Wampold, 1987).

Biggs (1988) proposed a case presentation model for teaching which could enhance the counseling students' divergent, relativistic reasoning. The need to find ways to facilitate the translation of complex conceptual knowledge into practice and sustaining the change in conceptual thinking are areas which counselor educators need to explore.

Many theorists in counselor education have claimed that the ability to facilitate client development necessitates high levels of cognitive functioning (Holloway & Wolleat, 1980; Peace, 1995; Reiman & Thies-Sprinthall, 1993; Sprinthall, 1994). Cognitive developmental theory assumes that reasoning and behavior are directly related to the level or stage of complexity of psychological functioning. Sprinthall (1978) reported evidence that a person's developmental stage predicts how they will function in complex helping roles such as counseling or teaching. Persons at a lower level of cognitive complexity tended to be more

rigid, concrete and less flexible in problem solving while those at higher levels displayed more adaptive behaviors and reasoned on a more complex problem solving level. Research has demonstrated that developmental stage growth is not static and can continue into adulthood (Reiman & Thies-Sprinthall, 1993).

A number of studies reported a correlation between higher cognitive development and essential counseling behaviors such as more complex hypothesis formation (Holloway & Wolleat, 1980; Morran, 1986; Morran, Kurpius, Brack & Rozecki, 1994), higher empathy levels and more complex descriptions of the counselor-client relationship (Peace, 1995). In this research, "conceptual complexity" was defined by the kinds of skills exhibited by the counselor. Researchers found that clinical hypothesis formation as measured by the Clinical Hypothesis Exercise Form (CHEF) significantly predicted all measures of counselor effectiveness (Morran, Kurpius, Brack & Brack, 1994). The higher the overall quality of the hypothesis and greater frequency of questions listed to test the validity of the hypothesis, the more accurate and more highly correlated were the results with counselor effectiveness as measured by the Counselor Rating Form (Morran, et al., 1994). These findings were consistent with prior research which demonstrated that there was a positive relationship between higher quality clinical hypothesis formulation and higher levels of facilitative performance during counseling (Morran, 1986). Effective counselors must not only attend to a wide variety of sources of information but also be able to flexibly integrate the information to develop viable explanations of behavior (Holloway & Wolleat, 1980; Morran, 1986).

An alternative, more comprehensive definition of conceptual complexity came from the research of Harvey, Hunt & Schroder (1961). These researchers theorized that the major dimension in personality development was the degree of abstractness or conceptual level (CL). Conceptual level was defined as a combination of conceptual complexity together with interpersonal maturity which resulted in a better ability to process information, work independently and cope with conflict (Miller, 1981). According to conceptual systems theory (CST) a person with a higher conceptual level (CL) was able to view situations from multiple perspectives and display greater reliance on internally developed standards for problem solving and more integrative ways of making meaning of information (Bruch, Heisler & Conroy, 1981). Students with higher conceptual levels were found to integrate seemingly dissonant information and make new and varied interpretations to the same event (Bruch, Juster and Heisler, 1982). Individuals on different conceptual levels required varying degrees of structure to learn and function optimally (Miller, 1981). This view of conceptual complexity did not examine discrete skills and connect them to counseling or teaching skills. Rather it assessed global measures of conceptual complexity and correlated them with skills in the human services.

Cognitive development of counseling students over the course of a counselor training program was studied using two different approaches (Fong, Borders, Ethington & Pitts, 1997). One format involved evaluating discrete skills such as counselor thoughts, intentions and cognitions through analysis of self talk, hypothesis development and goal intentions. The other approach to

studying counselor cognitive functioning used a more global measure to evaluate conceptual level or cognitive complexity of the counselor and its effects on the counseling process. This research suggested that in the study of the development of cognitive structures, content specific measures may be more sensitive to slight changes in conceptual level than global measures.

The validity of the method of measuring conceptual complexity as well as the use of graduate students in simulated conditions was questioned by McLennan (1995). He re-analyzed the meta-analysis of Holloway and Wolleat (1980) and found many methodological errors. He suggested that the use of the Paragraph Completion Test (Harvey, Hunt & Schroder, 1961; Hunt, 1971) was not adequate enough to detect changes depending on the type and intensity of the intervention. The use of graduate students as both counselors and clients was criticized with regard to the generalizability of the studies (McLennon, 1995). The research of both Fong et al. (1997) and McLennon (1995) suggested a need for both global and specific measures of conceptual complexity and the use of "real life" counselors and clients.

Researchers in the training of family therapists have noted that novice family therapists require both adequate support of and challenge to their conceptual, perceptual, therapeutic and personal skills (Liddle & Saba, 1982; Tucker & Pinsof, 1984) in order for the students to have an optimal learning environment. This concept of the balance between support and challenge has also been found to be important in creating a learning environment that supports conceptual and cognitive growth. A curriculum which challenges novice family

counselors to develop and maintain complex conceptualizations as well as apply such conceptualizations to therapeutic interventions is needed if such learning is to have lasting impact.

### Process Research in Family Therapy

Since the 1950s research in family therapy and family therapy training evolved from a theoretical/process focus to an efficacy and outcome focus (Moon, Dillon & Sprenkle, 1990). The link between the researcher and clinicians role, which initially was one and same, became more discrepant as the research became focused on justifying the use of family therapy through the results of outcome research. More recently there has been a wider discussion about the need for process as well as outcome research in order to better understand the interactions or significant events which produce change (Greenberg & Pinsof, 1986; Heatherington & Friedlander, 1994; Pinsof, 1989, 1986).

The last decade has seen an increase in articles discussing the practice or techniques of family therapy with little connection between these techniques to theories of change (Greenberg, Heatherington, & Friedlander, 1996). Research in family therapy has attempted to simplify complex phenomena by evaluating outcomes or looking at only observable behavior. Research in family therapy training needs to explore the complex processes of learning family therapy; that is, explore the patterns of interactions within the context of real life situations which effect the change process in the novice family counselor as well as the family. However, the need for different methodological approaches to studying family therapy, more consistent with systems theory, has been voiced by

numerous authors (Gurman, 1987; Gurman, Kniskern & Pinsof, 1986; Moon, Dillon, & Sprenkle, 1990; Pinsof, 1989, 1986; Schwartzman, 1984). This type of research is referred to as “process research”, as opposed to “outcome research”, because the focus is on what people do and on what people experience (Heatherington & Friedlander, 1990). Greenberg and Pinsof (1986) defined process research as,

the study of the interaction between the patient and therapist systems.

The goal of process research is to identify the change process in the interaction between these systems. Process research covers all of the behaviors and experiences of these systems, within and outside of the treatment sessions, which pertain to the process of change. (p18).

Process research is described as a young scientific endeavor, and family therapy process research as being even younger than general psychotherapy process research (Pinsof, 1989). However, as noted earlier, the early family therapy theorist-clinicians actually were using an informal participant-observer method of research to inform their hypotheses and theories as far back as the as 1950's (Moon, Dillon, & Sprenkle, 1990).

Both quantitative and qualitative methodologies have been recommended for process research. Qualitative research has been used to focus on the microtraining task analysis format to examine the interactions which make up significant change events (Heatherington & Friedlander, 1990). Task analysis research combines a discovery oriented, inductive model with a rational-empirical approach to create model building studies (Greenberg, Heatherington

& Friedlander, 1996). These researchers suggest that such a model links therapist's and clients' behaviors to each other and links these processes to client outcomes. The approach is described as bridging the gap between theory and clinical practice.

Another qualitative approach, discourse analysis, has also been suggested as a way to explore themes of the dominant culture which emerge within the therapy sessions and affect the nature of the change process (Hare-Mustin, 1994). Discourse analysis examines how the therapist and family categorize phenomena which occur in therapy.

The observer-participant nature of the early pioneers as well as the parallel skills needed in therapy and process research, such as skillful observation, analysis of patterns and themes of interactions, interviewing and self-examinations, suggest a need for a methodology which can address complex questions about the change process (Rafuls & Moon, 1996). A qualitative paradigm assumes that complex events such as human interaction, change and learning cannot be reduced to isolated parts if they are to be fully understood. Such a paradigm has been suggested for the study of family therapy (Friedlander, Wildman, Heatherington & Skowron, 1994; Heatherington & Friedlander, 1990; Moon, Dillon & Sprenkle, 1990). Some authors even posit that a qualitative, discovery oriented research model would create an isomorphic parallel between data analysis and family systems theory (Moon, Dillon & Sprenkle, 1990).

Chapter 3 will present the methodological design of this qualitative study. The procedures, strategies for analysis and interpretation will be thoroughly discussed and delineated.

## The Evolution of Family Therapy

1921—Flugel published an article entitled, The psychoanalytic study of the family.

1938- Ackerman published an article entitled, The unity of the family.

1949-Bowlby published an article entitled, The study and reduction of group tension in the family.

1930-1940's Moreno's work in group therapy introduced to the United States.

1940's- General systems theory developed by Ludwig Von Bertalanffy.

1940's- Theory of cybernetics created as a result of a conference on the study of communications sponsored by the Macy Foundation.

1952-1961-Founding decade of family therapy

1951—Bateson founded the Palo Alto Group

1952--Bateson was awarded a Rockefeller Foundation grant to study communication patterns

1953- Harry stack Sullivan integrated sociological and psychodynamic concepts

1954--Bateson awarded a Macy Foundation grant to study schizophrenia.

1956- Bateson, Jackson, Haley and Weakland published the Theory of schizophrenia —the double bind theory.

1956--Bowen developed family systems theory.

1957- Bell began to treat behavior problems in children with family conferences as an adjunct to individual counseling.

1959—Jackson published Conjoint family therapy.

1962--The Journal Family Process was established

1962-1977--The Second Wave of family therapy

1965-Minuchin became director of the Philadelphia Child Guidance Clinic and developed along with Haley and others structural family therapy.

1970's-Specialization and Denominations

1980's- Professionalization

1990's-Integration and Eclecticism

Figure 1. Describes the time line for family therapy development (Broderick & Schrader, 1991; Goldenberg & Goldenberg, 1996).

## CHAPTER 3

### Methodology and Procedures

#### Introduction

Research in the area of the effectiveness of family therapy has established its efficacy as a treatment modality (Avis & Sprenkle, 1990; Gurman, Kniskern & Pinsof, 1986; Kniskern & Gurman, 1988). However, the results of studies which evaluate the effectiveness of graduate school training of family therapists have been more equivocal (Anderson, 1992). Research has suggested that family therapy training can improve trainees' cognitive/conceptual skills, which means that the ability to translate observations into meaningful hypotheses can increase (Avis & Sprenkle, 1990; Greenberg & Neimeyer, 1986; Tucker & Pinsof, 1984). It is less clear that training improves intervention skills or the ability to apply the conceptual knowledge to intervene in a therapeutic manner with families (Avis & Sprenkle, 1990; Greenberg & Neimeyer, 1986; Pinsof & Tucker, 1984). A number of problems with measuring the effect of training on novice counselors have been noted. First, the intervention skills of novice counselors have not been assessed within actual family therapy sessions (Avis & Sprenkle, 1990). Further, the instruments used to assess novice counselors' progress have been largely self-report questionnaires, observational coding schemes of simulated dyadic interactions or observations using content based coding systems (Gaul, Simon, Friedlander, Cutler, & Heatherington, 1991). Quantification of the complex process of learning family counseling by

novice counselors has resulted in limited information pertaining to their development and growth in the application of cognitive conceptualizations to therapeutic interventions. Descriptive data with regard to the interaction patterns between the novice family counselors and all members of the family is needed.

Skills such as recognizing coalition problems, strengthening boundaries and conceptualizing family interactions were ranked as extremely important by experienced teachers of family therapy (Figley & Nelson, 1990). Yet, we have no studies that examine the interactions and communication patterns of novice family therapists which reflect the development and application of these constructs in real life family therapy sessions.

Researchers have noted that the field of family therapy has an element of messiness and that a qualitative methodology adds a systematic way of examining it, even with all its complexity (Moon, Dillon & Sprenkle, 1990). Since the focus of this study was on describing the reciprocal interactions between the context of real life family counseling and the interactions between the interactions and the development of the novice family counselor, a qualitative methodology was the most congruent and the only format in which such complex information could be thoroughly examined (Creswell, 1994).

Novice family counselors are often better at perceiving and conceptualizing a family's problems than actually intervening to create a change in the patterns of interaction (Greenberg, Heatherington & Friedlander, 1996). This study documented the perceptual-conceptual and therapeutic skills of the novice family counselors as revealed on

selected videotapes of their family counseling sessions, through document analysis of their responses to structured reflective questions as well as through the responses of their supervisors as they progressed through a nine month family counseling internship at a small suburban, research college. The research examined the conceptualizations of the counselors as well as their interactions with the families during real life counseling sessions. The study addressed the following questions with regard to the development of novice family counselors in real life counseling sessions:

- 1.) What do the interaction patterns of the novice family counselor look like and do these interaction patterns change over the period of the internship?
- 2.) How do novice family counselors conceptualize family problems? What hypotheses do they generate with regard to the relational patterns in the family? Does the counselor's conceptualizations change over time?
- 3.) What do the structuring and re-structuring skills of the novice counselor look like in counseling sessions? Do these skills change over time? How active do the counselors become over the course of their training?
- 4.) In what ways do the kind

of interactions between the novice counselor and the family influence the counselor's behaviors and conceptualizations ? Because of the nature of the questions being asked in this study and the qualitative methodology, the design of the study included multiple methods of data collection including observations of selected videotapes of actual family counseling sessions and written responses from the novice family counselors and their instructors. Each

novice family counselor and their videotapes of their counseling sessions were treated as an individual case in order to allow for the

in-depth examination of the counselor's development over the nine month internship (Gall, Borg & Gall, 1996).

This qualitative methodology was based on a grounded theory approach. Grounded theory is a way of thinking about or conceptualizing data as the essential element from which theory evolves (Rafuls & Moon, 1996). Grounded theory is developed by describing what happens and on the basis of observation, explanations are formulated about why it happens (Lincoln & Guba, 1985). The process involves the use of a constant comparative reciprocal interaction between the data collection and the data analysis (Rafuls & Moon, 1996). The analysis entails the building of abstractions, concepts, hypotheses and theories from the details of the data (Creswell, 1994). Thus, in this study as the data were collected they were analyzed for emergent categories and themes and then these were looped back into the continued data collection and analyzed further for interrelationships and meaning (Strauss & Corbin, 1990). The constant comparative approach is a way to analyze qualitative data to decide which categories are theoretically relevant (Gall, Borg & Gall, 1996). This design allowed the researcher to examine the complex interactional processes which included the verbal and nonverbal communication patterns and quality of these patterns within actual counseling sessions.

### Setting

Pine Tree College is located in a suburban upper middle class community which is surrounded by both rural and urban areas. The college graduate program in counseling is housed in the department of education and provides training at both a master's degree level and doctoral degree level. The graduate students in the counseling program may choose a community counseling, school guidance counseling or family counseling specialty depending on the courses and internships they choose. Basic educational foundation courses, such as educational research, as well as counseling techniques are required in all counseling programs.

Within the graduate program the following courses are offered in family counseling: marriage and family counseling, a survey course, a two semester family counseling internship and a one semester family counseling practicum. There are two full time faculty responsible for teaching the courses in the family counseling specialty and one half time clinical supervisor. The instructors also teach other counseling courses. The family counseling faculty, with the assistance of graduate students, administer and provide family counseling services through the Family Counseling Center. Although this center is administered through the counseling graduate program, it is funded by a regional program supported by a number of public school systems to the intent being to address the mental health needs of children and their families. These school systems are located within a 30 to 40 mile radius of the college.

Graduate students who choose a family counseling specialty are provided both a practicum and internship through this family counseling center. Some of

the family counselor interns provide the counseling services in the center which is located in the education department while other graduate students provide the counseling services in the schools in order to be closer to the families. The counseling rooms at the college are equipped with one way mirrors and videotape equipment in order to provide the supervision of the students necessary to protect the families and train the students. Graduate students who work in a school must carry their own videotape equipment or borrow it from the school.

Originally the regional program was established to provide services to families of children with disabilities. Over the years services have been expanded to include all children who are exhibiting school difficulties, such as failing grades or suspensions, or are considered at risk for problems. As school problems have increased in severity over time, family problems have intensified. Because of this factor, the schools have become more active in referring families for counseling. Over 300 families a year are referred to the Family Counseling Center. Typically, the school guidance counselor, school psychologist or school social worker refer families to the Family Counseling Center. The services of the Family Counseling Center are provide free to the families.

Graduate students who choose a family counseling internship at the family counseling center are expected to work with a minimum of eight to 10 families a semester. They are encouraged to work for about 12 sessions with each of the families, although depending on the needs of the family, they may meet more or less often. The graduate students receive weekly clinical supervision through the internship course as well as

individual supervision. The clinical supervision is given by the instructor of the class but may, at times, be given by other faculty and doctoral graduate students in the counseling department.

The supervision provided in the internship class is based on a fifteen to twenty minute videotape presentation of a family counseling session accompanied by a case report and oral presentation by the counselor. Suggestions concerning systemic hypotheses, interventions and techniques are discussed with the instructor and other graduate students in the class. Each graduate student is expected to make at least two presentations a semester on cases in which they are having difficulty and need assistance. Although faculty are the primary clinical supervisors, other doctoral graduate students also provide clinical supervision as well. The curriculum in the internship course in family counseling at the college is based on a cognitive developmental framework in order to promote cognitive growth and development in the students. (See Appendix B)

After the families are referred by the schools, the family counseling center administrative staff, composed of doctoral students and faculty advisors, assigns a novice family counselor. The families are informed that because this is a training program the counseling sessions will need to be videotaped for supervision, teaching and research purposes. Only those families willing to accept these guidelines can receive the counseling services. In addition, the counselors are expected to include the whole family in the counseling sessions. If a family chooses not to participate, they may be referred to another agency in the community for individual counseling.

## Participants

### Novice family counselor interns.

The participants were six graduate students enrolled in the master's and doctoral programs in counseling at Pine Tree College. Two additional students participated for the first semester but one dropped out of the program and one stopped seeing families. The six graduate students were enrolled in the two semester family therapy internship class with the internship placement at the Family Counseling Center associated with the college. The graduate students in the family counseling internship course provide the free family counseling services in either a school setting or a clinic setting housed at the College. All of the graduate students in the study, prior to the internship, had completed a one semester course in marriage and family therapy. The amount of clinical experience of the graduate students varied based on the number of years in the field and number of courses completed in the program.

All of the graduate students who volunteered became a part of the study. All of the students in the internship class were graduate students in the counseling program in the education department except one student who came from the psychology graduate program. One of the graduate students described family counseling as her area of focus. The other five described themselves as specializing in either agency counseling or substance abuse counseling. Only one male counselor participated.

### Families.

The families who participated in this study were those referred by the

public school systems to the Family Counseling Center at Pine Tree College. The problems that the families presented with to the Family Counseling Center ranged from moderate problems, such as behavior management of children, to severe problems including substance abuse and violence which may involve other agencies such as the police or social services. All of the families have children who are having difficulties both academically and behaviorally in school.

#### Instructors/supervisors.

The two instructors of the family therapy internship class volunteered to participate in this study. They both have doctoral degrees in counseling and are licensed professional counselors as well as licensed marriage and family therapists. Both of these instructors had input into the development of this study. One is a co-chair of the dissertation committee.

#### Experienced family therapists.

The researcher asked for volunteers from an experienced counselors' clinical supervision group which was run through Family Resources a private counseling agency. The researcher is a member of this group and made this request during a regular monthly meeting. Seven professional family therapists from this advanced clinical supervision group, volunteered to participate in the study. Two other experienced counselors started but dropped out due to prior commitments. The experienced family counselors all had more than 10 years of experience in family counseling, all had at least a master's degree in social work, counseling or psychology, and worked in social service agencies, schools and private practice. The researcher is also a member of this clinical supervision

group.

Master family therapists.

Two master family therapists participated in this study. One was the co-leader of the community supervision group and had worked and trained with Salvador Minuchin (father of structural family therapy) in the late 60s to early 70s. He was influential in the development of the theory of structural family therapy (Becvar & Becvar, 1988). The second master family therapist teaches in the psychology department at Pine Tree College, studied with Minuchin in the 1970's and wrote one of the first textbooks in family therapy as well as a number of other texts (Nichols & Schwartz, 1995). This man described himself as a chronicler of family therapy.

Informant.

A doctoral student researching the phenomenological experience of the internships and clinical supervision participated as an informant for this study. The doctoral student's research involved examining the experiences of all the graduate student interns in the counseling program through direct observations of the graduate students in the internship classes and in-depth interviews. The collaboration between the investigator and this informant helped to clarify the researcher's perceptions with the reality of the interns' perceptions. The informant also added important contextual information as well as checked the observations and interpretations of the investigator.

Peer debriefers.

In addition, two peer debriefers participated in this study to provide

sounding boards and objective perspectives to the researcher. One of the debriefers was not involved in anyway with family counseling while the other is a master therapist and expert on videotape analysis.

### Gaining Access

#### Graduate students.

At the beginning of first semester letters were mailed to each of the 12 graduate students enrolled in the internship class describing the study and asking for their participation. A stamped, addressed post card was included with the letter. The graduate students were asked to indicate on the post card if they were willing to participate in the study and to return it to the researcher in the mail. After receiving the post cards indicating interest in participating in the study, a letter was sent to the volunteers providing them with the informed consent forms and additional information to address other questions they might have about the study. The researcher's phone number was also included in case a student had additional concerns or questions. (see Appendix C for sample.)

#### The families.

The graduate students who volunteered to participate in the study were informed of the need to specifically inform the families with whom they were working about the nature of the research project. The families who participated in the Family Counseling Program signed an informed consent form addressing videotaping and research as part of the stipulations for receiving counseling. The families were provided with an additional letter describing the purpose of this

research and all members of the family signed an informed consent form specifically designed for this study. (See Appendix C for sample.)

The experienced family therapists.

Seven experienced family counselors were obtained from a clinical supervision group in the community which meets once a month from September to June. At the October meeting of the clinical supervision group the experienced family counselors were approached about participation in this study. At this meeting letters were distributed to all the members of the group who had five or more years of experience in the group and as a practicing family counselor. The letters described the nature of the research and asked for volunteers to participate in the study. Informed consent forms and an addressed stamped envelope were provided. The experienced counselors were asked to return the consent forms indicating their willingness to participate in the Delphi study. Questions about the nature of the research and what their participation in this study would entail were answered at this meeting. A volunteer from the experienced family counselors was asked to provide a videotape of a family session typical of their work. An informed consent form was provided for the family with a letter describing the research.

The master family therapists.

Both of the master family therapists were informed of the nature of the research and were asked for their consent to use information gleaned from the personal interviews in this study. Both agreed to participate and be audiotaped.

Ethical considerations.

Participants were treated in accordance with the ethical standards established by American Psychological Association and the American Counselors' Association. The proposal was approved by the Human Subjects Review Board at Pine Tree College. Participation was on a voluntary basis and strict confidentiality was maintained. Participants could withdraw from the study at any time without penalty to them in their internship class. Their grade in the class was not connected to participation in this study in any way. The interns, instructors, and experienced counselors all signed an informed consent form before participating in the study. Upon request of the interns and instructors, the results of the study will be made available at the completion of the research.

As a licensed professional counselor and clinical supervisor, the researcher is governed by the American Counselors Association (ACA) (1997) code of ethics which states "the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (p. 2). Although the investigator did not supervise the interns nor work directly with the families, according to the ACA code of ethics "the researcher is responsible for the subjects' welfare throughout the experiment and take reasonable precautions to avoid causing injurious psychological, physical or social effects to their subjects" (p. 8). The ACA code of ethics clearly states that information related to counseling services are confidential "unless disclosure is in the best interest of clients, is required for the welfare of others or is required by law" (p. 10). Because the entire videotape of the family counseling sessions was viewed, it increased the likelihood of the researcher seeing potentially risky behavior which an instructor may not have

seen and the novice intern may have missed.

A procedure was established with the dissertation committee to address potential concerns of the researcher with regard to the well being of the family. The researcher was to contact the counselor's instructor and have the instructor contact the intern and family. With regards to other issues of confidentiality, none of the families were known to the researcher on a personal level. If the researcher had recognized any of the families, the videotape would not have been viewed or used as a part of this study.

### Materials

Videotapes of the family counseling sessions which are used for clinical supervision of the novice family counselors were collected for this study. Because the graduate students were expected to present twice a semester, a minimum of 28 tapes were collected. The rate of referral to the Family Counseling Center was slow at the beginning of the first semester. Some of the graduate student interns did not receive families until November. Each graduate student intern was expected to present a videotape and case history of a family on which they need assistance to the internship class at least twice a semester. However, given the slow referral rate, many of the students did not present until the end of the first semester and a few only had one to two tapes while others had three or more. This also meant that some students were practicing skills from the beginning of September while others had less practice first semester.

### Development of Questions

The novice counselors were asked to respond to structured questions

(see Appendix D) prior to and after each videotaped counseling session with families. Some of the questions were based on the literature review which addressed the relationship between the development of complex hypotheses and counselor effectiveness (Holloway & Wolleat, 1980; Martin, Slemon, Hiebert, Halberg, & Cummings, 1989; Morran, 1986; Morran, Kurpius, Brack & Rozecki, 1994). Another source for the development of these questions was the results of the Delphi study of Figley and Nelson (1990) which polled family therapists trainers about the important skills necessary of beginning family counselors. Further, the results of the studies by Breunlin, Schwartz, Krause, Kochalaka, Puetz and Dyke (1989), Liddle and Saba (1982), Mohammed and Piercy (1983) and Lyman, Storm and York (1995) which discussed intervention strategies, the effects of age, knowledge, experience, other demographics, and the importance of systemic hypothesis, all influenced the development of the questions. Information such as the make up of the counselors' families, number of years of experience in family counseling, age of counselors and perceived severity of the family problems was collected. Additional questions examined the context of the session, the thoughts and systemic hypothesis before and after each session, the goals and strategies planned for the session and the intern's reactions to the learning process.

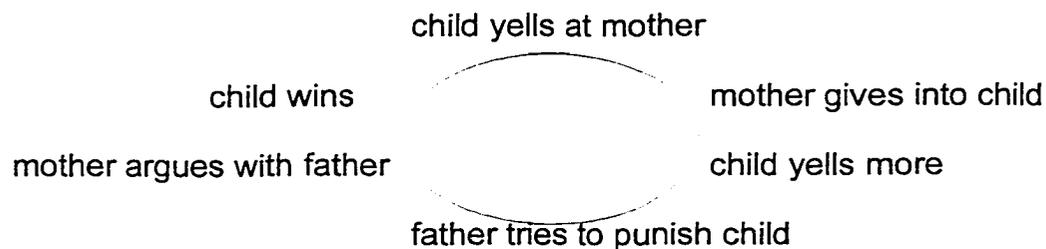
Consistent with the constant comparative approach, after the first semester analysis of the response forms, a visual example of a systemic hypothesis was added to the questionnaire in order to encourage the inclusion of more relational information rather than intrapsychic analysis. The response form

completed after the session was essentially to determine if the counselors changed their goals and systemic hypothesis based on their experiences in the session.

The following is an example of questions answered by the family counseling interns before the counseling session:

1). Describe the structure of the family. For example, who is in charge, what is the nature of the boundaries between subsystems, where do they lie on the continuum of enmeshed versus disengaged?

2.) What is your systemic hypothesis? (The following is an example of a systemic hypothesis. A child yells at the mother, the mother gives into the child, the father tries to punish the child, the mother protects the child, the child yells some more, the mother and father argue about the child, the child does what he wants.)



3.) What are your therapeutic goals?

The following is an example of some of the questions the family counseling interns were asked to complete after the counseling session:

1.) What did you learn from this counseling session?

2.) Did your systemic hypothesis stay the same? If no, how did it change?

3.) What thoughts and feelings were going through your mind during the session?

The internship instructors were asked to complete a questionnaire concerning their supervision of each of the participants. Questions addressing the supervisor's directives to the intern as well as any cues or themes they were using to assist the intern were solicited. The instructors were also asked to rate the severity of the family's problems since this area has been consistently noted in the literature as affecting the learning of novice family counselors (Breunlin, Schwartz, Krause, Kochalka Puetz & Dyke, 1989). The following are examples of the questions asked of the supervisors.

1.) If this intern has received supervision before from you on this family, what were your directives?

2.) What were your directives today concerning the present session and the future sessions with this family?

3.) Do you expect the intern will be able to follow the directives? Yes \_\_\_ No \_\_\_\_.  
If no, what do you think the problem will be?

4.) How would you describe this intern's conceptualizations of the family's problems?

## Videotape analysis

### Delphi study.

In order to inform the review of the videotapes concerning the development of structural family therapy skills, a list of the most important skills needed by novice family counselors was generated by the experienced professional family counselors. The research conducted by Figley and Nelson (1990) was based on the opinions of academic instructors of family therapy in university settings. Because the present study used actual family counseling sessions, a study of the opinions of experienced family counselors was done in order to provide an additional view of the most important skills for novice family counselors to learn ( See Appendix E). The seven experienced professional family therapists were asked to participate in a modified Delphi study at the beginning of the first semester.

The Delphi method is a procedure designed to sample a group of knowledgeable persons with the goal of gaining a consensus of opinion on a particular topic (Dalkey, Rourke, Lewis & Snyder, 1972; Fish, 1989; Fish & Busby, 1996). It is a strategy to obtain opinions from a group of competent experts. Dalkey et. al. (1972) refers to this process as "more or  $n$  heads are better than one" (p.15). The procedures for accessing the opinions are based on methods which diminish the influence of dominant individuals within a group, personal interests and group pressure for conformity (Dalkey, et al., 1972). The Delphi method structures communication by providing a chance for the participants to first express their opinions individually and anonymously, get

feedback from the group about these views in written form, see other views of the same ideas and have an opportunity then to revise their own views (Fish & Busby, 1996).

The Delphi study for this research was modified in two ways. First the participants were asked to rank the 10 most important skills needed by beginning family therapists. Ranking these behaviors rather than rating them on a seven point Likert Scale was a modification in the typical Delphi procedures. Secondly, a focus group was held at the end of the study to have the seven experienced therapists reach a consensus concerning the 15 most important skills needed by beginning family therapists which were generated from the previous two rounds of the Delphi study. Focus groups are generally composed of 6-12 people who share a common background or expertise (Piercy & Nickerson, 1996). A focus group typically involves an interactive group discussion with an open-response format with the purpose of understanding the participants views (Piercy & Nickerson, 1996). This focus group was different than most because the main directive was for the group to discuss the list of skills generated during the second Delphi round and to come to consensus about the most important skills needed by novice family counselors. Notes were taken on a blackboard during the discussion, the session was audiotaped, and transcribed and researcher notes were also taken.

The Delphi study employed the following procedures.

- First the experienced therapists were asked the following question. *List the 10 most important skills you believe are necessary for novice family counselors to learn.*
- Each participant mailed their list to the researcher who collated all the responses, collapsing duplications into categories.
- A list of 71 skills was sent back to the experienced therapists with the following instructions: *Of these 71 skills, rank in order of importance the top 20 skills you believe are the most important skills necessary for a beginning family therapist to learn.*
- The experienced therapists returned these rankings with additional suggestions concerning conceptual groupings as well as ranking of the top 20.
- From this information, a list was developed of the most frequently mentioned descriptors of skills and characteristics seen as important for novice family counselors.
- This list of skills was also divided into personal characteristics, conceptual and process skills based on the literature review and was then presented to the experienced family counselors in a discussion group (Figley & Nelson, 1990; Greenberg & Neimyer, 1984).

- The discussion group was given the following instructions. *Here are the top 20 skills broken into conceptual, perceptual and process categories. This group should rank these skills by coming to a consensus concerning the importance of these skills for beginning counselors.*
- The group of experienced counselors discussed together and created a new list based on the discussion and consensus of the group.
- Their comments were documented and the list used to assist in the analysis and interpretation of the novice counselors' videotapes.

A volunteer from this group was solicited to provide a videotape of his/her work to be viewed at the end of the study to provide an experienced counselor perspective to the researcher.

#### Flanders scale.

In order to inform the review of the videotapes concerning the development of general counseling skills, the Flanders Scale adapted by Fowler & DeVivo (1988) for counseling was used. The Flanders Interaction Scale was originally developed to analyze the verbal interaction between teachers and students in order to improve instruction as well as to prepare future teachers (Flanders, 1970). It was employed to record the presence or absence of particular behavior patterns during an observation of a teacher within the classroom (Flanders, 1970).

The Flanders Scale was modified and applied to counselor-client

interactions by Fowler and DeVivo (1988) so that counselors could modify their behavior to influence clients' to change in positive ways. In this scale verbal behaviors are divided into ten categories which are classified as either indirect or direct. (See Appendix E) The scale is also divided into counselor responses and client responses. In addition to the original categories, a number of additional categories were added and a few deleted which were not applicable to the counseling setting. The following categories were added to make the scale applicable to counseling: Asks content questions; asks feeling questions; positive confrontation and criticism. The categories, gives reprimands and scolding were eliminated (Fowler & DeVivo, 1988).

The Flanders Scale is used in the internship class by the instructors to provide feedback to the novice family counselors based on the absence or presence of observed behavior. Initially, the Flanders Scale was used in this study to count the presence of behaviors, but it became apparent that much of the interactional data was not included in this process. A different observation technique which provided more information concerning the interactional component was implemented based on the Mitchell Model Matrix (Fowler & DeVivo, 1988). This model entails noting the behaviors of both the client (a family member) and the counselor every 3-5 seconds by recording it in columns such that the counselor's response leads to another response which may or may not be the client's responses, etc. These columns of coded behaviors were then converted to couplets and transferred to a matrix (Fowler &

Devito, 1988). The categories were totaled and calculated to give percentages of counselor and client verbal behavior. (See Appendix G for matrices.)

### Interviews

In order to understand better the history of structural family therapy, two well known family therapists, who studied with Minuchin during different phases of the development of family therapy as a treatment modality, were interviewed concurrent with the Delphi study. Based on the literature review, open ended questions were used to elicit more contextual information with regard to the development of the theory and therapy. The interviews were unstructured and employed open ended questions which addressed the following issues:

- How did they become involved in family therapy?
- What was it like learning from the founding fathers?
- What were the primary issues in the early years of the development of this theory?
- How has their theoretical orientation and therapeutic practice changed over the ensuing years?
- What do they consider the “Best Practices” for training family counselors?
- What are their concerns for the future of the field and the profession?

Information from these interviews were included in the literature review and a summary is provided of the interviews in Appendix A. A reflective journal was written by the researcher which noted her responses to the data as well as discussions with the informant, the debriefers and doctoral committee members.

## Procedures

The following describes the sequence of the steps followed in this study.

- The dissertation proposal was presented to the doctoral proposal committee for approval in May of 1998. Changes in the design and membership of the committee were recommended.
- After consultation with research faculty, the dissertation proposal was re-written, with recommended changes and the dissertation committee was reconfigured with appropriate research faculty members. The proposal was presented in July 1998. Approval was received with further recommendations for the design.
- The last week of August the forms were given to the Human Subjects Committee representative in the department of education for approval.
- Approval from the Human Subjects Committee was received by the second week in September.
- A list of graduate students enrolled in the internship class in family counseling was obtained from the instructors of the course.
- All of the graduate students who were enrolled in the internship class were contacted by mail during the second week in September and asked to participate in the study.
- After informed consent was obtained, a list of participants was forwarded to the instructors so that they would be able to know from whom to collect the videotapes and responses to the questionnaires.

- The graduate student volunteers were asked to share videotapes of their family counseling sessions and respond in writing to structured questions addressing the context of their sessions, their systemic hypothesis as well as their thoughts and feelings before and after the sessions. They were instructed to give this material to their instructors after their class presentations. Because there was also another research study using some of the same students and it was the beginning of a new year, only two of the graduate students responded to the first invitation.
- The internship instructors encouraged the interns to participate in the study, and included the questionnaires as part of the course assignments for all the graduate interns,
- A second mailing of a letter inviting the graduate students who had not responded to participate was sent.
- The response rate increased to eight.
- A system was established for collecting the information and forwarding it to the researcher. The participants gave their case reports, videotapes of the counseling sessions and questionnaire responses to their instructors after each of their class presentations. The instructors shared this material plus their responses to the questionnaire with the researcher.
- On the third Wednesday in October volunteers were solicited from the professional family counselors' supervision group.
- The directions for completing the first form for listing the most important skills were given and their responses collected from some of the experienced

counselors. A few of them wanted more time to think and were given stamped envelopes to forward their responses to the researcher.

- An addendum was submitted to the Human Subjects Committee in the third week in October asking for approval of the interviews of two master family counselors.
- Approval was received the last week in October.
- The interview dates were established with the two interview candidates during November. Each of the two people were interviewed once for approximately one hour and fifteen minutes.
- Interviews were transcribed and reflections written up concerning the information and experience immediately after the interviews.
- The responses to the first round of the Delphi study were analyzed and re-distributed to the participating counselors at the November supervision group. The directions for ranking the list of 71 skills were given at that time.
- A date was set for the third Wednesday in January for the Delphi focus group.
- Videotapes from the novice family counselors were not turned in until late in October. There were only two videotapes provided in October. Because of this, the informant was consulted to determine what was interfering with the collection of the tapes. Due to the slow rate of referrals to the counseling center, many of the graduate students still were not assigned families.
- Each videotape was viewed four times. The first viewing of each occurred when the videotape was received in order to get a sense of the structure of the sessions, the comfort of the counselor in their new role, and the types of

problems of the families. The videotape was reviewed for the entire session.

The researcher took copious notes with regard to the behavior of the therapist and their interactions with the family. All of the videotapes were viewed once before the second viewing of the tapes occurred.

- A meeting was held with the informant to check on the progress in the internship class and in order to provide a context for the directives which were being given during the clinical supervision.
- The second viewing used the Flanders Scale to examine the kinds of communication occurring between the family and the counselor. The second viewing also entailed examining all of the tapes for the current semester in order to create a sense of what was occurring over the group of counselors as well as in individual sessions. Each videotape was viewed during the middle thirty minutes of the sessions.
- One of the male graduate student interns dropped out of graduate school. This left seven participants in the study.
- Delphi discussion group met on January 20th.
- Results of the Delphi study were analyzed and shared with the co-chairperson of the dissertation committee.
- The third viewing of the videotapes, which occurred after the Delphi discussion was completed in January, addressed the presence of structural skills by using the results of the Delphi study as well as the literature review to inform the viewing. Also during the third viewing hypotheses and themes

which emerged in the prior viewings were revisited. Once again the videotape was viewed during the middle 30 minutes.

- The response questionnaires were analyzed simultaneously with the third review of the tapes in order to compare and contrast the counselor's conceptualizations and the supervisor's directives to the counselor with what actually was happening on the videotapes.
- The fourth viewing of the videotapes was with a goal of finding specific examples of skills, themes, and interaction patterns to share with the dissertation committee for a document audit review.
- A consultation was held with the doctoral student peer informant to assess the climate of the supervision group as well as the kinds of challenges which were being observed in the internship class.
- February 11th was the first data audit by the co-chairs of the dissertation committee.
- After consulting with the dissertation co-chairs, the response form for the novice counselor's was revised and a visual example of a systemic hypothesis was added because of the limited relational descriptions provided by the interns.
- New response forms were distributed to the instructors of the internship classes.
- At the beginning of March the first viewing of the second semester videotapes began when two were submitted. The same procedures were used as with the first set of videotapes.

- At the beginning of April a consultation was held with the informant in order to have a more complete picture of the internship experience.
- The videotapes continued to be collected and previewed through April.
- A second data audit was held at the end of May by the dissertation committee after chapter 4 was written.
- On May 7th a sample of videotapes was viewed by an experienced family counselor and clinical supervisor from the community supervision group to confirm the appropriateness of the videotape analysis.
- After all of the novice family counselor's videotapes were analyzed, a videotape of an experienced family counselor was viewed.
- One female graduate student dropped out of the study.
- May 15th informant check.
- A final analysis and interpretation was completed.

Throughout the year the researcher met at least twice a month with an outside peer debriefer to discuss issues that arose as the dissertation progressed. Keeping a focus on the development of the therapist while being mindful of the well being of the families was a struggle which was processed repeatedly.

### Data Analysis

A constant comparative analysis which is a continuing process of developing working hypotheses about categories and themes based on initial information and then modifying and refining them on the basis of subsequent information was implemented (Lincoln & Guba, 1985). A number of sources of

inputs were utilized in this analysis. Figure 2. helps to visual the sources of these inputs.

Sources	videotapes	questionnaires	Delphi	Interviews
Interns	x	x		
Instructors		x		
Experienced therapists	x		x	
Master therapists				x
Informant				x

Figure 2. This figure represents the various sources of data collected for this study.

#### The Delphi study.

The Delphi study was analyzed as each round of responses was completed. The first round of analysis involved collating all of the responses of the seven experienced therapists and putting them into one complete list of skills. This list resulted in over 100 possible skills that were suggested as being necessary for novice family therapists to learn. After consulting with a peer debriefer, an attempt was made to collapse some skills which were considered duplications into one category. However, since this was just the first round of responses, most of the categories were left intact. This resulted in a list of 71 skills.

In the next round of responses, each experienced therapist was asked to reconsider the top skills needed by novice family therapists by ranking the 71 skills generated from all the therapists into the top 20 most important skills. This ranking was analyzed by tallying the number of times each item (1-71) was ranked as important. The item ranked most frequently became number 1 on the next list of important skills. Further collapsing of categories occurred at this point based on comments from the therapists and a redundancy of answers. For example, from the list of 71 items number 12.) identify family process--read the family--identify patterns in the family was combined with number 47.) process vs. content because so many of the therapists gave them the same rank. (See Appendix D)

Based on the frequency count, a list of 15 skills with the number of participants who ranked them as important was generated from most frequent to least. In addition, the investigator labeled the skills either a personal characteristic, conceptual or process variable based on research of Greenberg and Neimeyer (1986). For example, the item ranked most frequently by all seven of the therapists as important, tolerate intensity, was described as a personal characteristic. (See Appendix D)

This list of 15 items was then presented to the seven experienced therapists for their consideration, discussion and to develop a consensus. Once again they were asked to rank the skills in order of importance for novice family counselors, only this time they were to come to consensus as a group. Field notes were taken both during and after the discussion concerning who spoke,

who was listened to, who interrupted whom and how conflict was resolved. The effect of peer pressure was noted on the decision process. The following is the final list generated and grouped by the seven experienced counselors. This list was used to inform the viewing of the videotapes.

#### Conceptual Skills

1. Thinking systemically
2. Identifying and understanding family patterns
3. Conducting a structural assessment
4. Identify themes in families/ develop themes

#### Structural (Doing) Skills

1. Develop a systemic hypothesis about family functions

#### Structural and Conceptual

1. Establishing Boundaries
2. Creating Enactments

#### Relational

1. Tolerate emotional intensity
2. Be able to be quiet, sit with someone and listen
3. Taking care of oneself
4. Patience

#### Relational/structural

1. Giving a vision of hope for change
2. Find ways to join or connect with the family
3. Willing to take direction or supervision

#### 4. Use of the self in therapy; awareness of one's strengths and weaknesses

##### Videotape analysis and interpretation.

Based on the literature review addressing the sequence of learning of novice counselors (Alexander, Barton, Selievao & Parson, 1976; Breulin, Schwartz, Krause, Kochalka, Puetz & Dyke, 1989; Mohammed & Piercy, 1983 ; Tucker & Pinsof, 1984), the nature of structuring skills and family interaction (Friedlander, Wildman, Heatherington & Skowron, 1994; Greenberg, Heatherington & Friedlander, 1996) and the opinions of the experienced trainers reported in the Figley and Nelson (1990) study as well as the results of the Delphi study, an initial set of research expectations was developed. This initial set of expectations or conceptual model of possible performance and development for novice family counselors created a frame of reference in which the first viewing of the videotapes occurred. After the first viewing, this set of expectations was revised based on the observations of the videotapes and a more realistic expectancy was developed for subsequent viewings of the videotapes. With each viewing of the videotapes these set of expectations were revised and informed by the reality of what was seen as well as by additional readings and consultations with the informant and dissertation committee members.

An on-going intensive analysis of the videotapes of family therapy sessions conducted by the six graduate students was done over the course of the nine months. The videotapes were each viewed at least four times. The first observation was to get a sense of the structure to the counseling sessions, and

to develop a familiarity with each counselor intern's personal style. The second and third viewing looked for commonalities across tapes with regard to structure of the sessions, counseling skills, structuring skills and themes.

The second viewing of the videotapes, was enriched by examining the interaction patterns of the counselor interns and the families. The Flander's Scale focused attention more closely on the more generic counseling skills such as listening, paraphrasing and reflecting feelings techniques, employed by the interns and the responses of the families to these strategies. The third viewing was informed by the results of the Delphi study of experienced therapists and examined more closely the structuring activity of the interns as well as their ability to attend to the process of the counseling rather than the content of the conversations.

The fourth viewing was to find examples of each counselor's work which demonstrated a theme or skill to share with the dissertation audit committee in order to be sure of the interpretations. The researcher's experience being a clinical supervisor as well as with her own supervision was also used to choose and interpret the important segments of the videotapes.

Discourse analysis was used to evaluate the themes of the dominant culture such as power, control and authority which were revealed through the viewings of the videotapes (Hare-Mustin, 1994). Discourse analysis is a post modernist strategy which explores how forms of communication actively create the way we comprehend the social world (Bozic, Leadbetter & Stringer, 1998; Hare-Mustin, 1994). It analyzes units of talk larger than a clause or sentence and

includes both verbal and nonverbal aspects of speech (Hare-Mustin, 1994). Discourses highlight some phenomena and obscure other phenomena and are the ways most people in a society talk and act upon a shared viewpoints. Discourses do not just describe the social world, they categorize it (Hare-Mustin, 1994). Because family counseling by its very nature supports the dominant discourse which is to normalize or stabilize the family, it is important to examine the discourses present in the counseling sessions (Hare-Mustin, 1994; Hindmarsh, 1993). Although some authors equate discourse analysis with conversational analysis or microanalysis of conversations, for the purpose of this study the model used by Hare-Mustin, 1994 which explores both verbal and nonverbal indicators of themes of conversation was used. Throughout and after each viewing of the videotapes notes were taken which indicated patterns of behaviors, recurring themes, sequences of "turn" taking within the counseling conversations, kinds of questions asked by the therapist and emotional intensity of the sessions. Language samples were obtained through writing key phrases or categorizations that were made in the sessions. These notes were then analyzed in terms of their social implications or consequences (Bozic, Leadbetter & Stringer, 1998). The work of Hare-Mustin (1994, 1995) in the influence of gender roles, power and control in family therapy was used to inform the analysis.

The analysis of conceptual development was defined by the complexity of the interns responses to the questions. Complexity was interpreted to mean the number of different pieces of information, the presence of multiple perspectives,

the depth of understanding of a relational or interactional view of family problems demonstrated by the interns' responses and overall case conceptualization. The response categories and themes were then placed on an empty response form and re-analyzed by question, by intern and by instructor for unique categories and themes (Rafuls & Moon, 1996). The responses of the interns were also compared to their performance on the videotapes to look for consistency and application of concepts in the therapeutic setting. Further evidence for the discourse analysis was also gleaned from the document analysis.

Although the data analysis process is described as if it occurred in discrete steps, consistent with the constant comparative approach, each piece influenced the analysis of the other parts and vice versa. The videotape analysis was influenced by the questionnaire analysis which was influenced by the Delphi study. The discourse analysis of the tapes was also influenced by the statements of the interns on the questionnaires as well as the instructors directives to the intern.

Because these reviews of the videotapes occurred concurrently with the literature review and the Delphi study they influenced the literature review, as well as the interpretation of the Delphi information and Flanders Scale. (see figure 3)

<i>Interactional analysis</i>	videotapes	response forms	Flanders scale	Delphi study	Discourse analysis	Informant
videotapes		x	x	x	x	x
response forms	x				x	
Flanders scale	x				x	
Delphi study	x	x			x	
Discourse analysis	x	x		x		x
Informant	x	x			x	

Figure 3. This figure represents how the analysis of the data collected interacted with each other. For example, the analysis of the videotapes was influenced by the analysis of the responses form and the Delphi study.

### Enhancing Rigor

In qualitative research the credibility of data is concerned with the accuracy of information and whether it matches the participants reality (Creswell,

1994). In order to increase the credibility or rigor of the videotape analysis, an informant was employed to help validate the match between the investigator's perceptions with the reality of the interns' perceptions. Because the informant was interacting and interviewing the interns, the accuracy of the information and its consistency with the interns' perceptions of reality as experienced during the internship classes was checked (Creswell, 1994).

In addition, a professional outside of the research setting, with a doctorate in counseling, was a peer debriefer who assisted the researcher in maintaining objectivity, questioning hypotheses and helping the researcher organize her thoughts. Documentation of these discussions were part of a reflective journal along with information concerning the researcher's schedule, logistics of the study, insights and reasons for methodological decisions ( Lincoln & Guba, 1985). A second peer debriefer, who is a professional family therapy supervisor and counselor and an expert in assessing and supervising videotapes, was asked to view some of the tapes in order to confirm the analysis.

Triangulation is the use of multiple sources, methods and perspectives and is the primary means of ensuring credibility of a qualitative study (Creswell, 1994; Bischoff, McKeel, Moon, & Sprenkle, 1995; Lincoln & Guba, 1985).

Triangulation seeks convergence of results and allows for the same phenomenon to be seen from different perspectives (Creswell, 1994). Further, it assumes that most of the negative bias inherent in the method, sources and investigator will be neutralized when used together (Creswell, 1994). The triangulation of material, which adds to the trustworthiness of the study, was

accomplished through acquiring multiple sources of data including videotapes, written responses to questionnaires and input from professional family counselors through the Delphi study. The videotapes and the questionnaires provided an in-depth view of the actual behaviors and responses of the graduate students as they developed from novice to more experienced structural family counselors. The nature of the multiple methods and multiple sources of information provided reliability and validity of the observations of the process of the conceptual development of the interns. The addition of viewing experienced professional counselors' videotapes of family counseling sessions at the end of the study provided some boundaries around what does actually occur in the professional world in this arena. It provided a reality check for the researcher with regard to the differences between the set of expectations for the novice family counselors' development, what was viewed on the videotapes, with what actually occurs in the therapy of experienced therapists. realistic expectations for the interns.

In an attempt to limit the effect of personal bias on the analysis of the data, the following strategies were employed:

- 1) The researcher conferred with the instructors when ethical or safety concerns for the families emerged.
- 2) The researcher conferred with the instructors concerning the development of the response forms, and the skill development of the interns.
- 3) The researcher participated in data audits with the co-chairs to provide additional perspectives.

4) The researcher conferred with the informant who provided her with information concerning action taken within the supervision classes with regard to the interns.

Chapter 4 will present the analysis and interpretation of the data collected which examined the development of the six novice family counselors over their nine month internship.

## Chapter 4.

### Findings and Analysis

#### Introduction

Chapter 4 presents the findings and analysis of the data collected focusing on the growth and development of conceptual, perceptual and therapeutic skills in structural family therapy of six novice family counselors over the course of their nine month internship in a graduate school setting.

Conceptual skills refers to the novice counselors' knowledge and use of basic concepts of structural family therapy. Perceptual skills refers to the counselor's skills with regard to perceiving patterns of interaction and the therapeutic skills refers to the number and quality of the intervention strategies employed by the novice family counselors over the nine month period (Greenberg & Neimyer, 1986 ). This analysis was guided by four questions:

- 1.) What do the interaction patterns of the novice family counselor look like and do these interaction patterns change over the period of the internship?
- 2.) How do novice family counselors conceptualize family problems? What hypotheses do they generate with regard to the relational patterns in the family?
- 3.) What do the structuring and re-structuring skills of the novice counselor look like in counseling sessions? How active do the counselors become over the course of their training?
- 4.) In what ways does the kind of interaction between the novice counselor and the family influence the counselor's behaviors and conceptualizations ? A description of changes in the counselors' interactions which occur relative to the

nature of the families' problems and of the severity of these problems is presented to address this question.

Data was collected through videotapes of the family counseling sessions and through written responses to questionnaires completed by the novice family counselors and instructors of the internship class. An informant who was attending the internship class and interviewing the interns also served to corroborate and enrich this analysis.

This chapter is organized first by examining each counselor and their interactions with the families as represented by the videotapes and written responses. The Flanders Scale was used to inform the analysis of general counseling skills in order to assess the counselors' verbal and nonverbal interactions with the family members. The Flanders Scale analysis also provided information concerning the counselors' initial approach to counseling and if this approach changed over time.

Based on the results of the Delphi study with experienced counselors, and the literature review the following concepts, percepts and therapeutic skills were also analyzed: The counselors' perceptions and conceptualizations regarding the assessment of the family structure, interaction patterns, the systemic hypothesis, restructuring plan (therapeutic strategies) and the counselor's overall therapeutic approach were examined both as they appeared on the videotapes and on the response forms. The development of each of the counselors is analyzed using the following framework:

A.) The initial counseling approach employed by the counselor was identified; e.g., person centered (includes child focused), insight oriented, confrontative, family counseling, group counseling, etc.

B.) The results of the Flanders Scale analysis examined the counselors' responses with regard to direct versus indirect responses, content versus feeling responses, and the effects of the level of emotional intensity on the counselors' behaviors (See Appendix F for Tables charting these behaviors)

C.) An analysis of the counselor's structural family therapy concepts, percepts and therapeutic interventions was done by grouping the counselors' responses in the following three categories:

1. The structural assessment: The counselor's skills at assessing the the basic structure and organization of the family were examined.

Structure refers to the invisible set of rules that organize the way the family interacts and includes such things as hierarchy, boundaries and developmental stages (Nichols & Schwartz, 1995).

2. The systemic hypothesis : This examined how clearly the counselor described a circular hypothesis about the sequence of interactions among family members and subsystems (Becvar & Becvar, 1988).

3. The restructuring plan and interventions : This looked at the therapeutic plan and strategies employed by the counselors to break the dysfunctional transactional patterns that maintained symptoms. The following techniques were assessed to determine if they were part of a restructuring plan.

*Joining:* This involved assessing how well the counselors appeared to be able to create a therapeutic alliance with the families. Assessing this process involved studying the ways the counselors formed a partnership with the families with a common goal. Initially the counselors need to accommodate the family's world view and idiosyncrasies before presenting another viewpoint (Minuchin & Fishman, 1981).

*Reframing:* This involved assessing whether the counselors attempted to change the interpretation or organization of the family problems to offer the family a more useful perspective which allowed for a change in the transactional sequences and increased competence. In what ways did the counselors offer new views of reality that were helpful to the families (Minuchin & Fishman, 1981).

*Normalizing:* This looked at the ways the counselors attempted to assist the families by changing their perceptions of a problem from being pathological to a normal developmental issue (Minuchin & Fishman, 1981) or a normal response to a difficult situation.

*Enactment:* This assessed whether the counselor constructed interpersonal transactions in the session in which the dysfunctional transactions among family members were played out (Minuchin & Fishman, 1981). Enactments bring problems into the therapy room and allow the therapist to see dysfunctional patterns and then suggest alternative transactions. Families can, thereby, experiment with new behavior.

*Punctuation.* Was the counselor able to see strengths in the family and point them out when they were occurring in order to increase feelings of competency in the family (Minuchin & Fishman, 1981)?

D.) Instructors' Assessment of the counselors' progress is examined based on the instructors' responses to the questionnaires.

E.) Counselors' self evaluations were analyzed based on their personal reflections on their family counseling sessions described in the questionnaires.

F.) Themes which occurred within the conversations in the actual counseling sessions and on the response forms were examined.

G.) A summary of each counselor's progress is given in order to highlight the salient points in their development and growth in the conceptual, perceptual and therapeutic skills of structural family therapy.

Some of the families are grouped together for analysis because of similarities in the families and counselors' interactions. Other families are analyzed separately because of the uniqueness of the interaction patterns between the counselor and the family or the family's presenting problem was unusual.

The response form analysis involved examining the responses of the Counselors to the 13 "before session" questions and the 8 "after session" questions as well as the responses of the instructors concerning their supervision of the student counselor. The analysis was broken into an evaluation of the following categories:

- a. the structural assessment skills
- b. the quality (number of factors identified) of the systemic hypothesis
- c. the quality of the restructuring plan and intervention strategies
- d. the ability of the counselor to re-assess and evaluate their work
- e. the counselor's interpretation of the instructors' directives
- f. the counselor's willingness to implement the instructor's directives
- g. the instructor's assessment of similar issues with the counselors.

Words, phrases and themes were highlighted and analyzed. Interpretations of this data were made by comparing the instructor's comments, the videotapes and the student's responses across the two semesters.

The questions on the "before" and "after" response forms were grouped for the analysis based on whether they addressed the counselor's structural assessment, systemic hypothesis, restructuring/intervention plan and their personal reflections. Comparison of the counselor's responses to the before and after session forms provided information relating to how they perceived new information and integrated it into their previous conceptualizations of the family. The behaviors displayed on the videotapes and the written responses of the counselors were also compared and contrasted with the instructors' assessment of the depth and understanding of the novice counselors' conceptualizations, intervention skills and receptiveness to their supervision. The novice counselors' responses also were compared with their actual performance on the videotapes

in order to evaluate how well they applied their stated concepts and strategies in the actual counseling sessions.

The analysis of the response forms was integrated into the analysis of the videotapes in order to provide a clearer picture of the conceptualizations and perceptions of the counselors. A discussion of the themes from the response forms and videotapes is presented to provide a context to understand the ways in which the counselors categorized the phenomena occurring in the sessions. Finally, a summary is provided which highlights the changes observed in the counselors, the things that stayed the same and the strengths of the counselors. The severity level of the families is discussed throughout the case studies based on both the counselors' and instructors' assessments of the family.

Finally, group trends were examined by comparing the counselors to each other in a cross-case analysis. The counselors' answers to the questions on the response forms and their behaviors on the videotapes were compared and contrasted. The information was organized by the following categories: counseling approach, Flanders analysis, structural assessment, systemic hypotheses, and restructuring plans and interventions, themes, instructors' responses, and self-evaluations .

For the reader who is unfamiliar with structural family therapy concepts, definitions of basic terms are provided at the end of chapter one.

### Demographics

The six novice family counselors ranged in age from 24 to 50 with a median age of 38. There was one male and one Asian American in the group. All

six of the interns had one didactic course on marriage and family counseling before entering this internship. One student had a previous practicum and internship in family counseling and four had completed practicums in agency counseling or addiction counseling. Five of the interns had completed internships in agency counseling. Two of the counselors split their family counseling internship between family counseling and substance abuse counseling.

A number of variables addressing the influence of the counselor's personal characteristics on learning family counseling were noted in the literature such as the severity level of the family, the counselor's years of experience with individual counseling, the role of academic training, experience with families of their own, which effect the learning of novice family counselors and are, therefore, considered in this analysis (Breunlin, Schwartz, Krause, Kochalka, Puetz & Van Dyke, 1989; Greenberg & Neimeyer, 1986). Figure 4. gives a clearer picture of the demographic information relevant to the participants in this study.

Counselor	1	2	3	4	5	6
Courses in family therapy	1	1	1	1	1	1
Practicum	agency	FC	agency	school agency	agency	addict
Internships	agency	FC	agency	addict.	agency	agency
Hours completed	33	48	27	20	48	30
Degrees	BA.	BA.	MSW	MS.	M.Ed.	MSW M.Ed.
Years of experience as a counselor	0	0	7	0	0	12
Living in family	no	yes	yes	yes	yes	yes
Relevant experience	none	teacher	counselor with adolescent substance abuse program	military officer	none	social worker with substance abuse

Figure 4. Describes the demographic characteristics of the six novice family counselors who participated in this study.

## Case Analysis

### Counselor 1

Families	Reason for referral	Members of family	Fall	Spring	session number	severity rating
Family R.	10 yr. old boy w/brain tumor threatened suicide	mother 10 yr. boy	x (2 tapes)		session # 2 and 3	severe
Family Q.	9 year old boy defiant, destructive & disrespectful	mother in process of divorce 9yr.boy 13yr.boy 7yr. girl 4yr.boy ex-husband an alcoholic		x (2 tapes)	session 2 & 5	very severe; abuse possible by boyfriend

Figure 5 . Describes the families presented by Counselor 1 in the internship class.

Counselor 1 presented two tapes of the R. family in the fall. The 10 year old boy in this single parent family had had an operation to remove a cancerous brain tumor but his cancer was in remission. The school guidance counselor referred the family to the center because the child said he wanted to “kill himself”.

During the spring semester Counselor 1. presented two tapes of the Q. family. This family had been referred by the schools because the mother’s live-in boyfriend was hitting the children as a form of discipline and the mother approved. The mother was in agreement that they needed counseling, but she did not know how she could control the children without the boyfriend taking a

“hard line with them”. The mother was very negative about the two older boys saying such things in the session with them present as, “He (the 9 yr. old) needs to go live with his father, I can’t deal with him any more” or “I will not let these two boys destroy my relationship with my boyfriend. I deserve a life!” The mother, her three sons ranging in age from 13 to 4 and her seven year old daughter were present for the sessions.

*Initial Approach:* Counselor 1 had no prior experience as a counselor other than a practicum and internship in agency, or individually oriented counseling. Counselor 1 was splitting her internship by spending 50% of her time doing family counseling and 50% doing substance abuse counseling. Counselor 1 started the fall sessions with family R. by using basic listening and reflecting skills to provide support to the mother who seemed quite anxious about her son’s emotional well being. Counselor 1 appeared to have a person centered approach based on her focus on the individuals. The Counselor began the first semester session, which included the mother and her son, by asking open ended questions and reflecting back what she heard in a very calm, quiet voice. She said, “I just want to get to know, kinda what’s been going on with you two? I know B.(the son) did not want to come”. The son interjected in a louder voice, “ Right, I don’t want to be here!” The counselor responded in her quiet tone, “ I understand you don’t want to be here, cause this is hard, but I hope it will get better after you been here a while” The boy said, “ I didn’t want to come!” and Counselor 1 replied, “there is no problem with you saying that, I understand. I want you to feel free to say what you like to me, so mom would you like to tell me

how you're doing? How have things been for you?" The mom went on to give some basic information and then described how she discovered that her son "had brain cancer". Counselor 1 listened attentively, nodding her head and saying "um,hum". The mother's voice cracks and she said, "I don't know if I can do this" and started to cry. The boy hid his face with a magazine and said "I don't like this crying". The counselor ignored his response and has him go play with toys and talks some more to the mother about the son's cancer and some events which took place in the school.

The Counselor's reflective, indirect style, which was relatively effective with the R family in the fall, was not as applicable with the Q family because there was so much negativity and activity within the family. At one point the mother grabbed the daughter and told her in a harsh tone, "stop being so disruptive". Another time when one of the older boys pointed out that they thought the youngest child had a black eye, the mother responded with "pardon me, we're talking about one thing and will talk about the other later". The children changed chairs, talked loudly to each other, giggled, sat on each other's lap, kicked each other and roamed around the rooms. The youngest ran in and out of the room screaming and both the mother and Counselor seemed overwhelmed and ignored it.

#### Flanders analysis.

According to the Flanders analysis of the two sessions with the R. Family, 47% of this counselor's responses were indirect (accepting feelings, encouraging the conversation, asking open ended questions), 25% of the

counselor's behavior was silence and 47% of the counselor's and clients' combined responses were related to feelings. Most of the counselor's indirect behavior entailed nodding her head or saying um-hum to encourage the family members to talk (18%). In the second session the counselor tried to have the boy and his mother talk to each other. The Counselor became more direct when she said to the mother and boy, "I'd like you two to talk about your feelings". Both the Counselor and the family stayed in the same positions in the room, even when more physical closeness was needed. The Counselor faced the mother and child so that she could maintain eye contact. The Counselor's tone of voice was gentle and expressed empathy for the family's plight. When she asked questions she focused on feelings (47%). For example, she asked, "How about now, do you still have those feelings?" or "When you hear your mother talk about your operation and your responses to it, do you still have those feelings?" She responded to feeling statements with such reflections as, "It is difficult to talk about that time and your feelings. I understand".

The Counselor's most typical sequence of communication was to ask an open-ended 'feeling' question, but when feeling responses became very intense or caused some tension between family members, the Counselor asked content questions, changed the topic of conversation or was silent. In the first tape when the child vehemently asserted, "I don't want to be here", the counselor focused on the mother. When the mother's voice cracked as she said "he was diagnosed with brain cancer" the counselor asked "how did the school deal with his problem". In the second tape of this family, when the child cried because, "I don't

want to talk about it! You don't always know what's best" and then he hid his face in his hands, the counselor and the mother had a conversation about how his hair was growing back in and was finally covering the scar. Neither the counselor nor the mother attempted to physically comfort the child. When the boy became more visibly upset by the line of questioning about feelings, the counselor said "Well, tell me how you are doing in school now". In both tapes, whenever the feeling tone became more intense, that is, someone was angry or crying, the counselor remained quiet or joined the mother in talking about content information. Counselor 1 seemed hesitant of where to go with the feelings.

The Flanders analysis could not possibly give a complete picture of the amount of conflict and intensity of emotions present with the Q family. It did, however, highlight the Counselor's reaction to it. The Counselor's non-verbal behavior and verbal behavior were distinctly different than in her previous tapes. The nodding of her head and verbal encouragement for the family members to speak was almost non-existent (5%). Her voice had an edge to it as if she were holding back her anger. The Counselor and the mother seemed to match each other in their irritability and impatience as shown by their comments to the children. At one point the Counselor said to one of the children, "Go into the other room", which was so unlike her non-directive supportive voice with Family R.

The Counselor did attempt right from the beginning of the sessions to take a leadership role by setting the topic of conversation. She started by asking, "How have you followed our plan this week?" The Counselor tried to

maintain some control of the conversation by keeping it on how the children were experiencing the household rules and regulations while at the same time looking for ways to support and join with this very stressed mother. Thirteen percent of the Counselor's responses were direct in the spring compared to seven percent in the fall.

The Counselor began the second session following the directive of the instructor, "to join with the mother and soften her (the mother's) attitude toward the children", but the following patterns emerged. The Counselor responded to the chaos and emotional intensity by asking more content questions (37%), being silent (30%) and talking less (28%). She asked, "Tell me about your goals for the family, is it about getting them to do homework or ?.. " The mother interrupted the Counselor and replied..." I want to change my relationship with him" (points to one of the older boys) and then the mother grouped the older two boys together by saying "they need to understand that an adult is an adult and they need to respect that and that they have responsibilities. I want the fighting to stop between myself and him." The Counselor then picked up on this theme of fighting and calmly asked the mother about the content of the fights. "What have you all been fighting about most recently?" Up until this point the voice tone of the mother and Counselor was calm and quiet but it was obvious that the mother was making an effort to contain herself. The mother responded to the question about fighting by changing her voice quality from quiet to angry and intense, "Look at them! They can't even sit in the room and behave themselves at this

important meeting.” She was pointing at the two boys who were sitting quietly and attending while the four year old was choking the seven year old girl.

Thirty-six percent of the Counselor’s responses were involved in content questions while 20% were involved with feelings. Although the Counselor increased the directness of her style to 14% from 7% in the fall, and her indirect messages were at 22%, down from 47%, this family was running over her. The Counselor was struggling to take leadership and direct the sessions, but her attempts to join with the mother by talking about feelings resulted in the mother exploding with feelings. The Counselor turned to the children to challenge the mother’s perceptions, or complimented the older children for taking care taking of the younger children. These strategies resulted in the Counselor indirectly criticizing the mother three times during this observation.

Structural analysis.

*Structural Assessment:* Counselor 1 had a somewhat simplistic view of the concept of enmeshed boundaries and family hierarchy. Counselor 1 described the structure of the R. family as “the family consists of a mom and a son who share control in the family. The boundaries are diffuse between the mother and the son and the mother is enmeshed with her son. Because the mother spoke for the child and monitored the child so closely, the Counselor believed that the mother was too intrusive and enmeshed with the child. Although this was partially correct, it did not reflect an understanding of the effects of a life threatening illness on family functioning. The son appeared to be taking care of the mother’s feelings. He seemed unsure of how she would deal

with them. When the mother asked him, “are you still mad at me for not being able to make you better”, the boy covered his head and said in a squeaky voice which was struggling for control, “I can’t talk to you about this!”.

Counselor 1 described the structural assessment of family Q as, “mother has too rigid boundaries with regard to showing her children affection or rewards for good behavior, but the boundaries become less clear and more diffuse around adult issues like the mother expressing her dislike of their father in front of the children”. With regard to the hierarchy in the family Counselor 1 described the mother as “struggling to maintain control of the family and be in the power position”. The Counselor was partially correct about the rigid boundaries or disconnect between the mother and children. The mother needed to re-connect with her children and slow the integration of the boyfriend into the family. The developmental stage of the family with respect to the mother’s separation from her first husband and entrance of a boyfriend into the home was in only a beginning phase. This process was not assessed by Counselor 1. The Counselor’s focus on control and power only served to fuel the mother’s anger.

*Systemic Hypothesis:* The Counselor reported “the problems (Family R.) are a result of shared control/power in the hierarchical organization and mom’s fear of losing her son”. Because the Counselor did not have a clear vision of the patterns of interaction the Counselor had trouble coaching the mother to emotionally nurture her son.

The Counselor described the interaction patterns as “the Q. family’s patterns of interaction maintain the presenting problem by creating a high level of

chaos and focus on the negative aspects of the family so that positive communication or productive interactions are eliminated". Because the Counselor lacked a clear understanding of the interaction patterns and developmental stage of this family, she did not have a vision of how to block the mother's negative interactions or know how to encourage her to become more connected and nurturing toward her children.

The Counselor attempted to follow the directives of the instructor which were "to become more connected to the mother( family Q)", but the Counselor appeared to become distracted by the children and inducted or reflected the negative activity in the room as evidenced by her critical tone of voice. It seemed to leave her paralyzed.

#### Restructuring plan and interventions.

*Joining:* The counselor was able to join with the mother of the R. family around the child's trauma of having cancer which allowed her to lead them into discussions of difficult issues. Thirty-seven percent of the conversation was either the mother or the child talking.

However, Counselor 1 had much more difficulty joining with the mother in family Q who was rejecting and neglecting her children. The Counselor asked about the mother's feelings which resulted in a torrent of "these children are so disrespectful...he (the boyfriend) didn't hit with anything but his hand..it barely touched them...I am so sick and tired of their lack of appreciation". In response to this verbal torrent, the Counselor turned to the oldest son, whom the mother was verbally attacking and asked "How are things going for you? Is mom home

more?", which made the mother even more defensive. The mother talked over the child, the child half yelled a reply to her and the Counselor became silent and watched the mother and child argue. Becoming connected with this mother was a challenge for Counselor 1.

*Reframing:* The counselor also was able to reframe the R. family's problems as a normal result of the trauma of the cancer and the mother having to deal with the problem alone. However, she did not elaborate on the affect of a life threatening illness on a family. The counselor also attempted to reframe the students who were bothering the boy about his scar by saying "they are just being curious about it, they don't mean to hurt your feelings". The boy did not accept this reframe. It only seemed to make him more irritated and he said, "no one understands".

The Counselor did not reframe the problems in family Q.

*Normalizing:* As part of her reframe Counselor 1 told the mother in the R. family, "it is normal that you and your son would have these feelings given the trauma you have been through".

Counselor 1 did not use this strategy with the Q family.

*Enactments:* Counselor 1 also tried to give support to the mother of the R. family with regard to the importance of the child and the mother talking about what had happened. However, on the videotapes, the counselor did most of the talking about feelings with the child through reflection, paraphrasing and open-ended questions and allowed the mother to talk for the child or over the child. The child responded to the Counselor's attempts at reflection and paraphrasing

as if she were just another person poking and probing him. The Counselor did not reflect this feeling but he stated it clearly. At one point he emphatically said "I don't want to feel, talk about this".

During an enactment with the R. family, the counselor was able to sit back and allow the mother and son to talk, but she seemed to ignore the patterns of communication which were happening in the therapy room. When the mother and son became stuck in their typical pattern of conversation, such as when the mother would say "are you still mad at me" and the boy would cry or say "you don't always know what's best", the mother and counselor either talked about his feelings or the counselor interpreted the conversation either to the mother or child. The counselor did not coach the mother on how to talk to her child about feelings or encourage the mother to physically move closer to the boy to comfort him when he was crying. The counselor did not move closer to the mother to comfort or coach her on dealing with such intense emotion. The emotional intensity of the sadness and anger which both the mother and child expressed seemed to distract the counselor and resulted in a focus on content. The Counselor did not have a systemic hypothesis about the interaction patterns within this family that could direct her with regard to where she wanted them to go with the enactment.

Counselor 1 attempted to set up an enactment by telling the mother in family Q to "tell the children how you want them to behave". The mother responded by giving the oldest boy a sarcastic compliment, " he was pretty good this week, he watches the kids while I'm at work, supposedly, ha, ha". The

Counselor then turned to the oldest child for facts about his care taking of the three other children with which to challenge the mother's perceptions. The mother then became even more critical of the older boys, the boys became belligerent and the counselor sent the younger of the two boys to the other room to play. By moving into an enactment without first joining with the mother and challenging her perceptions, the Counselor inadvertently gave the family a task they could not handle. The Counselor attempted to empathize with the mother but ended up empathizing with the children. At one point the Counselor was seated with the two boys on either side of her separated from the mother and challenging the mother. The Counselor's activity level and directiveness increased, topics were initiated, seating arrangements changed, children sent out of the room, but the needs of this family demanded more. The presence of an underlying threat of violence and harm to the children also permeated the room but was not addressed except by the Counselor insisting on an agreement that there would be no "hitting" at home and that "the boyfriend must come to the next counseling session". The mother agreed to the later but insisted that "he was not harming them and what other ways can I gain control of them?"

The Counselor's attempt to deliver a message to the mother by going through the boys resulted in making the mother more defensive and angry. The Counselor asked the boys "how does it make you feel when your mother is home more often?" This question led to the mother explaining her absences away. By siding with the children the Counselor unbalanced the family but not in the way she intended.

*Punctuating:* Counselor 1 told both the boy and his mother in family R., “you have such strength to have been able to get through this trauma and be doing so well now”. Counselor 1 was able to show her admiration for their strengths.

However, Counselor 1 had more difficulty perceiving strengths in the mother in family Q. The Counselor referred to the mother’s strengths as “commitment to counseling and following through on a behavior chart”. She did see strengths in the children. She wrote, “the children really care and watched out for each other”.

*Instructor’s Assessment:* The instructor consistently focused on “keeping a structural focus” and “empower the mother rather than the child(ren)”. The instructor stressed that Counselor 1 needed to “join and support the mothers and not side with the children”. The instructor noted that there was not much change in these behaviors over the two tapes in the fall. The instructor saw Counselor 1 as more “clouded by her own feeling on this one”, which referred to her difficulties with the mother of the Q. family.

*Counselor’s self assessment:* In the fall Counselor 1 seemed fairly satisfied with her progress with the R. family. She reported that she “was surprised at how authoritative the child in the R. family was, but glad to have them interacting so much. Counselor 1 felt that she could “support the mom in her role as the adult in the interactions”. This family seemed workable and hopeful to Counselor 1 and she was able to feel successful.

In the spring Counselor 1 was very aware of the need to intervene more with the Q. family, but attempted to “model appropriate behavior” rather than to block family interactions. She reported “I don’t think I really implemented effective strategies . I was so alarmed at what the kids were saying about the boyfriend.” She went on to write, “the family is very dysfunctional and how can I help them?”.

*Themes:* Counselor 1 had two themes for herself in the fall, one was to create successful enactments with the families and the second was to empower and support the mothers. In the R. family she interpreted this as needing to “help the mother gain her own strength and support separate from son”, meaning support the mother in separating from the son. In the Q. family Counselor 1 described empowering the mother by “supporting the mother to facilitate her role as the adult in their interactions”. Counselor 1 mentioned a number of themes over the year with regard to her structural assessments and conceptualizations of the families. All of the families were described in terms of needing to have the hierarchy better established in order to give control and power to the parents. The instructor agreed with these descriptions but not the strategies the counselor used to achieve these goals.

*Summary:* Counselor 1 was able to use her well developed generic counseling skills of listening and reflecting as a strategy to elicit feelings but did not seem to know what to do when the feelings expressed were very intense, negative or angry. For the R. family which was more sad than angry, this approach did foster more communication between the mother and son. In the Q.

family where there was a threat of violence and chaos ruled, these generic counseling skills were not enough.

Counselor 1 displayed a willingness to take a risk and try new strategies. Counselor 1 appeared to work at making the enactments work, and to follow through with the instructor's directives. Counselor 1 was open to instructions but at times her misunderstanding of the instructor's directives resulted in her applying strategies which were not necessarily effective. The instructor wrote that "Counselor 1 needed to model appropriate behavior for ways to discipline the children by coaching the mother (Q. family)." Counselor 1 interpreted and applied this instruction to mean that she was "to model for the mother " how to discipline the children. This strategy failed because the mother seemed to take it as a criticism of her skills rather than helpful.

Counselor 1 appeared to be able to communicate a caring, empathetic stance with the families and children. Her quiet, calm tone set an atmosphere of caring. Counselor 1 was able to conceptualize that her role was to support the parents, but in the counseling room she was drawn to the children. The Counselor tended to take over for the mother rather than support their strengths. Counselor 1 had problems with conceptualizing interactional patterns and displayed limited understanding of the concepts of boundaries, hierarchies and developmental stages of families. Counselor 1 did the enactments but the strategy was not connected to a conceptual map which left her floundering about what to do once she had the family talking to each other.

As the year progressed, Counselor 1 appeared to develop a more complex understanding of the families as evidenced by the instructor's comments as well as her own more detailed descriptions of the family. The Counselor appeared to become more aware of the fact that supporting the mothers to "gain control" meant more than just providing empathy. The Counselor reported a need to increase her own "directiveness" and she voiced an understanding that "supporting a mother" and "preventing damage to children was a complicated process". Counselor 1 did increase her directiveness by trying to take leadership in setting the topics of conversation and by directing enactments, but her training in generic counseling skills had not prepared her for the kind of activity needed with a family. Her assessment of the problems of the families became more accurate.

The themes which this Counselor mentioned throughout all of the response forms were to provide the mothers with power, control, and the strength to take on their adult role rather than to give this to their children. The other pervasive themes were this Counselor's willingness to evaluate herself realistically and follow the instructors directives to the best of her knowledge. Counselor 1 was not afraid to try new things and was quite able to take a leadership role particularly after she had clinical supervision. The problem was sustaining her focus on the parents and the process in the room particularly when the families were more difficult and felt out of control.

Counselor 2

Families	Reason for referral	Members of family	Fall	Spring	Session number	severity rating
Family H.	granddaughters' disrespect	grandmother granddaughter grandfather mother, not in home	x (1 tape)	x (1 tape)	24+	moderate
Family R.	ADHD child plus severely disabled brother	mother father 3 sons, 17, 9,7	x (1 tape)		2nd session	moderate
Family B.	Nephews fighting at school	mother father 3 sons and 2 nephews		x (1 tape)	2nd session	severe
Family J.	ADHD child	pregnant mother father son, 6		x (1 tape)	3rd session	moderate

Figure 6. Describes the families presented by Counselor 2 in the internship class.

Counselor 2 presented 5 tapes of four different families. Two tapes were of family H.(See figure 6) In the fall Counselor 2 presented two tapes of two different families. Family R. had three sons ranging in age from 17 to 7. The

youngest son (7) was severely disabled and required constant care and supervision. The middle child (9) was diagnosed with ADHD and had significant problems with anger management. The oldest son (17) who helped to take care of the youngest child, was becoming disrespectful toward his parents and asserting his independence. This was the family's second year of counseling and their second counselor from the Family Counseling Program. They were originally referred because of the problems in school with attention, work completion and compliance of the middle child. The Counselor rated this family as having severe problems based on the needs of the disabled child. The Counselor reported that this family displayed a lot of "love and caring" as well as "commitment to counseling since they are returning for a second year of counseling" with the Family Counseling Center.

The second family (family H.) was one in which the fifteen year old girl lived with her grandparents with limited visitation for her mother who lived nearby. The grandparents were referred to the Center because of the granddaughter's acting out and defiant behavior in the home. The Counselor rated this family as having a moderate problem. Counselor 2 described this family's strengths as "the grandparents have more than adequate financial resources and, although they are not close emotionally, they care for each other".

During the spring semester the counselor presented three videotapes. Family J. was composed of a pregnant mother, a father and a first grade boy who was diagnosed as ADHD. Counselor 2 presented another tape of Family H.

, the granddaughter, grandmother and mother, which showed a session in which the mother was going to have the daughter for a month while the grandmother traveled.

Counselor 2 also presented a fifth tape during the spring semester which was of an African American family, Family B., composed of a mother, father, their three sons and two nephews whom they had recently taken in because their mother was in a New Jersey jail. It was the second session with the family but it did not appear as if the Counselor had connected with the family well enough and the family was holding themselves back, evaluating the Counselor. They had been referred by the school because the younger nephew was getting in fights and refusing to do any school work. He had set a fire in the yard at home and had stolen from his aunt. Because the family did not talk very much, the Counselor reported that she "had difficulty answering accurately any of the questions on the response form". In response to question 13 on the response form which asked what kind of day the counselor had she wrote, "extremely exhausting. I have a headache. I have a schedule that could choke a horse. Seeing this family makes me want to consider other employment options". This family presented many challenges for Counselor 2 and for this reason was analyzed separately.

*Counseling Approach:* It appeared as if Counselor 2 was applying a behavioral model to the family counseling process. The counseling sessions seemed directed toward operationalizing the nature of the problem and then designing a behavioral intervention to remediate the problem. The counselor

asked “how often does the behavior occur and what are your rules about this behavior?”. The Counselor presented herself as confident and experienced in the area of discipline, particularly of teenagers. Counselor 2 had previously taken both a practicum and internship in family counseling and had been a high school teacher. Counselor 2’s approach tended to be direct and business-like, which could be consistent with a structural approach. Her “get right to business approach” gave structure to her sessions right from the start but it also gave her voice and mannerisms a negative critical edge.

For example, Counselor 2 started her session with the R family with a focused open ended content question, “Can you tell me what you and N (last year’s counselor) covered last year?” It was a good place to start, but she held the family’s chart with N.’s report on her lap and referred to it as the mother began to talk. The mother, whose voice was full of emotion, described problems she was having with her 17 year old son (who was home baby-sitting the other 2 sons). The Counselor asked two more opened ended questions, but then went right to “can we make a behavior chart to deal with his disrespectful behavior?” while the mother was still quite emotional about the behaviors. Counselor 2 ended the session with “why don’t you make a behavior chart for disrespectful behavior for the 17 year old so that he could earn an allowance based on the points on the chart”.

Counselor 2 started the session with the H family by saying “so what was the report from the school on the granddaughter’s behavior and grades this week?”. This opened the floor for the grandmother to say, “she’s not doing her

homework even when her grandfather offered to help.” The granddaughter replied, “he just wants to show how stupid I am!”.

With the J. family Counselor 2 asked about” how did the chip system work this week?” And the with the B. family she started by asking,” tell me about the fight in school this week”.

#### Flanders analysis.

The Flanders analysis found the first semester counseling sessions were involved with content 32% of the time, (tracking factual information, asking factual questions, dispensing information) while addressing feelings only 13% of the time. With both families Counselor 2 allowed the family members to talk while she listened attentively. Twenty-four percent of the time was spent with family members talking to each other or to the counselor and 28% of the time the Counselor was silent. However, the content of the talk and the direction that it took is not reflected in these numbers.

In the grandparent family much of the conversation was critical, negative talk directed by the grandmother to either her daughter or granddaughter. Her daughter, the adolescents’ mother, only spoke once throughout the entire session. The grandmother would relate a litany of things such as,” when I tried to tell her what the teacher said to me, she just ran upstairs crying so I followed her to her room to get her to understand that she had failed to complete her work in....” The granddaughter attempted to defend herself by turning to the Counselor and saying, “I didn’t understand the material, the words were too hard.” but the grandmother would not stop to hear her. The content of the conversation was

about school and grades. The Counselor asked content probing questions which addressed the rules for doing homework and the grandmother responded back with content involved answers. The Counselor gave advice and suggestions almost 10% of time. At one point the Counselor told the granddaughter, "I also had problems with my reading comprehension. I used the strategy of reading and re-reading to help me. Sometimes that's the only thing you can do to help your self".

The Counselor's responses to the R. family were very similar to the H. (grandparent) family. The family members in this session were the mother, father and severely disabled son. The father sat the entire time with his hand gently on the son's arm, patting him to quiet him every so often. The child had to be strapped into the chair in order to remain upright. The counselor never mentioned the patience exhibited by both parents which was evident in the room. It was as if the child did not exist in the room. The counselor did not explore the parents' feelings and frustrations with regard to parenting two disabled children rather she discussed their rules and consequences for misbehaviors for the non-disabled 17 year old who helps take care of his two brothers. The Counselor said, "what are the consequences for when he speaks to you in that tone of voice?". The 17 year old is the only one the mother will allow to baby sit the two younger boys because of their disabilities.

Once again the majority of the time the Counselor focused on content (38%) rather than feelings (13%) or process. The topic of conversation was the 17 year old son (who was at home baby-sitting the other boy) and his disrespect

for his parents and the 10 year old's anger management. Thus, the conversation was about things not occurring in the room with family members who were not present at the Counselor's request. At one point the mother commented to the father, "I have found that if I just go in and sit on the bed while he (17 year old) is playing nintendo, he will actually talk to me". The Counselor responded, " That's a good example of what you are going to have to do. Find creative ways to give your other children attention. I've noticed that whenever J.(the middle child) is talking to you, and you attend to M. (the disabled child), J. flares up. This pattern is obvious to me as an outsider to the family and you need to find ways to give attention to your other children without being distracted by M. (severely disabled child). Particularly you, mom "(Counselor points to mother. Dad folds his arms over in defensive position. Mom looks like she's been slapped).

Two of the spring videotapes were analyzed together using the Flanders scale, the family with the ADHD child (family J) and again the grandparent family (family H.). The session with the African American family was analyzed separately using the Flanders in order to present a more in-depth picture of the cultural differences which were so apparent from this videotape.

The Flanders analysis of the two videotapes revealed that Counselor 2 did follow the instructor's directive "to become more direct". Her information giving, direction giving and confrontations increased from 26% in the fall to 42% in the spring. The nature of this direct behavior was tied into her continued focus on the content of the session 37% of the time, but there was a reduction in the examination of the feelings, down to 3%. Part of the reason for the increase in

the direction giving and information dispensing was that the session with the young ADHD boy in family J. was spent primarily with Counselor 2 reviewing a behavior modification plan which used chips and concrete rewards to increase appropriate behavior. Counselor 2 started the session by asking, " how well did the chip system work this week?" The counselor had Xeroxed copies of instructions from a parent training manual which she gave to the father and said," these come from my parent training manual. I thought they would be of help to you because you need to be in charge since mom will be busy with the new baby shortly".

The videotape of the H. family was not as directive. However, Counselor 2 did keep the conversation on the logistics of having the granddaughter stay with the mother and avoided any discussion of the feelings surrounding this despite the fact that the granddaughter and grandmother were quite angry with each other during the session. At one point in the session the grandmother stated, "we will never let our granddaughter live with her mother full time because we do not feel her mother can supervise her or provide for her as well as we can". Even as the mother responded by saying," I have a full time job now and we will be moving into a two bedroom apartment", the grandmother kept saying to the mother, "but how are you going to be there when she gets off the school bus or how will you help her with her school work?" Meanwhile the granddaughter is saying under her breath, "I don't want your money or the things you buy me". The grandmother hearing this says, "I'm glad you told me that, I'll stop buying you all those clothes". The grandmother continued, "if you do not return home

after my trip, we will not pay for your trip to Canada". The Counselor tolerated the emotional intensity created by this exchange, but kept redirecting it to logistics of the move to the mother's place while the grandmother was traveling. It turned out to be an excellent strategy.

The Counselor's percentage of indirect behavior remained approximately the same as the fall semester while her direct behavior increased from 26% to 35%. The Counselor seemed to have connected or joined well with both the granddaughter and the grandmother given their willingness to be redirected by the Counselor, but the Counselor was just beginning to become aware of the potential of the mother. She used more positive praise for the parents in both families, but actually talked more in the spring (47%) than in the fall (38%).

With family B. (African American) the fifth videotape, the Flanders analysis revealed that the Counselor increased her talking to 70% of the time with 57% of that talk being focused on content and 34% of the talk being directives given to the family from the Counselor. The family talked 22% of the time while the counselor was silent only 16% of the time. The Counselor used words and phrases which tended to reflect her culture particularly with regard to describing the counseling process, such as "patterns of interaction", "expectations", and "observations". The Counselor talked about "expectations of the parents and the schools". Because the family did not volunteer any information, the counselor said, "let me explain the family counseling process, it is one in which the families talk about issues and the counselor observes them talking to see any patterns to their conversation". Talking about patterns of

conversations and the process of counseling seemed to reflect her academic training and may have been a factor in decreasing the families responses. The father never removed his sunglasses and the children never removed their coats.

The Counselor moved the chairs closer to each other, and directed them to talk to each other while she “observed their talking”. No one talked. When no one volunteered to speak, Counselor 2 asked many direct questions to the children with minimal response, they shrugged their shoulders or just hung their heads and looked down. The children appeared frightened and confused. At one point the Counselor directed the mother, who would talk particularly in a critical manner about the nephew’s biological mother, to tell the boys her expectancies for their behaviors at school. The mother said, “we don’t expect the boys to do no fighting in school unless they have to defend themselves”. The Counselor then asked the two nephew to “repeat back to your aunt what you heard her say”. The boys mumbled, “no fighting at school”.

#### Structural analysis.

*Structural Assessment:* Although Counselor 2. had some understanding of hierarchy with family H. she described the “grandmother as being in charge”, but she did not know how to integrate the biological mother into the hierarchical structure. Counselor 2 wrote that “the grandfather, (who does not come to the sessions) was estranged, disengaged from all the family members. The mother lives separately with her boyfriend and has minimal contact with her daughter. The mother and the granddaughter “behave like siblings and seem to be on equal footing with each other in the hierarchy”. Counselor 2’s structural

assessment was fairly accurate. Counselor 2 was able to conceptualize the structure of family H. including subsystems, (the mother and daughter) hierarchy (the grandmother), boundaries ("granddad distant and unconnected to anyone"). However, the inappropriate hierarchical problem of the grandmother dictating to the mother and controlling the daughter was not assessed.

Counselor 2's assessment of the structure of the R. family was fairly accurate although incomplete. She described the mother as being "enmeshed with the youngest (severely disabled child), mom and dad were in charge but the boundaries were somewhat blurred". She went on to say that "mom's life was completely devoted to the boys but mostly to the youngest. Dad is a bit distant but not really disengaged". The role of the disabilities and their impact on the families' developmental life cycle was not discussed.

The structural assessment of the J. family (ADHD child) described the "need to support the hierarchy and clarify diffuse, enmeshed boundaries. She wrote that "the father was disengaged and under involved in the child's life and mother was overly enmeshed with the child". Further, the child had "too much power and the parents allowed it'.

The Counselor did not appear to have any idea of the hierarchy or boundaries in the B. family. She described the structure as "mom is in charge more than dad, boundaries seem flexible. Parents do not appear enmeshed with the kids. There may be some rigidity between parental and the nephew subsystem". Her difficulty with the hierarchy was apparent in the videotapes because she consistently addressed the majority of her comments to the children

rather than supporting the parental hierarchy. When she did speak to the adults she tended to talk to the aunt rather than the uncle. The aunt and uncle appeared to have a different view of the boy's behaviors, but the Counselor did not seem to perceive this split. The counselor noted "the family is reluctant to acknowledge feelings" as the problem. The aunt's negative feelings about the biological mother which were expressed freely, were not acknowledged or explored by the counselor. The uncle did eventually follow along with the Counselor and talked to one of the nephews about what happened in school, but the Counselor interrupted him to tell him how the boys might be feeling. All of these behaviors of the Counselor suggested that she did not have a conceptual map of the structure of this family.

*Systemic Hypothesis:* Counselor 2 did not present a systemic hypothesis in terms of patterns of communication which maintain the problem on the first tape of family H. In response to the question about the systemic hypothesis she wrote, "weak spousal subsystem of grandparents. Grandfather is disengaged from family members. Structural chaos has resulted in very poor self image for mother and her inability to parent. Low nurturance of grandparents result in inappropriate attention getting maneuvers (in granddaughter)." The counselor's reference to low self esteem implies an intrapsychic explanation of the daughter's dysfunctional behavior. Later in the year, Counselor 2 wrote another systemic hypothesis about family H. This time she wrote, "granddaughter gets very little positive attention, so she goes after any kind she can get. She wants to live with her mother; she wants her mother to act like a mother. Grandmother

doesn't want her to live with mother but when she behaves badly, grandmother takes her to the mother." This systemic hypothesis reflected a more in-depth understanding of some of the interaction patterns and laid the ground work for a change in her strategies and restructuring plan.

In the fall in the session Counselor 2 said, "I think I see a pattern to your communication problems". Then the Counselor turned to the granddaughter and said "explain to your grandmother what happened to you when she criticized you". The granddaughter did not seem to understand the question. Going through the granddaughter rather than the mother placed the granddaughter in a position to challenge the grandmother and unbalanced the hierarchy.

In the spring the counselor said to the granddaughter, "just sit here and listen while your mother and grandmother work out the arrangements". Counselor 2 made a gigantic leap with the grandparent family by becoming more directly encouraging of the mother to nurture the child and to become more involved with her day-to-day care. The Counselor did appropriately challenge the grandmother's belief system about who should care for the child and did it in a manner that the grandmother was able to hear. It was apparent that the Counselor had a better picture and assessment of how the family hierarchy should be and what needed to happen to support this. This last session occurred after almost a year of counseling with this family so that the Counselor's connection was secure and she could afford to take a risk.

Counselor 2's systemic hypothesis for the R. family (disabled children) was to "see question #2 (structural assessment)". The

Counselor described some of the pattern as “mom (& to a lesser extent dad) is unable to attend to other 2 sons because of youngest child’s needs”. The present problems “signal the dysfunction” in the family. The Counselor knew that her role was to support the hierarchy, but she seemed to interpret this as meaning to provide the parents with information about behavioral programs, which at times, undermined the hierarchy. With the J. family (ADHD child), although the Counselor described a problem in the control and power of the hierarchy she missed the interaction pattern in the family with the ADHD child. Counselor 2 described the systemic hypothesis as the child’s problems “signaling the dysfunction in the family.” It appeared as if the ADHD had defined the problem in the family, which fostered a perception that the problem was in the child. The child frequently interrupted the parents and the mother would remind him” to wait or to be quiet”. The Counselor ignored what the mother said and turned to the child and said, “come on and join the discussion”. At other times when the parents disciplined the child in the room, the Counselor turned to the child and said, “ you’ve been so well behaved during the sessions” rather than praising the parent for disciplining appropriately. The parents appeared to be making obvious efforts to control the child in the therapy room. The Counselor not only talked over their discipline strategies but actually interfered by talking to the child when the parents were instructing him to be quiet. At one point the mother said she was “uncomfortable talking about “the child” with him in the room”. Rather than addressing this discomfort, the counselor said well, “let’s

have him join us". The child actually continued to play with blocks and only joined the parents for brief visits.

With the J. family (ADHD child) Counselor 2 had met with the child's classroom teacher and presented the teacher's view of the child's problem to the parents. The teacher had described the child as "not wanting to share her attention with the other children in the class". The Counselor did a good job of exploring the parents' views on their expectancies for the child's behavior and was able to point out "there seems to be a split between the school and your views of how he should behave". The Counselor attempted to highlight the split between the parents' views and the teacher's views but the Counselor voiced "you (the parents) need to re-evaluate to see if you have the right expectancies for your child." The fact that Counselor 2 was assigned to an elementary school setting for part of her internship and had direct contact with the teachers as well as the families presented another hierarchical system to integrate into her work. It was apparent that with the J. family Counselor 2 had more difficulty sitting quietly and allowing this family to problem solve which was not typical of her behavior with family H. (grandparent).

With the B. family (African American), Counselor 2 wrote "boundary difficulties and nephews, lack of permeability and easy affection, lack of openness" as her systemic hypothesis. She added at another point "possibly due to a lack of nurturing for these 2 boys and a reluctance to share and acknowledge feelings". Because the Counselor had limited assessment of the structure of the family, her systemic hypothesis did not exist. She lacked a clear

map of how to go about supporting the aunt and uncle and at the same time find ways to nurture the children. Her words on the videotape were focused on limit setting, yet her written comments allude to the need for nurturing of the nephews.

Restructuring plans and interventions.

*Joining:* Initially, Counselor 2 appeared to be connected to both the grandmother and daughter in family H. but seemed totally distanced from the mother. The grandmother came early to the session to have some time to talk to the Counselor. The granddaughter stayed with the Counselor at the end to talk to her. By the spring session, the mother also seemed to be connected to the Counselor and asked the Counselor to help her by “talking to her daughter while I talk to my mother alone”.

Counselor 2 had joined with the R. family around the fact that she had lived through having adolescents in the house. The mother even said at one point to the father, “she knows what it’s like to have a 17 year old boy, she can relate to this”.

With the J. family (ADHD) it was less clear how well joined Counselor 2 was with them. She had focused on the behavioral plan because this was the last session before the mother’s due date and they were not returning for a while.

With the B. family (African American) the counselor seemed to move too quickly into details of the school behavior problems and did not take the time to connect with the aunt and uncle.

*Reframing:* Counselor 2 used reframing with the R. family in order to describe the 17 year olds desire for privacy and independence as normal for his age. Similarly, she joked with the grandmother in family H. that unless “you let your 15 year old granddaughter learn to drive, you’ll be carting her around for life”. Thus, she could use humor to reframe the grandmother’s restrictions of the granddaughter as more severe than was good even for the grandmother’s well being.

Counselor 2 attempted to reframe the J family’s son (ADHD) as “behaving inappropriately by most people’s standards” but the parents did not seem to totally accept that reframe. The parents appeared to think the ADHD made it more difficult for their child to behave and so held him to a different standard.

Counselor 2 attempted to reframe with the B. family (African American) by describing the nephews as being sad and not feeling good about themselves, but the family did not respond enough to assess whether they agreed or not. This seemed to be something the uncle related to, at least he nodded his head in the affirmative as the Counselor spoke. This strategy might have worked if this line of thinking had been followed instead she asked , “what the family had done together that was fun”.

*Normalizing:* Through the use of reframes Counselor 2 did try to normalize the granddaughter’s need for independence, and the 17 year old son’s need for independence. Counselor 2 seemed more knowledgeable about the transitions of adolescence and the family transitions with adolescents than she did with the

younger children. She did not try to normalize any behaviors with the J. family or the B family.

*Enactment:* In the fall Counselor 2 set up an enactment with family H. which allowed the grandmother and granddaughter to converse, but ignored the presence of the mother in the room. Although the Counselor did a good job at allowing the conversation to go on, when the grandmother became critical of the granddaughter or mother, Counselor 2 did not block or stop the pattern but rather said, "I see a pattern here" but did not followed up to stop it. The Counselor was very distracted by the content and missed the processes. The Counselor did not comment on how far apart everyone was seated in the therapy room or the sense that they all needed to be better connected to each other in order to raise this girl.

In the spring the Counselor set up the enactment with family H very differently. This time she directed the conversation toward the mother as well as the grandmother and did not go through the granddaughter to challenge the grandmother. In addition, she also noticed the physical distance between the daughter and mother and this time told the daughter to "move closer to her mother so she is not left out".

Counselor 2 encouraged the couple in family R. (disabled children) to talk about some creative ways to address the issue of the disrespect of the 17 year old. Counselor 2 wrote "I did better by not having all the children in the counseling session". The mother had many good ideas and Counselor 2 encouraged the parents to talk. However, often when the father did talk the

mother talked over him. Counselor 2 clearly perceived the patterns which set off the dysfunctional communication, and attempted to block them in the room. She told the parents “only one of you should talk at a time” which was correct but her tone of voice made it seem more like an admonishment.

Counselor 2 attempted to set up an enactment with the B family by telling the uncle to “talk to your nephew about what you expect from him”. The uncle repeated what the aunt said about “no fighting at school” but that was the extent of the conversation. Counselor 2 attempted to create an enactment between the uncle and one of the nephews about what had happened in school that caused him to be sent to the office. The child did not respond. The Counselor did praise the father for his attempts at talking to his nephew. It was clear from the videotape that the family was not comfortable with the counselor or the counseling process and were somewhat intimidated by the demands of the setting. The boys appeared timid and hurt. To express their feelings in such a strange place was not what they had bargained for. Even when the counselor asked if there had ever been a better time for them, there was no response. In an attempt to get an enactment, the Counselor even gave the uncle words to say to the nephew, but it did not work. At one point the Counselor changed her tack to empathizing with the nephews about how hard it must be to live in a new home and one of them actually admitted to being sad, but then the Counselor changed the topic of conversation to “when was the last time they had fun together as a family?” She gave the family a homework assignment of coming up with one fun thing to do as a family.

*Punctuation:* The Counselor made good use of positive punctuation to point out good things occurring in the room particularly with the R. family (disabled children) and H. family (grandparent). She told them, “good idea” or “keep going with that”. She had fewer positive things to say to the parents in family J.(ADHD), although she punctuated that the child was behaving which was not effective at the time. In the B. family (African American), Counselor 2 tried to point out how the uncle was doing a good job talking to the nephew, but the lack of conversation made this seem like an exaggeration rather than a real success.

*Themes:* Phrases which appeared frequently on her response forms were disengaged fathers, discipline, educating, making contracts with the children for improved behavior, conversations about expectations for behavior, limit setting and consequences. Counselor 2's themes seemed to be behavior control, yet the granddaughter's family needed to become more connected emotionally and the family with the disabled children needed to receive more emotional support to sustain them in managing their children. Counselor 2 did perceive these needs as evidenced by her statement that the granddaughter needed more nurturance from grandmother and her statement that she “needed to develop a real relationship” with the parents who had the two disabled children, but application of skills and strategies were a definite challenge. Further, on her response forms she often referred to “the need to challenge perceptions of the family” but she did not have the strategies to know how to challenge without it taking power away from the parents.

*Instructor's Assessment:* The instructor's assessment of Counselor 2 was that she was "accurate, seems to understand the family structure and its patterns. Clear about the interactions across and within subsystems and has a good sense of family strengths and deficits". The instructor recommended "opening a broader range of topics for conversation" in the families and that Counselor 2 become "more direct". The instructor did not write what topics of conversation nor in what ways the Counselor should become more direct.

The instructor's supervision forms described Counselor 2 as "very open and invested in using supervision but tending to work through the children to create change" rather than through the parents. It was also reported that she was much too intent on the "content than the process" of what was happening in the therapy room. It was recommended that Counselor 2 make more use of reframing and directives to restructure the interactions in the sessions. However, it appeared that applying these strategies in the midst of therapy was a challenge for Counselor 2 without more immediate feedback to keep her from being distracted by the content of the conversations.

*Counselor's self assessment:* Counselor 2 wrote very revealing, in-depth assessments of herself. When she was off target she was aware and when she was doing a better job staying present with the family she could acknowledge it. She seemed to be very self aware but that did not make changing her behavior during the sessions any easier. Counselor 2 commented repeatedly that she had "to attend more to the process" of what was happening in the session rather than get lost in the content. Yet, as was seen from the Flander's analysis of the

videotapes, attention to content continued over both semesters. She worried that, “ I talked too much” and struggled with the desire to confront the parents with their negativity while at the same time support them in their need to nurture the children.

It is interesting to note that although Counselor 2 never revised her systemic hypotheses, she did revise her strategies based on the information gleaned or experienced in the sessions. In her “after” session form Counselor 2 once again displayed her ability to analyze herself and situations. She realized that “the cultural differences mean that it will take longer for the family to become comfortable with me” and “with the counseling process”. She reflected on the idea that it felt like she “was suppose to be the expert and fix the problem” which was an exhausting role. Counselor 2 realized “I don’t think any of my strategies worked. I am very frustrated”. On some families she realized that her strategies didn’t work when she “attempted to maneuver through the children”. However, with the B. family (African American) she attributed the problem to “they are so resistant to participating--the adults, I mean--kids will follow their lead.” Her next written statement was ,”Help! Get me out of here.” Counselor 2 was very able to reflect on her own feelings and was able to risk expressing them.

*Summary:* Counselor 2 developed more complex conceptualizations and with at least one family with whom she worked for most of the year, she made a shift in her conceptual map and attention to the process in the counseling room. She attempted to use a variety of therapeutic interventions including enactments, reframing, normalizing and punctuating. She was very reflective and often was

able to write about issues but not act on them in the counseling room. Counselor 2 had trouble developing a clear systemic hypothesis or picture of the specific relational patterns which shaped the verbal and non-verbal communication patterns in the families with whom she was less familiar or where she was not well connected. Although Counselor 2 did not rewrite her systemic hypotheses based on information gleaned from the sessions, she did elaborate more and changed her interventions. Part of the problem was that initially she seemed to think that assessing the structure of the family was the systemic hypothesis. Another difference between the fall and spring response forms of Counselor 2 was that the need to increase nurturing and discussions of feelings were noted.

Counselor 2 appeared to be able to create enactments and sit back and listen. She even seemed able to tolerate some intense emotions without jumping in too quickly. But because she did not have a clear systemic hypothesis for families R., J., and B., she did not have a restructuring plan which included strategies to change behaviors. The Counselor did not seem to know when to intervene or how to do it without educating or lecturing about a concept except after she had been with a family for an extended period of time. The strategies and goals mentioned in the restructuring plans of Counselor 2. were family conversations about expectancies, rules, limit setting, use of enactments, strengthen subsystems, stop interruptions, shore up boundaries, challenge parents, educate parents, contracting, art therapy, family game playing in session, and focus on nurturing. Counselor 2 did attempt to interrupt patterns of communication which were unsuccessful for the family.

*Themes:* Counselor 2 began the year focused on limit setting, supporting mothers to gain control and power in the hierarchy, and parenting skills. Fathers were described as disengaged, mothers as needing to nurture more. Phrases such as a “need to challenge the parents”, “confront the parents” and “educate the parents” were used with regard to interventions and goals. Her description of the family’s strengths always acknowledged their willingness to come to counseling as an indicator of their caring and commitment to the children. Counselor 2 repeatedly referred to her own difficulties with focusing on the content rather than the process, and talking too much. As the year progressed Counselor 2 expressed more frustration, even a bit of desperation. with regard to the difficulty of family counseling. She referred to “trying lots of stuff” and “ this may be just a “matter of teaching the family how to manage their dysfunction”. Counselor 2 seemed to be losing hope for the families and for herself. From Counselor 2’s written comments she appeared very committed to the families, and to supervision but her pleas for “help” and “get me out of here” and “I have a schedule which could choke a horse” suggested that she became more frustrated and overwhelmed during the spring semester.

### Counselor 3

Families	Reason for referral	Members of family	Fall	Spring	Session number	severity rating
Family P.	10 year old son with history of violent behavior, ADHD, ODD, seizure disorder	mother has MS, MD, depression, father retired military, sister, 16, lives with aunt	x (2 tapes)	x (1 tape)	1st, 5th, 11th session	very severe social services involved

Family H.	son 12, poor school performance, oppositional, poor anger management	mother stepfather 2 sons, 13 and 16 yr. old step brother, a 5 yr. old daughter and an 18yr. stepsister lives with mother		x (2 tapes)	18th session, 24th session	moderate
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Figure 7. Describes the families that Counselor 3 in the internship class.

Counselor 3 presented five videotapes of two different families for supervision over the year. First semester Counselor 3 presented two tapes of the P. family and second semester she presented two videotapes of the H. family and a third tape of the P. family. (See figure 6.)

The P. family had multiple medical, social and personal problems and had been involved in therapy with a number of therapists from different agencies for years, as well as with social service agencies, police and the medical community. The mother had two degenerative illness (multiple sclerosis and muscular dystrophy), one of which was hereditary, the son was diagnosed with ADHD, seizure disorder, oppositional defiant disorder, conduct disorder and learning disabled. The 16 year old daughter inherited one of her mother's degenerative illnesses and has a history of running away. The father recently retired from the military and is in school to develop a new career. The sessions involved the mother, father and 10 year old son. The daughter is currently living with an aunt in the midwest. The family has regular visits from a social service case worker to monitor the cleanliness of their home. The family is also under a

court order to seek counseling because the school reported the mother for hitting the boy. The boy has a long history of aggressive, violent behavior. This family is one of Counselor 3's first families that she has been assigned. She meets with them in a school setting, but not the school the boy attends because of the centralized location.

Family H. was a blended family referred to the Center because of school related problems with the 12 year old son including failing grades, poor anger management and oppositional behavior. Currently living in the home were two boys and a girl. The 12 year old boy and five year old girl are the mother's children and a 17 year old is the son of the stepfather. The stepfather has an 18 year old daughter who resides with his former wife. The husband and wife have been married for a year. The videotapes are of the 18th and 25th session of counseling with this particular family.

*Counseling Approach:* Counselor 3 presents herself as being very child focused and trained to perceive problems intrapsychically, or within the child. She appears to have a gentle, caring style in which she talks to children. Her experience as a substance abuse counselor for adolescents has provided her with many skills in interviewing and counseling children. Counselor 3 approaches counseling from a seemingly person-centered model in which she asked open ended questions and reflected the feelings or paraphrased the content of the client's responses. Counselor 3 directed questions to the child in family P. such as, "You were telling me you are ADHD, ODD, what does that mean? Those are big words". The child responded, "it means oppositional defiant". The counselor

continued to talk to him by saying, "what would happen if someone told you, you weren't ODD?". The child said "I would beat him up". This conversation continued between the Counselor and the child with the parents just sitting silently and yawning and looking bored.

In addition, Counselor 3 appeared to be interested in the lives of children and was able to elicit much about their interests through her non-threatening, patient, accepting style. Typically, anytime the child in the family brought up a subject, Counselor 3 was very accepting and followed their lead in the discussion. For example, the child in the P. family started talking about snakes "the anaconda lives in the jungle in the water". The counselor replied, "did you see that in a movie?". The parents were expected to sit and listen and wait their turn to talk to the counselor which relegated them to a less important position. Counselor 3 was child focused, so much so, that perceiving and attending to interactional patterns was very challenging to her.

The Counselor's approach did not change with the H. family. She asked such open ended questions to the two boys as "tell me about your roles in the family and how did you get them?" Counselor 3 acknowledged their feelings, "how do you feel about being the mediator in the family" or "you seem to be taking the role of the bad child, does that feel bad to you". She did, after the boys responded, ask the mother about her "role in the family" but when the mother responded, "I'm the disciplinarian and I don't like it" the Counselor turned to the boys and asked them what they thought.

Counselor 3 mainly employed an insight-oriented approach which was accomplished through her listening, reflecting and paraphrasing as well as joining in a nurturing manner with the child.

Flanders analysis.

Consistent with Counselor 3's counseling approach, in the fall 36% of her responses were indirect while only 1% were direct. Most of her direct responses were open ended questions concerning facts surrounding the P. family's life and circumstances. Given that these sessions were some of Counselor 3's first with this family whose circumstances were quite complex, there probably was a necessity to collect a detailed history. Thus, 66% of these sessions were directed toward content provided either by the father or the boy which entailed 59% of the talking in session. The mother did very little talking and in fact fell asleep during 10 minutes in one session and 15 minutes in the other session. The mother fell asleep during the boy's long soliloquies which were elicited by the Counselor asking him to describe a response he had in the past. For example, the counselor asked, "How come if you miss your sister so much, you always are fighting with her?" The boy's response was, " She (my sister) took me skating to the rink and left me there. We did the chicken dance, do you know the chicken dance. It's when you ..." and he continued to describe the chicken dance. The boy responded to the first part of the Counselor's question relative to missing his sister but not about the fighting. The child would talk on rambling from topic to topic in a whiny, monotone until he struck at topic in which he could accuse his father of being mean to him and tell him he was mad. The boy also gave a

detailed description of the fact that he was ADHD, ODD, on Dexedrine and Depacote in a very matter of fact, almost bragging manner. The mother awakened when the Counselor asked "did you son inherit one of his mother's illnesses?". The mother suddenly awakened from her sleep and immediately said, "he is lucky he does not have to worry about having my gene which produced this disease". The father then said to the boy, "Aren't you lucky, you have one less thing to worry about". In this family having no life threatening disability was deemed as positive.

The Counselor gave no directions during these sessions with the P. family which resulted in her being quite inactive. The child on the other hand was quite active. The boy had a temper tantrum within the first 10 minutes of the first session and roamed the room or sat on top of tables much of the time. The Counselor directed her questions as frequently to the child as to the father and mother. When the father expressed frustration, the counselor was more likely to turn to the child for the next question.

In the spring, Counselor 3 continued to maintain the majority of her responses in the category of indirect communication; however, her direct communication increased from 1% to 8%. The Counselor attempted to direct the mother and son in the H. family (anger management) to "talk to your son about his grades and behavior. Counselor 3 also used questions with this family which had a theme around each family members role in the family and how they felt about it. The Counselor kept the conversations fairly focused by asking directed questions, giving more information and clarifying what she wanted them to do.

This resulted in her taking greater leadership as well as a higher percentage of silent time for the counselor 16% compared to 1% in the fall.

In addition, with the H. family Counselor 3 consistently asked about feelings rather than for facts which resulted in an increase in feelings being discussed from 22% to 29%. However, the counselor was much more likely to clarify and accept the children's feelings than the mothers or step-father's feelings. Whenever the mother expressed frustration and anger with her children or husband the Counselor either changed the topic of conversation or asked a question of one of the children. At one point mom even interrupted to express her anger with the children and her husband for making her the "disciplinarian in the house" and the Counselor used this to ask the 12 year old "How did you get your role as trouble maker?" The counselor was able to pick up on the nonverbal cues of the adolescents and would ask them, "what did that sigh mean, or did you notice you aren't looking at your mother?" but she ignored the very obvious signs of the mother's dis-satisfaction with her life. The older son said, "mom always looks unhappy". The 12 year old chimed in "Yea, even when she could be laughing at a joke, she hides her face so you can't see her smile". Right after that statement the counselor asked the mom to "tell the boys about how pleased you are with their improved grades".

In the third videotape in the spring with the P family (disabilities), the Flanders analysis indicated that Counselor 3 did not maintain her directiveness and leadership with the P family which was demonstrated with the H family. Her percentage of direct responses went down to zero. Further, the discussion of

feelings also went down to 2 %. The Counselor continued to allow the boy to dominate the conversation. The severity of the family's needs may have played a role in this.

The Counselor appeared more comfortable nurturing and listening to the children's feelings than the adults' feelings. Counselor 3 was very child focused.

Structural analysis.

*Structural Assessment:* Counselor 3 did not behave as if she had a clear picture of the hierarchy, given that she consistently attended to the children and supported the children rather than the parents. Her attention to the children served to further undermine the hierarchy. Counselor 3 described the structure of family P. as, "Father, and son are very enmeshed. Mother has been alienated in her role as mother due in part to her MD and MS, but also because of the intervention of social services which has deemed that she should not take on the parenting role. The parents have managed to maintain their marital subsystem".

Counselor 3 also did not appear to assess correctly the distancing role of the disabilities, nor the developmental stage of the family. The Counselor did see the problems in the nurturing and limit setting with the boy, but was not clear about how this related to the family structure. The developmental stage of the family was also not recognized with regard to the teenager who tried to assert independence from the demands of this family as well as the retirement of the father from the military.

Nothing seemed to change in the spring from the fall's assessment of the P. family's structure, systemic hypothesis or intervention plans. Although the

Counselor attempted to engage the mother with the son, by seeing them together without the father, the Counselor continued to focus on the son and did not support or praise the mother for her efforts. Counselor 3 did not perceive how her skillful work with the children undermined rather than supported the parental hierarchy.

In the spring, Counselor 3 described the structure of the H. family as J. resides in P. with his mother and his 5 year old sister, his stepfather, and his stepbrother, who is 16 years old. His stepfather has a daughter, who is 18 years old and resides outside of the home. The 13 year old's father, whom he stays with every weekend, lives in H. is not remarried. The 12 year old's preference is to live with his father and his mother indicates that he could do so if he lived in P. The parental subsystem is fairly solid, however, stepbrother, is the self-identified family mediator, and is in a parentified role. The 12 year old and his mother have an enmeshed relationship while his relationship with his stepfather is somewhat strained.

Counselor 3 goes on to report that the 12 year old boy has a "fantasy of his mother and father reuniting because he was never given a reason that his parents separated".

Counselor 3 seemed to not only have a limited understanding of the concept of structure but she also had an intrapsychic theme for her assessment of the problem with the H. family hierarchy. She interpreted the 12 year old boy's behavior as an indicator that he had not adjusted to the divorce and continued to

undermine his mother's remarriage by questioning the right of his stepfather to discipline him. Because this boy had said that he wished his parents would get back together again, the Counselor believed that the problem was that he did not accept the new family and hierarchy in it. However, from the mother and stepfather's discussion it was very apparent that they did not agree on the disciplining of the children. There was a huge split in the hierarchy as a result of the two families coming together and having different values and expectancies for behavior.

The Counselor did assess correctly that the boundaries between the 17 year old son and his father were too permeable. The Counselor wrote that, "the 17 year old serves as a companion to the father and takes care of his emotional needs". The 17 year old son's declaration of his homosexuality served as a way to distance himself from the family.

The Counselor was aware that developmentally the creation of a new family was in its infancy, but she attributed the problem to the 12 year old boy and his longing for the old family rather than seeing it as a normal process of bringing such two very different families together and creating a new one. The Counselor took the view that the problem was within the 12 year old boy.

*Systemic Hypothesis:* Because the Counselor's assessment was unclear, in both families, the systemic hypothesis concerning the interaction patterns was not developed. Counselor 3 appeared to have difficulty focusing in sessions on the interaction patterns. Her systemic hypothesis for the P. family (disabilities) was

the family system is seriously out of balance. Mother needs to be allowed to be a more fully participating parent. Mother is dealing with some issues of depression regarding her health. She is currently taking 100mg. of Zoloft, but does little else to address her grief/loss issues. She has recently began volunteering at a community center which has helped give her a reason to get up in the morning.

Counselor 3 understood the need to bring the mother back into the hierarchy, but became person focused and focused primarily on the mother's emotional needs in the systemic hypothesis. She did not describe an interactional pattern.

Counselor 3 did not change her systemic hypotheses concerning the P family after additional sessions. She just noted "refer back to first response form."

In the H family Counselor 3 described the systemic hypothesis as. The 12 year old boy is caught between two family systems, his new blended family with his mother, sister, stepfather and stepbrother; and his biological father with whom he spends every weekend. The boy's function as the IP (identified patient) ensures that his mother and stepfather continually renew their commitment to each other while taking on the role of IP which his stepsister had previously held. While his mom states that she wants the boy's behavior to stabilize, she is unwilling to look at the family structure which facilitates the continuance of that behavior.

Counselor 3 continued to have difficulty attending to the interaction patterns in both in her written analysis and in the sessions. She did not have a map about what interactions to block or how to address the unproductive interactions. Although she became uncomfortable when the mother started to criticize the boys, she changed the topic of conversation rather than address what was happening in the room. Because there seemed to be no systemic hypothesis the restructuring plan and interventions were not mapped out.

Restructuring plan and interventions.

*Joining:* The Counselor appeared to be able to join well particularly with the boys in both families. Given that she usually changed the topic of conversation when the father in family P and the mother in family H. spoke of their frustrations, it seemed she had more difficulty becoming connected to the adults. Counselor 3 ignored the mother in the P family, it was as if she was not there.

The Counselor seemed to join better with the H. family as evidenced by their continued attendance. Counselor 3 had an excellent connection with the boys in this family and seemed to be working on getting better connected to the mother and stepfather. She did congratulate the families for caring enough to come to counseling and for working for the best for their children.

*Reframing:* The Counselor accepted the P. family's definition of the problem by continuing to address the child's anger as the issue and the parent's discipline needing to be improved. Rather than address the obvious issue, the overwhelming fear and sadness, and the exclusion of the mother from the

interactions, the Counselor chose to focus on the child, just like the family. The Counselor was inducted into the family's definition of the problem.

In the H. family the counselor attempted to reframe the 12 year old boy's problems with anger and school work as related to his fantasy about having his parents reunite.

*Normalization:* Counselor 3 did not use any strategies to normalize some of the son's or the parents behaviors in the P. family.

The Counselor did not use normalization enough with regard to the process of creating a new family for family H. Much of what this family had experienced could be attributed to their first year of being together. Counselor 3 actually wrote that she wanted to "normalize the boy's behavior with regard to blended families, but this was not observed on the videotapes.

*Enactments.* Although there was a considerable amount of client talk in these sessions (59%), there was little interaction between the family members rather the conversation flowed from the Counselor to the individual members. Only when the child spoke angrily to the father or the father corrected the child was there interaction in the P. family. Usually the counselor interrupted the exchange to ask a question. Counselor 3 talked to each person individually and did not encourage or direct the creation of an enactment. Counselor 3 by her reflective style and focus on the son seemed to decrease the intensity, emotional reactivity and anger in the P. family. However, her attempts to increase intensity around feelings such as sadness were usually addressed through the child who was a master of distraction. This therapy-wise family seemed to use distraction

and crises to effectively avoid confronting any difficult issues. Counselor 3 appeared to be doing individual therapy in a group setting.

The Counselor attempted two enactments during the 18th session with the H. family. The first one was started by the Counselor telling the boys to, "tell your mother how you are doing in school" and then she told the mother, "tell them your expectancies for their school performance". However, the second enactment during that session in which the Counselor asked the mother to "tell the boys how pleased you are with this week's report" fell short because the mother said instead, "I'm very frustrated with how things are going at home, no one but me cares about the rules". The Counselor turned to the boys and asked them a question about their performance in school.

*Punctuation:* The Counselor did not use praise to punctuate the progress the father in the P. family had made in disciplining his son, even when he removed him during the session and put the boy in time out. The father kept track of how many minutes the boy was in time-out and appropriately requested his return. All of this was ignored by the Counselor. The counselor used praise to encourage the son to talk and tell her about things that had happened to him.

The counselor attempted to punctuate in the H. family the 2 boys progress in school by having the mother acknowledge it, but first the Counselor had to acknowledge the mother's issues and progress. The mother reacted to the Counselor praising the boys as if it was a criticism of her.

*Instructor's Assessment* : As the year progressed the instructor became less optimistic about the Counselor's skills at conceptualizing systemically. The instructor commented on the first form "like most, viewing the situation from a systems view" was what they were working on. On the final supervision form of the spring semester the instructor stated in response to the question about the area that they were working on, "sounds repetitive but looking at the families systematically-Counselor 3 has some difficulty ...in identifying the hierarchical structures". Counselor 3 did not appear to be struggling to master family therapy rather the instructor said on the last form she was "more focused on individuals than the system". Counselor 3 continued to do individual therapy within the family setting. This difficulty with developing a conceptual map and focusing on individuals was also observed on the videotapes. Counselor 3 did not absorb the directives of the instructor and work to implement them. Despite the directive of the instructor to "reframe social services as a part of the necessary external support the family needed in order to function, Counselor 3 continued to describe social services as having a "negative impact on the family".

The instructor commented that Counselor 3 "did not understand how the child in the H. family was triangled or caught between the families prior to supervision" which was a concern.

*Self Assessment*: It is interesting to note that Counselor 3 did reflect upon the sense of helplessness and hopelessness that permeated the P. family (disabilities). Counselor 3 was able to see the themes in the family as "the grief and loss issues which are not being addressed in this family ..particularly how

they are impacting the child". However, how to help the family address these themes within a family counseling paradigm was a challenge for the Counselor.

Counselor 3's responses to the P. family initially was " I was feeling a little overwhelmed with the hopelessness that the father was expressing" seemed a bit of an understatement. The needs of this family would overwhelm even an experienced counselor. Further, all the diagnoses in this family could easily result in both experienced and inexperienced counselors focusing on the intrapsychic dimensions of the problems rather than the interactional nature of the issues. It is surprising that Counselor 3 did not express more frustration and feelings of helplessness and seek more supervision and instruction.

Counselor 3's goals for treatment of the P. family were developed with little attention to the severity of the nature of their problems. On the second response form relating to the P. family Counselor 3 stated, " I feel prepared for this session, which is an improvement because usually it is difficult to find time to prepare fully". This family caused Counselor 3 some stress. The instructor noted that "this is a family for whom counseling was only one small part of a survival plan".

Counselor 3 seemed unaware of any discomfort with the structural family model. When her strategies did not work she tended to blame the mothers for the lack of success. Counselor 3 wrote about the mother in the P. family, "my strategy did not work today because the mother was having trouble staying awake". In reference to what she had learned in the session she wrote "I am amazed by how hard it must be for the mother to deal with her health and having

a son and daughter who have both been difficult to raise". This last statement was referring to the fact that the mother reported being full of life prior to the onset of her illnesses.

The only time Counselor 3 reported discomfort was when describing her counseling approach with the H family. She wrote, "I was very aware of being very directive and 'lecturing' which I was uncomfortable with".

*Themes:* Counselor 3 reported that the spousal subsystems in both families were strong, children were in "parentified roles", roles of family members were unclear, and there were many enabling behaviors. Reasons for strategies not working were attributed to either the absence of the mothers involvement or the Counselor's discomfort with the interventions. The Counselor stated " I was unsure of whether to coach the dad with regard to the temper tantrum ... I was very aware of being very directive and lecturing which I was uncomfortable with". The Counselor noted a concern with "how to change the patterns" between specific family members. Providing support to the children and parental subsystem was mentioned throughout the Counselor's responses.

*Summary:* Counselor 3's intervention plans appeared to be a myriad of strategies, which were not based on a conceptual map and, therefore, some were on target and some were not. Counselor 3 was attempting to use enactments, reframing, normalizing as well as increasing her directness and activity level with the H Family. She seemed to attempt fewer strategies with the more severely involved P. family. The severity level may have inhibited Counselor 3 from attempting new behaviors. Counselor 3 continued to do

individual counseling in a group setting with both families over the five videotapes. She seemed to be frozen in an intrapsychic approach to understanding human problems and her need to nurture and focus on the children blurred her vision of the interactions patterns in the families. Counselor 3 did not seem to be struggling to implement directives from the instructor. She reported being uncomfortable being more directive and with the decision of “whether to coach the parent”. She felt like she “was lecturing”. Perhaps she was comfortable with her orientation since she is so skilled at talking to children and adolescents and has probably experienced much success at joining with them.

Counselor 3 did not seem to have the language and concepts of structural family therapy needed to describe the structural issues map of this family. The Counselor described the son and the father as being enmeshed and stated that “the mother’s helplessness enabled the father’s “superhero act” which allowed other family members to remain incompetent”. The term “enabled”, which the Counselor used frequently, seemed to come from her experience in the field of substance abuse and was frequently used to describe interactions. Counselor 3 described individual problems such as the mother’s depression or the 12 year olds fantasy but had difficulty translating this into the language of interaction patterns and systemic structures.

#### Counselor 4

Families	Reason for referral	Members of family	Fall	Spring	Session number	severity rating
Family G.	11 yr. old son did not complete school work, fights with brother, talk back to parents, ADHD	mother, father, 3 sons- 11, 9, & 3	x (2 tapes)		1st, & 3rd session	low
Family F.	10 yr. old daughter having difficulty with academics, depression, parents divorce, social skills	mother, in military, son- 14, twin daughters- 10, ,a daughter 17 lives in detention home in CA		x (3 tapes)	sessions 1-3	moderate
Family C.	9 yr. old son poor grades, lack of respect, ADHD Mother presented suicidal	father, mother, 2 sons-9, 11mos. 1daughter, 7		x (1 tape)	13th session	severe

Figure 8. Describes the families Counselor 4 presented in the internship class.

Counselor 4 presented two tapes of Family G for supervision. This family is made up of a husband, wife and three sons ages, 11, 9 and 3. They were referred to the Center because the oldest son, who was diagnosed as ADHD, has difficulty controlling his temper and completing his school work. The mother also expressed a desire to have less fighting among the children in the family and better communication between family members.

Counselor 4 presented two tapes of family F. second semester. This family was composed of a mother, 14 year old son, and 10 year old twin girls. Another daughter who was 18 was in a detention home in California. The mother was divorced in 1993 from the father of these children and has been single since. The mother is in the military and is able to provide for the children. They

were referred to the Center by the schools because one of the twins, D., was having difficulty with her grades in school, depression, her parent's divorce and lack of social skills. Although the older son was not referred by the school, he requested help in the area of anger management. The family moved to Virginia recently and were having some adjustment problems to their new environment.

Counselor 4 presented one tape second semester of Family C. which is made up of a mother, father, and three children, a nine year old son, a seven year old daughter and an 11 month old son. The family was referred to the Counseling Program because the nine year old son, was having difficulty leaving his mother at the door of the school. The guidance counselor at the school was concerned that he was school phobic. This child was also diagnosed as ADHD in kindergarten and was on Ritalin. The mother, who is originally from Puerto Rico, reported problems with depression and suicidal ideation. Counselor 4 referred her for a psychiatric consult through which she was placed on an antidepressant and anxiety medication. The mother reported she was doing better partly because of the change in medication and she had left her part time job.

*Counselor Approach:* Counselor 4 has had little experience in a counseling role. The Counselor had completed practicums in school and agency counseling and an internship in agency counseling. All of these past experiences were with more intrapsychic models of therapy. The Counselor appeared rather stiff, almost frozen in his chair, and uncomfortable in his new role as family counselor. Although many of the other counselors seemed to impose their past counseling experience on to the family counseling, Counselor 4 did not seem to

even have such a framework to use. Counselor 4 appeared to be an observer or a visitor in the counseling sessions, polite but uninvolved. Counselor 4. prior experience was as a military officer.

Counselor 4's approach did not change with family F. This family presented a challenge to his history in the military because the mother informed him she was a lesbian. He responded respectfully by saying, "I understand how tough that is when you work in the military system". However, that was still said in his low key, unemotional tone.

Counselor 4 changed his approach with family C. He followed the instructor's directive to "become active any way you can". For the first time Counselor 4 changed his seating, got closer to one of the family members, and appeared to be involved in the process and not just a distant observer.

#### Flanders analysis.

The most typical sequence of conversation which occurred between the Counselor and the clients in the G. family was the Counselor asked an open ended content question which pursued facts, and the clients responded with a content or factual answer. This resulted in a very indirect style of responding to the clients, 31% of the Counselor's responses were open ended questions and 44% of the interaction was around factual information. The Counselor began the first session by asking, "What are your expectancies for the children? Do you both agree on these rules?" When the parents hesitated and talked more about what the kids did not do than their expectancies, the Counselor spent considerable amount of time discussing the rules in the family. He told them to

tell him “ what are your rules, ..are they the same for all the children,.. who enforces them, do both of you (the parents) agree on the rules?”.. As he pursued this line of information, the children became bored, roamed around the room, leaned on the mother and played with each other. When the Counselor attempted to have the parents discuss the rules, they did not seem to understand what he wanted them to do. The mother nervously laughed as she said “he (father) usually ignores the kids, I’m the one doing the enforcing”, which showed her area of disagreement with the father, but the Counselor turned to the children to see what they thought. The mother went on to even compare her husband to her sons saying, “none of them respond to me when I asked them to do something”. The Counselor continued to talk to the two older boys about their chores. The sons criticized the father in a very disrespectful tone by saying “he does nothing in the house”, but neither the father nor Counselor commented on this.

Both parents spoke for the children whenever the Counselor asked them a question. Even when the mother and father disciplined the boys in the session, the counselor did not respond. The Counselor seemed intent on the facts. Only eight percent of the interaction involved discussion of feelings. The Counselor’s pacing was slow with many long pauses (1-2 minutes) which seemed to be more related to confusion than working silence given that his responses did not seem related to any kind of a theme or a structural map. Counselor 4 could be described as having a low activity and low intensity level in the counseling rooms.

As with the previous family, the Counselor continued to have a low activity level with very little intensity to his sessions with family F. At the beginning of the second session the Counselor asked the mother “well, did you get to implement any of the things we talked about last week?” The mother responded with surprise “what ideas?” The counselor then proceeded to spend the remainder of the session going over one by one the suggestions that he made in the previous session. He even gave the mother a pencil and paper to write them down. The twins giggled, yawned, left the room and bickered with each other. The 14 year old told the twins “stop playing around and being rude”.

Session 2 was almost completely devoted to making a list of strategies for the mother to attempt in order to bring some order to the chore list. The twins kept interrupting to say, “how much time is left?” and one left the room for 10 minutes. During this session the mother, the son and the counselor all spoke in low monotone voices which trailed off at the end of the sentences. There was little inflection to their speech patterns.

The Counselor increased the amount of direct behavior with the F. family over the course of the three sessions. Counselor 4's indirect behavior decreased to 22% and the direct behavior increased to 12%. However, the focus of the sessions continued to be very content or factual based. Fifth-one percent of the discussion had to do with content such as making lists. Discussion of feelings decreased to 4% and the counselor's silence remained high at 31%. When the children misbehaved both the mother and the counselor ignored it, but the older brother disciplined the girls quite appropriately. The adults did not notice but the

girls argued back with the 14 year old who was actually correct in his perception of the twins' inappropriate behavior. The mother appeared to have depressed affect and expressed very little emotion. The counseling sessions lacked energy, few emotions were expressed, the pace of the conversations were slow with many pauses of a minute or more, and the counselor did not move his body or display a facial reaction other than a neutral one.

The session with family C. was distinctly different than Counselor 4's prior counseling sessions. Counselor 4 displayed more activity in the form of movement in the room as well as direction during this session. The typical interaction pattern of the Counselor which was to ask an open ended content question and receive a content answer varied. With the C. family the counselor asked many more questions which dealt with feelings, as evidenced by the fact that discussion of feelings was up to 14%. Early in the session he asked the mother "was she having any other thoughts of suicide this week?". The counselor's direct behavior was 11% which was not necessarily an increase, but it reflected the Counselor directing the discussion of the parents rather than the Counselor describing a behavioral list for the parent to implement.

The Counselor started the session with the C. family with a question that reflected the tone for the counseling. He said "how are things going this week? Did you make time for yourselves to celebrate your anniversary? How was that for the two of you?". This was very different from his more typical questions asked to the G. family such as, "How was the boy scout trip? Who cooked the meals? Did you eat the fish you caught?"

This time the Counselor's silence (32%) with the C. family was more productive rather than confused. He appeared to be following a strategy to have the parents talk. Once the parents started a conversation he sat back and listened but intervened if they had trouble with the topic.

Structural analysis.

*Structural assessment:* Counselor 4 described the structure of the G. family (ADHD) as "having a fairly strong parental subsystem but father is somewhat distanced from the older son. Older son closer to mom. Middle sons closer to dad. 3 1/2 year old is close to mom, dad and older brother. Two older brothers often at odds. Parents appear active in the children's lives". After the first session Counselor 4 added that the "parents do not spend much time alone with each other-none. I suspect the spousal system may be a bit stressed".

Counselor 4 was somewhat aware that having a strong parental system was important as indicated by his focus on what expectations the parents shared for the boys. The Counselor also seemed to be trying to support the parents in the role of "being in charge " of the children. However, he missed the parental conflict about how and who disciplined the children. When the wife and the children criticized the father's "doing nothing to help. At one point in a videotape the children had moved their chairs and were all seated nearly on top of mom across from the father. Usually, the only one who distanced himself from this alignment was the middle boy, who sat on the periphery of the group.

The mother spoke in a sweet quiet voice as if she was very timid. The mother laughed nervously whenever disagreements were mentioned and spoke

to her husband as if he was one of the children. Rather than address any of this through the parents, the Counselor attempted to go through the children to have them say what the Counselor wanted to say. The children did not cooperate. When he asked the problem child "what was fun about having his father go camping with him?" the child responded, "nothing". The father became defensive and the Counselor rephrased the question to the child trying to elicit some praise for the father's efforts. The child did not cooperate nor did the mother help. By aligning with the children the Counselor undermined the hierarchy.

The parental split was obvious by the seating arrangements in the room each week. The identified problem child (11 years old) sat almost on top of the mother with his head either on her shoulder or on her arm. The "good" child sat at a distance in an isolated position from both parents and the toddler went between the parents but ended up on the mother's lap. The mother and the boys seemed to be a subsystem which was critical of the husband. The Counselor did note when the older boy changed his seat to be almost on top of the mother, but did not know what to do with this piece of data with regard to assessing the boundaries between the subsystems or for an intervention. The Counselor did attempt to find out when and if the parents ever had time to themselves but did not use their response as an indicator of the state of the spousal system. Counselor 4 lacked a clear, in-depth concept of structural assessment.

With family F. (military) the Counselor described the structure as the "boundary between the parental and child subsystem was somewhat diffuse. For

instance, none of the children were accustomed to knocking on their mother's door and waiting for permission to enter." The older son seems parentified. His manner of speech is often adult like and he frequently attempts to parent his sisters. He usually speaks to his mother as an equal and at times he strongly challenges her authority. The mother seems close to the children but not enmeshed. May have been enmeshed earlier with oldest son." Counselor 4 was very interested in supporting the mother to be in charge by implementing a behavior management plan; however, she did not seem to have the energy or interest in implementing his plan. Although he seemed aware that the hierarchy needed supporting, the Counselor did not have a vision of what a well-functioning single parent family hierarchy would look like.

The older son was very aware of the Counselor's strategy to elevate the mother's authority. At one point he even commented on "yea, my mother leaves here on an authority kick from being built up by you". In this case the oldest son needed to be appreciated for his role in caring for the twins.

The Counselor also was aware of the need for boundaries in this family. He questioned if family members respected each others privacy by knocking on doors before entering. The counselor was told that this was not happening and interpreted this as problematic. The mother agreed and so too did the older son. What the counselor missed was the mother's private life also was too much into the children's lives. When the Counselor suggested that she spend one night a week with one child doing something special, the older son said he didn't want to be with her because "she tells me things I don't want to know about her private

the life". He said they would have to spend time "doing something rather than talking about her problems". The mother had come out to the son as a lesbian five years ago. The Counselor did not pick up on this or ask about the nature of the things being told to the boy.

Although the Counselor began his work with the C. family by contracting with the mother not to kill herself and to get a psychiatric consult, he was able to see that the spousal and parental subsystems needed to be strengthened in order for this family to function. He described the structure of this family as "mother is the spokesperson and this seems okay with the husband who appears very laid-back about matters. The marital subsystem is strained because they do not have time to spend alone. Boundaries are too diffuse....mom was enmeshed with the 9 year old boy but addition of baby brother changed their relationship. Dad is disengaged at home and spends many hours watching television."

By starting out with his question about making time for their anniversary and following through with what happened and how did it feel, he established the priority, the spousal relationship. The Counselor also appeared to understand that the father's passivity and lack of involvement were damaging to both the spousal and parental relationship. The Counselor perceived that the boundaries between the mother and children were enmeshed but this was related to the distance between the mother and the husband. The Counselor's actions suggested that he understood that the father's disengagement and weak boundaries around the spousal system weakened the hierarchy of this family.

Counselor 4 had made a conceptual change with regard to assessing the structure of this family.

*Systemic Hypothesis:* Because Counselor 4 initially lacked a structural assessment, he did not seem to have any idea of what the dysfunctional patterns were. Even when they occurred in front of him repeatedly, Counselor 4 missed them. For example with family G.(ADHD), the Counselor would ask a question of the mother or children. They would criticize the father, but the father would talk over them before they could complete what they wanted to say. The father would defend himself in a sing-songy voice that one might use with a much younger child. The mother would then jump in to defend the child, particularly the problem child. She attributed his problems to ADHD and said " I've taken the time to read up on ADHD but he (the husband) has not. That's why I'll let some things go while he gets upset with little things. " He wrote his hypothesis as "spousal subsystem needs strengthening. Family communication patterns need to be enhanced".

Because of the unclear structural assessment and lack of perceptual observations, the Counselor did not appear to have a well formed systemic hypothesis about the patterns of interaction which were keeping the F. family (military) depressed. He wrote that the systemic hypothesis as, "the parental subsystem needs to be strengthened. The son needs to reassume the role of a son rather than a parent. The boundary between parent and children needs to be less diffuse." Although his statements seemed fairly accurate, they do not

present an interaction pattern of how these boundaries and hierarchy is maintained.

The structural hypothesis with family C. was the same as the description of the structure; however, it was a more in-depth picture than what he had with the other two families. Given the clearer assessment of the structure of the C family, the counselor seemed to understand the problems in the interaction pattern between the parents was maintaining the problem. Counselor 4 said, "the mother was over-involved, the father was passively escaping and unresponsive to both his wife and children. The mother then over-responded and the father withdrew." The Counselor moved himself next to the father in order to activate him and support the mother by going through the father. By activating himself, Counselor 4 activated the father. By role playing with the father, the Counselor became an guiding force not to be ignored.

Even with the final case, although Counselor 4 presented an in-depth view of their lives, he had difficulty clearly articulating the actual pattern of communication which needed to be blocked or changed. The complexity of his understanding increased but the integration into a clear picture was still a challenge.

#### Restructuring plan and intervention.

*Joining:* Counselor 4 did try to join with the G. family (ADHD) around there common interests in camping and other activities the Counselor enjoyed with his own sons. The Counselor attempted to be non-threatening and respectful of the parents. However, he seemed to join more easily with the children and the

mother. Counselor 4 tended to ignore the mother's comments about the disagreement she had with her husband and tried to soften the father's criticism of the children by asking him if "he appreciates what the kids do for him".

The Counselor was attempting to join family F. (military) by supporting the mother in gaining her authority in the hierarchy. However, she initially did not seem invested in the process as much as the Counselor. The children were actually less joined with him. At one point he commented on the girl's hat and she told him in a critical voice "you have the same clothes on as last week". The 14 year old son was not sure if the Counselor was going to do him more harm than good with all this supporting of his mother. The Counselor needed to explain to the son what was in it for him to have his mother in charge more often.

The Counselor with family C. had established a strong relationship with the mother by responding to her suicidal ideation and taking her seriously. The father's response to his gentle prodding and pushing for action, suggested that the father was also well joined with the therapist and would follow where the Counselor wanted to go.

*Reframing:* The Counselor did not use any reframes to attempt to define the problems in family G in a more manageable problems. The Counselor defined the problem in family G as "the negative critical view of the children by the parents".

The Counselor attempted to reframe family F. problems as due to the lack of structure in the home. Mom seemed to eventually agree and tried to institute new rules around knocking on doors before entering.

The Counselor used a reframe with family C. by changing the focus of the problem from the child's school phobia and the mother's depression to the father's lack of involvement with his wife and with his children. The lack of connectedness to the school and community was also presented as part of the problem. Both of these reframes made their problems more manageable. This family could reach out to the school for additional assistance as well as become involved in community services such as a church. Both the wife and the husband agreed with the Counselor's reframes.

*Normalizing:* The Counselor try to normalize in family G. the boys' reluctance to talk in the session by telling the parents that "this is normal for kids their age". The Counselor also normalized the disrespectful way these children spoke to the father by saying "kids act that way but don't mean it" which was in fact not something which should have been normalized.

The Counselor attempted to normalize the F. family's adjustment to Virginia, but it didn't seem to take. The family did not agree with him that adjusting to Virginia was a problem for them. The mother reported that "the children and she had already made many friends and were settled in their home".

With the C family, by pointing out that the nine year olds problems began really "with the birth of the baby", some of their difficulties appeared to be the developmental stage of the family. It was to be expected that some changes would occur with the introduction of a new baby into an already stressed family.

The mother particularly seemed relieved to have that frame of the boy's problems.

*Enactments:* The Counselor attempted to have the parents of family G. discuss their rules but they did not seem to buy this strategy. Mom laughed very uncomfortably as she brought up some differences between herself and her husband. There was almost a sense of trepidation in the way she presented. When the Counselor asked the boys "do your parents appreciate what you do around the house?" The mother answered in a high pitched, surprised voice, "of course we do" and then proceeded to tell the Counselor how "the 11 year old has been mowing the lawn for years but he never does it right, dad has to finish the lawn for him". The mother talked for the children and spoke to the children and husband as if they were all much younger children. The Counselor seemed uncomfortable with the criticism of the children and continued to try to get the parents to praise them to no avail except to make the parents defensive.

The Counselor ignored the interactions in the room between the mother of family F. and her children and made no attempt to set up an enactment. He was trying to support the mother's authority but was not using this to start a discussion or to have her actually discipline the children in the counseling room. The girls giggled, arm wrestled, interrupted to ask what time it was and how much longer they had to stay, they walked out to the bathroom and did not return for 10 to 15 minutes. Instead the mother said to the older boy, "I did not like your using the F word here in counseling last week". The boy proceeded to tell the mother, "look at the girls they are much ruder than I am. I used the F word to

express a feeling not to be rude". The Counselor did not point out this process of treating the girls so differently than the son. Nor did he ask for the mother to get the twins to behave in the room. The son eventually told the twins "to be quiet" and they turned to the mother and said, "tell him to butt out".

However, in the C. family, by supporting the mother's view, the Counselor made it possible for the parents to discuss what needed to change in the family in a productive manner. Although the enactment took the form of a role play, it was appropriate for the needs and developmental stage of this family. Counselor 4 moved his chair close to the father and said, "please respond to your wife's statement about wanting the family to be together in a different way. Tell her what you feel". If the father did not respond, the Counselor would say "well if I were in your shoes I might be feeling....is that how it is for you?" The family needed the structure of the role play and so too did the Counselor. The Counselor increased the intensity of the session by his expectancy that the father would respond to his wife during the session.

*Punctuating:* The Counselor tried to praise the children in family G. but did it in such a way that it undermined the hierarchy. He asked the children "what do you do that your parents appreciate". This strategy backfired since the children could not think of a thing and the parents became defensive.

With the F. family the Counselor consistently praised the activities they did together as a family and pointed out how unusual their Friday night "game night" with their friends actually was.

The Counselor with family C. was able to point out the progress they were making and appreciate how difficult this was for the couple, particularly the father. These were very young parents, 28 and 29, with demanding children and little money or family support.

*Counselor self assessment:* The Counselor did not re-evaluate his systemic hypothesis based on new information, but he did ask good questions about where he should be heading. For example, he wrote about the F family, "is the mother's lover's habit of "sleeping over at the house with mom a good idea this early in the relationship?", with the G family he wrote, "Is this family as functional as they seem?". He was aware of pieces of information that he did not know how to integrate into a picture of the family and that he needed to look beyond the appearances. The Counselor also assessed his weaknesses accurately. At one point he wrote, "I still have not separately addressed the family communication patterns".

The Counselor appeared to be receptive to the directives of the instructor even though they were difficult for him to interpret and implement. In the counseling session with the C. family, Counselor 4 displayed a perceptual, conceptual and therapeutic awareness which was missing in the prior sessions. He was obviously struggling to follow the instructor's directives and had seemingly benefited from his experiences.

*Instructor's assessment:* The instructor's comments concurred with the Counselor's self evaluation. The instructor wrote, "Counselor gets stuck when the family says things are OK" and "doesn't follow up on questions well". The

instructor stated that the Counselor was “struggling to gain conceptualizations and needed to be careful not to pathologize”. The instructor appeared concerned that the Counselor did not take a systemic view but rather an intrapsychic one. The instructor consistently gave him directives to become more involved and less passive. The instructor perceived this intern as struggling to gain the concepts of structural family therapy. The instructor also was aware that the Counselor needed to “look at his own personal issues” and needed to “move out of his chair to become active”. The Counselor was described as having difficulty “with the conceptualizations of family therapy” and required “lots of supervision.”

*Themes:* The Counselor wrote about his confusion with the concepts of structural family therapy. Boundaries were unclear to him, the relationships in the marital subsystems, perceiving the conflicts between the spouses, perceiving the interactions within the therapy room, stepping beyond seeing the father as disengaged and the mother enmeshed all were mentioned in his response forms. as well as validated in the counseling room.

It is interesting to note that Counselor 4 reported that he was frustrated with the C. family because the father “was so passive and did not follow through with the things he agreed to in counseling”. Becoming more involved, more active and less passive was a theme for this counselor. Looking beyond appearances, not accepting the veneer that families presented and really assessing the interpersonal component of people’s lives all were part of the lessons that this Counselor was learning this year. This Counselor benefited from all the supervision but will continued to need instructors to support him in

his growth in both the conceptual aspect of family therapy and the therapeutic aspects of family therapy.

*Summary:* Counselor 4 began the year with the focus of his sessions mainly revolving around indirect content questions (content ranged from 40-51%). His initial approach tended to be inactive and indirect as evidenced by his behavior on the videotapes, written responses and instructor comments. He did not seem to have the generic counseling skills as well developed as some of the other novice counselors. Counselor 4 had only a partial understanding of the structure of the family, and an incomplete picture of structural family therapy concepts. Counselor 4 appeared to have a limited idea of how to assess the boundaries between parents and children, but had even greater difficulty assessing spousal relationships and patterns of interaction. If the family said things were OK, he agreed. He had trouble looking beyond appearances. The concept of hierarchy seemed relatively clear to him in a traditional two parent family, but when a single parent family presented with a 14 year old who was very effective at caring for the younger siblings, Counselor 4 had trouble factoring this into his equation. Counselor 4 typically missed the relational interaction between parents because he was distracted by the children. Counselor 4 was not perceiving the patterns in the room nor attending to the process until his last videotape. The Counselor was over-focused on the content of sessions and often missed the process occurring in front of him.

Counselor 4 seemed to have profited from both the instruction and supervision experiences. For example, he started out by defining boundaries

rather simply, with regard to mothers being enmeshed and fathers disengaged. However, he began to look more closely as the year progressed and saw more complexity.

Counselor 4 did not even attempt to write a systemic hypothesis until the final family. He kept referring to the family composition or he would write things such as “communication patterns need to be enhanced as the systemic hypothesis”. As the year progressed his attempts became more detailed and elaborate but unclear. For example, for the single parent family he noted that when the older son “attempted to parent the girls, they resisted, an argument ensues and the mom attempted to break it up”. This was an accurate statement of a pattern, but Counselor 4 did not understand that the this family needed the older boy to take some responsibility the only problem was how much.

Because of a lack of a clear systemic hypothesis, Counselor 4 inadvertently undermined the hierarchy in the families by going through the children and reinforcing the children when the parents were in fact very frustrated by their children’s behaviors. The Counselor actually seemed to support the siblings rather than the parental subsystem. The Counselor appeared unaware that he often became inducted into the family’s problem by supporting the children.

In the fall semester he did not write about any intervention strategies other than “structural family therapy”. Counselor 4 actually wrote on each form that his strategies were “structural family therapy”. By the second semester he began to

refer to techniques as enactments. However, integration of the concepts with a conceptual map with strategies continued to be a challenge.

Counselor 4 progressed over the year from using a non-directive approach to a more active approach. He was very aware that he needed to become more involved and to use himself more to direct and intervene in the patterns which blocked the family's progress. Along with this increase in activity came a change in Counselor 4's intensity level. The Counselor's slow paced style and long silences along with sticking to the facts and avoiding conflict resulted initially in a lack of intensity to the sessions. However, as he became more involved in the counseling and more active the intensity level increased.

Counselor 4 demonstrated a significant change in his conceptualizations and behaviors on the last case in which he seemed to have developed a more complex understanding of the structure of the family. Counselor 4 demonstrated that he did take the instructor's directive seriously and created a way for himself and the family to become more active through a kind of role play. It was a successful strategy and he displayed skills that up to this point were not apparent.

As the instructor so aptly said, the Counselor employed "a systems focus and use of self in the counseling process" which was dramatically different than how he was at the beginning of the year.

Counselor 5

Families	Reason for referral	Members of family	Fall	Spring	Session number	severity rating
Family R.	10 yr. old daughter threatened suicide, ADHD on Ritalin, step brother also on Ritalin	mother, stepfather, daughter-10, stepdaughter -6, stepson-8	x (1 tape)		2nd session	severe
Family H.	13 yr. old son, ADHD, disrespectful attitude, question of domestic violence between father and mother	mother, father, son-13	x(1 tape)	x (1 tape)	session 2 and 15	severe
Family BB	9 yr. old son who has tantrums, fights with brother, yells, whines is out of control, ADHD	mother father 2 sons-9 & 13		x (1 tape)	4th session	moderate

Figure 9. Describes the families presented by Counselor 5 in the internship class.

Counselor 5 presented two videotapes of the same family first and second semester and one videotape each of three other families. (See figure 7)

Counselor 5 presented two different families to the supervision class first

semester. Family R. was composed of a husband and wife, a 10 year old daughter of the wife, and a 6 year old daughter and 8 year old son of the husband. Both the wife's daughter and the husband's son were diagnosed as ADHD and were on Ritalin. There are other half siblings who do not reside in the family. Both the husband and wife were married before. The family was referred because of concerns about the mother's daughter who talked to the guidance counselor about killing herself. The family has many other issues involving both current and past marital relationships.

The second family, H., was composed of a mother, father and 14 year old son. Both of these parents were married before and this son was a late in life child. He has much older half siblings from the mother's first marriage. The son is diagnosed ADHD and has had some trouble in school. However, the mother defines the problem as her husband and their difficult marriage. The mother does not drive due to vision problems and requires the father and son to accompany her shopping. The mother speaks in a low, calm but sarcastic tone, while the father yells and has a harsh edge to his voice and speaks loudly even when he speaks in a normal conversation.

Although these families are very different, Counselor 5 dealt with them in very similar ways. Because of this they will be analyzed together rather than separately.

During the second semester Counselor 5 presented another videotape of family H. and a totally new family, family BB. Once again both families presented plenty of conflict in the counseling room. Family BB was made up of a mother,

father, and two sons, 13 and 10 years old. The 10 year old son was diagnosed as ADHD and was referred for counseling because of his temper tantrums, fighting with his brother, yelling, whining and out of control behavior.

*Counselor Approach:* Counselor 5 appears to have a person-centered approach to counseling. She asks open ended questions, reflects feelings as well as content and is comfortable sitting back and allowing long silences (1-2 minutes). Her approach tends to be quiet, calm and inviting. If anything, she tends to under-respond by her lack of reaction and silence rather than over-respond to problems. Her experiences with counseling have primarily been within the college's practicum and internship in agency counseling yet she did not seem intimidated by the problems of the families. Counselor 5 seemed to apply the format of individual therapy to family counseling based on her focus on talking to each individual, one at a time.

Second semester Counselor 5's approach to counseling became more focused on problem solving and on the relational aspects of the families. She was able to work particularly well with family H. (marital conflict) when she only had the husband and wife together. When children were also included in the sessions, she appeared to be less focused because she directed her questions to them and became more child-focused.

#### Flanders analysis.

Both families, family R. and family H., first semester were very active with regard to talking, arguing and interrupting each other. Because Counselor 5 tended to have an indirect style to counseling, much of the conversation

occurred without her initiating or directing it. According to the Flanders analysis 34% of the Counselor's responses were indirect meaning they either reflected what was said or were open ended questions or some kind of verbal or nonverbal encouragement given to keep the client talking. Both mothers in these two families dominated the conversations but the children attempted to interrupt. Both women were angry with their husband's lack of involvement and conflict arose almost as soon as they began the conversation. The focus was much more on the marital relationships than the children's issues because the marital problems were so pervasive. The Counselor seemed to have a hard time taking charge of the conversations in order to focus the discussions. Although the percentage of content discussion (27%) and feelings discussions (25%) was fairly even, because the counselor was not directing the discussion (only 6% direct responses from the counselor) the intensity level rose quickly and the typical conflict of the family played itself out in the session. In family H. the father's tone of voice was quite loud and harsh and the mother freely laughed at and criticized the husband. In the R family the topics of conversation jumped from one thing to another always coming back to the mother's run away anger. The counselor did not respond to the conflicts occurring in her presence or use them to highlight the process in the family. Rather she directed questions to the children or asked questions about when the family had fun together, rather than comment or point out the process of the conflict which was occurring. The Counselor met the intensity by being very quiet and non-intense. The Counselor was silent 21% of the time while the clients were talking at least 32% of the time,

if not more. Because of the nature of the Flanders coding system, it was not possible to include all of the interruptions and conflicts which arose. The problem for the Counselor was that the family members did not wait their turn for her to talk to them one-on-one even though she attempted to do just that. Frequently in responses to a family member either using an angry tone or reporting that they were angry, Counselor 5 would ask a question like " how does this family have fun together?" The Counselor seemed to try to refocus the negative on the positive. She did not comment directly on the negative expression of feelings or the intensity with which the family members were expressing themselves. For example, the father in family H, a man of few words, suddenly spoke loudly with a very harsh edge to his voice saying "we were out last night waiting for you (the mother) at the grocery store until almost midnight...ask your son! He and I are always waiting on you! Here's what you can do. Take the bus to the store and I'll pick you up on my way home from work. Then he and I can do something we want to do!" The mother laughed and essentially belittled the husband as "always being angry", The Counselor's comment was , "so it's quite a distance to the store?" Counselor 5 seemed to want to keep conflicts to a minimal and to come up with solutions before the problem was defined.

Second semester, Counselor 5's percentage of direct behavior increased significantly to 18% while her indirect behavior decreased to 19%. This was most noticeable with family H. Counselor 5 had a session with just the two parents and explored the reasons, if any, for them staying together. Counselor 5 took control of the session right from the way in which she set it up and her very first

statement, "Today I wanted us to meet without your son so we can discuss your marriage". The Counselor interrupted the mother's litany of complaints about the husband, to point out how difficult her life would be if she were a single parent of an adolescent male. Counselor 5 displayed leadership skills with this family and also did not seem afraid of dealing with some tough issues such as their sexual relationship.

However, also in the second semester, Counselor 5 was less direct with the BB. family. This was only the third session with this family and the Counselor still did not seem to have control of the session. The 10 year old boy started talking and the Counselor had difficulty talking over him. The Counselor did not ask the parents to quiet him, and from the way the boy was laying on the father it did not look like he was expected to behave. When the mother expressed her unhappiness with how the family interacted and described how the "boys are always hitting each other and teasing each other when they are in public", the Counselor asked "when do you have fun together?" Although the Counselor talked more in the spring (33%), there was also long (1-2 minutes) times of silence (30%) which encouraged talking in the family members. However, the 10 year old boy controlled the session.

#### Structural analysis.

*Structural assessment:* First semester, Counselor 5 described the structure of both the families as "there are no boundaries between subsystems, the family is enmeshed". Both mothers were described "as being in charge" although they "shared the power ". By sharing the power the Counselor meant

that in the H. family the mother gets her way through “passive-aggressive behavior and she does get what she wants”. While in the R family she sees the mother as “having most of the responsibility for caring for the children..but both parents tell the children what they want”. The Counselor attempted to focus on these issues but was distracted by her intrapsychic perspective which is exemplified by her description of “ the mother as depressed or passive aggressive” rather than the problem as the relational aspects of the fathers ignored the mothers’ requests for assistance with the children.

With both of these families the counselor accurately assessed that the children were caught in marital issues that spilled into discipline. In response to “how does the child’s presenting problem help the family”, Counselor 5 responded that in the H. family “the children take the focus off of the weak spousal subsystem” or for family R. she wrote “the behavior distracts the parents from the problems in their relationships”. Counselor 5 also appeared to have an awareness that because of the conflict the hierarchy in the families was skewed. She described both sets of children as being caught in a “dysfunctional triangle with the parents’ marital conflicts”.

Counselor 5’ s understanding of enmeshed and disengaged was somewhat confused. Because the mother and stepfather spoke for the children in family R., the Counselor assumed they were enmeshed and even told the parents “you all are enmeshed with your children”. However, these parents seemed to talk for the children because they did not want the children to speak or to reveal any information. At one point, early in the counseling sessions, the

mother told the referred child, "before you speak remember what can happen... Social services could get involved". Further, the boundaries between the daughter and the step-father appeared to be too permeable, beyond enmeshed. The stepfather reported that the mother's daughter "came to me to talk about her period rather than her mother". The Counselor seemed to miss these comments and others which suggested that these children were at risk for being abused and could not speak for themselves. The concerns about this family were reported to the instructor by the researcher.

Counselor 5 had obviously developed a clear picture of the problems with the Family H.'s marital relationship and was ready to have them bring it out into the open. The Counselor was clearly following the instructor's directive. She wrote that "the wife threatens divorce and uses it as a tool over the husband" and the husband being "declared the bad guy brings the mother and son closer together" At one point the counselor said to the mother, "if anyone should be left out, it should be your son. It is you and your husband that should be planning a life together, not you and your son".

In the second semester Counselor 5 's structural assessment of the H. family became somewhat more detailed and complex. She described the "weak boundaries between the subsystems..the mother is in charge most of the time either by working with her husband to discipline the son or by shutting out the husband by siding with the son. Counselor 5 was beginning to come a little closer to describing the problem in interactional terms.

The Counselor's structural assessment of the BB. family was not as clear. She described the structure of the family as "the 9 year old boy is in charge of the family. However, given that the father laughed when the boy was in trouble, it appeared like the 9 year old was being elevated by the father to this position. The father and the son formed a subsystem with the power. She went on to describe "There are weak boundaries between the subsystems. They are engaged during the counseling sessions, however, at home when they engage everyone gets angry, then they disengage. The family had no limit setting before beginning counseling." Not only did she did not seem to see the coalition between the father and son, but mother and brother were seated so far from the father and the 9 year old that they appeared isolated and detached from them. The split between the parents was quite pronounced from observing them on the videotape. Counselor 5 did write that the "presenting problem does allow the parents to blame the child for the family's problems".

The issue of hierarchy in the BB. family was not addressed directly by the Counselor on the videotape or on the response forms. When the father appropriately disciplined the 9 year old boy, the Counselor did not encourage it rather she turned to speak to the 13 year old boy. When the 9 year old boy was obviously pleased at how he had stolen and destroyed his brother's belongings, the Counselor proceeded to admonish him rather than encourage the parents to do it. The parents actually interrupted the Counselor's lecture to the boy, and followed her lead in a manner that suggested they would show her they could do this themselves.

*Systemic Hypothesis:* Counselor 5 described the systemic hypothesis for family R. as “the girl is caught in a dysfunctional triangle with the parents suggesting marital conflict”. Counselor 5 appeared to be partially aware that the conflict between the parents of Family R., the mother’s anger at “doing all the work for the children” and the father’s ignoring the mother, spilled on to the children but she did not have a clear view of just exactly what that pattern looked like. Even when the pattern occurred in the room, the Counselor did not seem to perceive it or comment on it. Family R. was more complex and had more distractions than family H.

The Counselor seemed to have a more accurate view with family H. that the child was caught in the middle of the interaction between the husband and wife. Her systemic hypothesis was that “the parents argue and son is used to take pressure off the marital subsystem”. Although this hypothesis is not in clear interactional terms, it does partially state the process. Within both families the identified client was caught in a triangle between the parents and Counselor 5 did perceive this trap. However, Counselor 5 was not able to articulate it clearly with regard to interaction patterns in the counseling room.

Counselor 5’s thinking about the patterns of interaction in the families lacked clarity. Counselor 5 seemed to have more clarity around Family H. and could present a precise example of the interaction pattern in which the child was caught between the two parents. This is also the family with whom Counselor 5 was the most successful within the counseling session and received the most supervision from the instructor. With this family, Counselor 5 was able to think

systematically and intervened accordingly. The Counselor had a more precise and less vague systemic hypothesis for the H. family which made her interactions with them more productive, particularly in her second semester session with them. Counselor 5 described the systemic hypothesis as “a result of the mother’s enmeshment with the son which weakens the marital subsystem. By focusing on her husband’s lack of a relationship with the son, the mother can ignore the issue of their marital relationship”. Counselor 5 was able to interrupt the mother, and support the father when needed. It would appear that Counselor 5 profited from working with this family and receiving supervision. Counselor 5 was obviously following a theme and directive from her instructor and this was noted on the instructor’s response form.

Because the structural assessment of the BB. family was unclear, the systemic hypothesis about patterns of interaction was not exact enough to help the Counselor know what parts of the communication pattern she needed to support and what parts to block. Counselor 5 described the systemic hypothesis for this family as “the 9 year old picks a fight with his brother, parents try to break it up, fight escalates, parents break it up, the older son goes to a friends on his own and all the family members go their separate ways (to separate rooms)”. Although this was one of the better interactional descriptions of an interactional pattern, it starts with the boys fighting rather than with what happens before that point. Therefore, since the boys are unlikely to fight in the counseling room, the Counselor needs to look at the patterns in the room and assess them to validate her hypothesis.

Restructuring plan and interventions.

*Joining:* Counselor 5 appeared to make the families comfortable and seemed to communicate caring towards them. Both of these families came to counseling on a regular basis and did not miss appointments both indicators of a connection to the counselor. The father in the H. family originally told the Counselor, "don't expect me to come back, counseling is not my thing and I'm real busy...I'll wait in the car for the son and the wife". Yet, he came to every session and participated. Counselor 5 was doing a good job of joining with that family.

With the BB family it was difficult to tell since they had only just recently returned to counseling after a break. The BB family had just decided to recommit to counseling after missing some appointments prior to this one.

*Reframing:* The Counselor attempted a couple of reframes with these families. With family R. the Counselor tried to get them to consider "what have been the effects of blending two families together?". They didn't seem to hear her reframe or to take it in because they dismissed the idea that blending the families could be problematic.

With family H. she attempted to redefine the child's difficulties as being a result of him "being caught between battling parents". She told the, "your son is disrespectful to his father because you two (parents) are always fighting and being disrespectful to each other. There must be a lot of tension in your house". Both parents nodded their head in agreement and the son said, "yeah".

Counselor 5 attempted a number of reframes with both families, some successful, some not. At one point she tried to reframe the BB family as liking each other so much “the boys can’t keep their hands off each other”. The timing of this was off because it occurred right after the mother had expressed how unhappy she was with the family. The mother did not buy the reframe and disagreed with it.

However, Counselor 5 was more successful with the H family. She reframed the problem between the marital pair as “Dad just doing what he knows to do because of how he was raised”. Dad did not like this reframe because he felt it implied “that means something was wrong with my family?”, but mom did like it. The Counselor tried a reframe later when the husband said the only thing he wanted from his wife was “for her to sleep in the same bed”. The wife interpreted this as wanting sex, but the therapist reframed it by saying “he just wants you to be close to him” and he agreed. It was a nice way to get the wife to see where the husband was coming from.

*Normalizing:* The Counselor tried to use this strategy to make the wife in Family H. feel that the “difference between you and your husband in the area of discipline is because you were brought up differently and these differences should be expected”. The wife dismissed the Counselor by saying , “oh we’ve been together for a long time now”. The Counselor used a similar strategy with family R. Neither family seemed to accept this explanation of the behaviors maybe because the message was delivered as a lecture rather than through discussion.

Counselor 5 attempted to point out to Family R that blended families often have difficulty establishing discipline procedures because everyone brings different expectancies into the new family. At one point Counselor 5 attempted to normalize the problems in the blended family by blaming some of the discipline problems on the fact that the biological parent needs to be the one to discipline particularly when a new family is forming. Similarly, with Family H Counselor 5 tried to talk about the difference in the parents' upbringing as the reason they differed so much in their discipline style in an attempt to get them to stop blaming each other and think about coming up with a compromise.

Counselor 5 used normalizing to describe how in Family H. the son needed "to find his own friends and be spending more time with his friends than with his mother"...this was normal for his age. She also used an explanation of developmental stage of the family to explain some of the teenager's behavior. The counselor tended to have an educative approach to this strategy but the H. family seemed to listen attentively.

She attempted a number of times to normalize through educative statements such as her statement about "do you know the statistics about single parent families..." When the normalizing did not work it was usually a result of the fact that the parents were having such a hard time with the behaviors they could not believe they were normal. Although she attempted to explain to the R. family how the biological parents need to be in charge of their children, she did not fully seem to understand the developmental stage of the blended family.

*Enactments:* Because the counselor was relatively silent and these were very active families, arguments and discussions occurred without her directing them. However, Counselor 5 had difficulty blocking dysfunctional patterns of interaction, partly because she did not have a clear systemic hypothesis and partly because she tried to deal with the problems individually. The Counselor did not block the mothers when they talked on and on about their frustrations. Counselor 5 was able to sit with the intensity that came up in the room, but just didn't seem to know what to do with it. Thus, although there were enactments in the counseling sessions, they were not necessarily effective at changing patterns of behavior.

The Counselor did create a very successful enactment in the second tape of the H. family. She had the mother and father meet alone with her to discuss whether they should get a divorce. She told them to "name the things they needed to stay in the marriage" and she listed them on the blackboard. The Counselor tried very hard not to take sides with family H. as they discussed the pros and cons of staying married; however, she set this enactment up nicely and when the wife kept up with her yes, but-ting, the Counselor said "do you know the statistics about single parent families with regard to monetary circumstances and dealing with adolescent boys? The women have less money and have great problems dealing with the adolescent sons because the father is not there". The Counselor increased the intensity with Family H. by being able to stay on the subject of what there was to gain or lose by this couple divorcing. By increasing

the intensity herself, the father did not have to be so intense and angry which was a fear the Counselor expressed on her response forms.

With the BB. family, the Counselor did not set up the enactments, they just occurred naturally. In this family the Counselor became inducted into trying to parent the child rather than coaching the parents to do it themselves. When the Counselor heard the description of the 9 year old's stealing precious things from the 13 year old and destroying them, she immediately said to the 9 year old, "how would you feel if your brother did something like that to you? What do you think you owe him?" The child responded, "I wouldn't care". The father had the 9 year old on his lap, and laughed at the son's remark, but the mother became angry at the boy and said, "it's terrible how you treat your brother, you should apologize to him!". The Counselor turned to the brother and told him to "tell your brother how this makes you feel." This family felt out of control. This did not turn into an enactment but rather an example of the typical argument in the family and the Counselor missed this process because she was so tied into the content of the stealing.

*Punctuating:* The Counselor did not use this strategy with the R. family. The Counselor consistently punctuated the participation of both spouses in the discussion in Family H. She was too frustrated with the BB family to find something positive. She attempted to use what they did that was fun together, but they did not have anything to say about it which could be praised.

*Themes* for Counselor 5 were related to limit setting, enmeshed mothers, lack of parenting skills and blocking interactional patterns. She seemed to have

more than her share of families with marital conflict and was able to sustain her focus on this issue when there were no children present. Her focus was to strengthen spousal subsystems and parental subsystems. The Counselor's conceptualizations at least in written form became more complex over the course of the year.

*Instructor's assessment:* The instructor's written responses indicated that the theme for Counselor 5 "was to focus on systemic thinking, empower the parental subsystem and focus on the spousal subsystem as much as the parental subsystems and gain self confidence in the sessions". The instructor voiced a concern that although Counselor 5 looked "not bad on paper" she was more "individually than systemic focused at the applied level". On the final assessment of her skills the instructor wrote, "getting better". When the instructor's directives were contrasted with the counselor's performance, it appeared that Counselor 5 was able to follow directives if she clearly understood them, had seen the family for a number of visits and there were no children in the room. Counselor 5 had more difficulty attending to and focusing on the spousal or parental subsystem when children were in the room.

*Counselor Self Assessment:* Counselor re-wrote the systemic hypothesis once after a session with the H. family. Although she did not change the rest of her hypotheses she did repeatedly mentioned "how complex the process of family counseling was and how she had to realize "I can't address every area in one counseling session". For the most part she rated herself as being fairly successful. She wrote in response to the question of how well did she implement

the strategies?.., “pretty good, got them talking, encouraged father to speak more and mother to speak less”. To the question of what blocked your strategies she replied, “resistance by parents”.

When asked about her thoughts during the sessions she described them as being about individuals in the family such as the “mom looked depressed” or surprise about “how quickly the father began a new relationship after his divorce” or “can this marriage be saved” which was her last entry.

*Summary:* Counselor 5 began the year with an interpersonal approach to counseling. The Flanders analysis indicated that she was not comfortable with direct responses (ranged from 6-18%) and was more comfortable with indirect responses (ranged from 34%-19%). Counselor 5 was able to maintain a fairly even split between discussions with feeling versus factual content.

Counselor 5 began the year with somewhat simplified, limited understanding of the conceptual concepts of structural family therapy, but her conceptual understanding became more complex and enriched as the year progressed. She continued to struggle with her person centered , individual focus, but she was aware of this problem. The families with whom she worked were quite verbal and she had many opportunities to have discussions; however, she was able to be more focused on the adult subsystems when the children were not present. The children distracted her either because she tended to direct her conversation to them or because she was unsure of what to do with them. Counselor 5 attempted a variety of interventions from joining, to reframing to normalizing to enactments. She was able to join well with the families because of

her gentle, non-threatening reflective style and they seemed willing to listen to her. Counselor 5 was successful at bringing up emotions for the families to discuss but less successful at orchestrating a productive interchange because as her instructor said, "at the applied level she appeared to be more individually oriented" than systemically focused.

### Counselor 6

Families	Reason for referral	Members of family	Fall	Spring	Session number	severity rating
Family M.	16 year old son phoned in a bomb threat, ADHD	mother and son live in one household; father and daughter-12 live in another household-family has been separated since 3/1998	x (2 tape)		2nd & 3rd session	severe
Family C.	10 year old boy aggressive behavior at school and outbursts at home	Mother, Father, son-10, daughter-8		x (1 tape)	session 2	moderate

Figure 10. Describes the families presented by Counselor 6 in the internship class.

Counselor 6 presented two videotapes of the M. family during the first semester. This family was composed of the mother, father, their 16 year old son and their 12 year old daughter. The parents were separated for almost a year. The son lives with the mother and the daughter lives with the father. The father called and requested the family counseling because of his poor relationship with his son. The son had been involved in a bomb threat at the local high school and had other incidents which brought him into contact with the police. According to the father, the daughter was the "perfect" child. The father reported that "my ex-wife and I have disagreed about the discipline of my 16 year old son ever since our daughter was born". The son was diagnosed with ADHD and was on Ritalin.

Counselor 6 only presented one videotape second semester of family C. This family was composed of a mother, father, 10 year old son and 8 year old sister. The son had temper tantrums at school, at home and even at the mall when shopping with his mother. This was the second time the counselor had seen this family and she had not received supervision as of this point. This session was more like the other counselors' first semester videotapes because the counselor was much less directive and seemed more unsure of her strategies.

*Counseling Approach:* Counselor 6 is the most experienced of all the counselors with regard to individual counseling. She has been involved in treating adult substance abusers for 12 years. In the first semester videotapes Counselor 6 appeared quite comfortable in the therapist position but struggled at times for words which belied the fact that she did more confronting and

challenging of perceptions than any of the other the novice counselors.

Counselor 6 also seemed very comfortable with emotional intensity and was able to stay with it longer than most beginning counselors. Counselor 6 appeared to apply a model of reflection and confrontation. Counselor 6 repeatedly asked the mother and father to reflect on their experience of the “process” and confronted the father by asking him “what are your goals for being here?” These techniques may have been part of her substance abuse training.

Counselor 6 was not at all confrontative with the C. family in the videotape of the second semester. If anything, Counselor 6 appeared hesitant, and lacking confidence as evidenced by her dysfluencies in her speech. She seemed to grope for words which was not as evident when she was working with the M. family. She did not have a focus to the start of the session and asked “who would like to start the talking” rather than addressing anyone in particular which was very different than her structured beginning with the M. family in which she had them bring in their homework from the week before.

#### Flanders analysis.

Counselor 6's style which she applied to the family counseling appeared to be consistent with her training. Counselor 6 was quite adept at asking open-ended feeling questions, commenting on the process in the room, but also challenging the belief system, at least with the M. family. Unlike the other first semester counselors, 19% of Counselor 6's responses were direct with 5% being confrontative. This forceful style was also evident in that 40% of the talking was done by the counselor. Counselor 6 began each session with the M family with a

focused opened ended question such as “Dad I want you to go first and share what you listed as the positive things you liked about your ex-wife”. The intensity of the session was not measurable by the Flanders, but as she kept the focus on the parent’s relationship and disagreements the son became quite agitated and finally left the room.

Second semester Counselor 6's responses were more indirect (41%) than direct (2%) with the C. family. The counselor started the session very unfocused by asking “who wants to tell me what happened this week” which allowed the family members to argue about who was going to talk. The Counselor’s direct responses decreased from 19% first semester to 2% second semester.

Counselor 6 did not comment on the process occurring within the room which she had been observed doing on the first semester tapes. This lack of focus on the process decreased the intensity(tension) of the session as compared to the fall sessions. In addition, the conversation was directed toward content (44%) relative to rules and expectancies rather than feelings (24%). The amount of counselor talk decreased (31%) and as noted above she stammered and searched for words as if she didn’t know what to say. The counselor seemed to have lost confidence in herself and seemed much less comfortable in the counseling role. Counselor 6 was one of the counselors who did not present a family to the internship class until November. She also only provided two tapes for this study. Whether this was because she had a limited number of families or for some other reason is unknown.

#### Structural analysis.

*Structural assessment:* Counselor 6 had difficulty understanding the boundary and hierarchical issues of the M. family which she was uncovering and challenging. She described the family structure as “the 16 year old son seems to have a great deal of power. He and his mother form a subsystem, probably enmeshed. Dad and the daughter are a subsystem. The daughter seems, on the surface, to want to engage with all family members. The son does not seem interested in being involved with either his father or his sister.” The Counselor goes on to state that “mom and dad both want the son and the father to have a better relationship”.

By having the two parents who are in the process of a divorce sit next to each other and tell each other what positive things they liked about each other, she violated the boundaries they had established in their separation. For example, the father read his list first but the first thing he said to the ex-wife was, “ I’ve always liked how you care for other people”. The wife had turned her body away from him, even though they were almost sitting knee to knee. The Counselor asked the mother, “ how did you experience that process?” The wife responded, “I know he thinks I always cared for others not him!” It should be noted that Counselor 6 was following a supervision directive provided by a peer group supervision which occurs when an instructor is not available and a graduate student runs the class. Focusing on the spousal relationship was not appropriate for this session and suggested a lack of understanding of family structural concepts. The Counselor thought she was establishing a stronger hierarchy but actually was only showing the split in the hierarchy which, in the

past, resulted in the son acting out the anger which exists between the two parents. The relationship between the parents appeared potentially volatile which was not assessed accurately by the counselor. The Counselor seemed to understand the idea of subsystems and alignments but not in the developmental picture of a divorcing family.

By the very nature of her first questions to the C. family, "Who wants to tell me what happened this week", the counselor displayed a lack of knowledge and awareness of hierarchical issues. Although she eventually turned to the father and asked him to talk, it was not clear that she was doing this purposively. She described the structure of the family, "mom is in charge. Mom and the kids form a subsystem while dad is somewhat disengaged. The two children form a sibling subsystem and are fairly engaged. Mom and dad seem uncomfortable in their positions as leaders of the family. The boundaries become fuzzy between parental subsystem and the son as he makes decisions and parents feel helpless to enforce their rules." Although she did see the mom in charge, she missed the evident split between the mother and father with regard to disciplining the son. The counselor became inducted into listening to the mother list all the bad things the son had done while the father sat back and at one point mumbled "you can only be so negative but at some point you start disliking yourself". This was said in reference to the mother describing what she had done to get the son out of the mall and him wondering if she is too harsh on the boy. The mother told the story about how "the boy had a temper tantrum, screaming and crying, in the record store because he could not have what he wanted. I had to leave him

crying on the floor and go out into the mall. It was so embarrassing. I think he has gotten worse since we've been coming here to counseling".

Even the way the family was seated with the mother surrounded by the children and seated across from the dad, it looked like the dad was disempowered and mom held the high ground. Perhaps because the counselor had not received instruction or supervision, she was unclear of the structural make up of the family.

In both families the counselor assessed the mothers as being overly involved or enmeshed with the sons and the father somewhat distanced or disengaged. She had a clear view of what made up the subsystems but had a rather unrealistic view of what being in charge meant. The instructor evaluated her conceptualizations as being "simplistic-needing greater depth and complexity". The Counselor did not have a systemic view of the interactional patterns. Although she knew the father in family M. was angry at the ex-wife, she did not clearly describe this behavior as fueling his anger with his son.

*Systemic hypothesis:* The Counselor's systemic hypothesis for the M family was described as the "son is triangulated. He is the focus of mom and dad's disagreements. Dad blames mom. Mom defends herself. Dad lists sons' negative qualities. Mom defends son. Son erupts". Although the counselor did have an idea that the parents disagreement was being acted out by the son, and that the son's behavior was a distracter for their anger, the counselor did not look beyond appearances to the power struggle or struggle for control of the marital relationship. The father appeared to be dangerously angry at the mother and one

could only wonder if domestic violence had been a factor in this divorce. The fact that the father had initiated the request for counseling with his ex-wife and her resistance to it, was cause for concern.

The Counselor was skilled at picking out the process in the room, but did not know what to do with it within a structural model once it was named. At one point after the father told the mother what he saw as her positive traits which "she shared with others not him" , the counselor asked the mother again "how she experienced that process". The mother said, " I already said thank you!". The counselor persisted and the mother said " it makes me extremely uncomfortable to be sitting here talking about our personal relationship which has ended". At another point the counselor asked the mother to respond to the process of being in the room and the mother said again, "this is very uncomfortable and I've already heard his anger and criticism. What are you asking me?"

Counselor 6 described the systemic hypothesis for the C. family as "there is a problem with the relationship between mom and dad. The son is the symptom bearer of trouble in spousal relationship. By focusing on the child's misbehavior they do not have to focus on their relationship". Although this was part of the story, the Counselor did not have a working systemic hypothesis about the interaction patterns which allowed this 10 year old boy to have temper tantrums. One can only wonder what kind of behavior the mother tolerates until either she, or probably the father, become physical with the boy.

The Counselor is aware that there is a problem in the spousal systems. With the M. family it was more obvious since they were in the

process of divorcing. However, even though she is aware that this is somehow related to the children's behavior, she does not seem to be clear about the connection and what is actually happening. Her systemic hypothesis is somewhat clearer with the M. family, but then the parents are more obvious about their disagreements. Counselor 6 also used the term "triangled" to describe the position of the son between the parents, but did not describe what that would mean in the pattern of interaction. Her description just labeled this as "being caught in the middle".

#### Restructuring plan and interventions.

The counselor in the second videotape presented a session with the family with just the father after she had received some individual supervision. This session was very focused on the father's blaming his poor relationship with his son on his ex-wife and the father's negativity directed toward the son. The counselor had been directed to "find out what this man really wanted" since he did not seem motivated to change his relationship with his son. The Counselor followed this directive. She kept asking him, "do you really want a better relationship with your son? It doesn't sound that way. You sound as if you have given up on him".

Counselor 6 seemed to be adrift with the C. family, with no plans except to support the parents to become firmer and take "leadership" in the family. The

goal is good but she did not seem to have an idea about how to get the parents on the same side.

*Joining:* The counselor did not seem concerned about this aspect of the relationship particularly with the father in the M. family as evidenced by the confrontational statements she made. The counselor had not joined with the C. family but rather was inducted into their system which was examining the boy's behavior and feeling helpless to change it. The Counselor had difficulty joining with the M. family since she placed them all in an intensely uncomfortable situation to start with by having the mother and father sit with their knees touching. Further, she was very confrontative with the father and did not have a clear enough picture of what was happening to articulate it for him in a less confrontative manner. It looked like she wanted the father to become more nurturing toward the son, but she was trying to argue him into it.

*Reframing:* The counselor attempted to reframe the problem in the M. family with the son and father's relationship as being a result of the father's unrelenting negativity toward the son. At one point she touched upon very briefly that "your anger toward your wife is also a factor in your anger toward your son", which the father agreed. But she did not clearly articulate that the war between the parents was being acted out by the son. The father admitted to his anger toward his wife, but would not accept that his negativity toward the son was unreasonable.

With family C. no reframe was used.

*Enactment:* Counselor 6 initially attempted to structure an enactment with the M. family around an inappropriate topic, improving the positive statements between the mother and father, which resulted in the family focusing on the son's leaving the room. Counselor 6 was obviously attempting to try to focus on the process, but the process was too intense and unsafe for the family the way it was structured

When she met with the father of the M family alone, the Counselor role played the son's response to the father saying "my door is always open. If you want to come over just be sure you act appropriately". The Counselor said if I were your son I'd say, " why should I come if I can't be who I am and you are expecting me to be a problem?" Do people come to your house to visit when you say my door is open? Why would your son?" Confronting the father's anger and getting him to be clear about his agenda for counseling was the goal of this interview. The father defended himself as only expecting what most parents would expect of their children. He was "not going to pursue the kid, the kid would have to come to him."

The counselor did not set up any conversation between the parents of family C. The only time conversation arose between family members was when the boy interrupted the mother to help her describe more accurately his misdeed. The Counselor did ask the boy to "role play what a temper tantrum would look like for me", which was not a bad idea, but the boy said that was too embarrassing and the Counselor did not pursue that line of reasoning.

When she received directives either from the instructor or her peer groups, Counselor 6 definitely attempted to implement them. The peer group supervision appeared somewhat off with regard to work on the mother and father's relationship in family M. which resulted in the session with the divorced couple working on their relationship.

*Counselor self assessment:* The Counselor was very intent on following the supervisor's directive to focus on the process. Counselor 6 was anxious to receive supervision because she felt that she "tended to go off with the families on tangents" and supervision assisted her in maintaining her focus.

She attributed problems with her strategies to "uncooperative, resistant clients". She blamed both fathers for the lack of success of her strategies. The father in family M. was "uncooperative and feeling hopeless because of his anger towards the mother". The father in family C. was "depressed and overwhelmed by the parenting responsibility". In family C she noted that the "kids' interrupting was a problem" and seemed to have no idea that such interruptions make great enactments for discipline by the parents.

Counselor 6 did not reflect or mention any loss of confidence, discomfort or confusion about the process of learning to do structural family therapy.

*Instructor's assessment:* The instructor's directive was for the Counselor "not to get lost in the content and to focus on the parental systems rather than the children". The instructor stressed meeting alone with the father in family M. and learning "to articulate more clearly family dynamics". Although the instructor mentioned that Counselor 6 tended to have simplistic conceptualizations and

needed greater depth, it was also mentioned that she needed to learn to focus on a smaller part of the process. The instructor noted that the Counselor was “moving toward greater depth” on the last evaluation form.

*Themes:* Counselor 6 mentioned the following phrases to describe the families: disengaged fathers and enmeshed mothers, problems in the marital relationships, a need for power in the family and leadership in families. The Counselor repeatedly expressed not getting lost in the content and staying focused on the process.

*Summary:* Counselor 6’s conceptualizations appeared to become more complex as the year progressed. She had an understanding of subsystems and boundaries, but applying this understanding to create a conceptual map or to develop interventions was still a challenge for her. Her concepts of interventions tended to be limited to having the parents discuss and collaborate more about the children.

Counselor 6 seemed eager to have supervision and definitely could be observed attempting to follow the directives, even when they made her and the families uncomfortable. It is difficult to account for the change in her behavior from confrontative to hesitant which happened over the two semesters. It could have been because she did not have supervision on the last tape or the kind of family she was working with. The Counselor did not write any indication of discomfort on the response forms.

As noted earlier in this section, Counselor 6 provided fewer videotapes for this study and incomplete response forms. Thus, there was less data to analyze her development over the nine months of the internship class.

### Group Analysis

The next section compared the counselors to each other to look for the commonalities and differences between their conceptualizations, perceptions and therapeutic interventions over the nine month internship. The analysis compared the results of the Flanders, counseling approaches, videotape observations and the results of the structural analysis. The structural analysis examined the assessments, systemic hypotheses, and restructuring plans. The main source of data for the group analysis was the counselors' written responses to the response forms, the Flanders analyses and the videotape observations.

*Counseling Approach:* All of the six counselors appeared to be very child focused. Three of the counselors even noted that they did better when they met without the children present because they had difficulty focusing on the parental or spousal subsystems when the children were present. All of the counselors tended to be drawn to talking to the children particularly if they believed the parents were too negative and harsh toward them. The therapists all started the year trying to go through the children to get change in the family. By the end of the year only one of the counselors persisted in their focus on the children.

Three of the counselors began the internship with a very clear person centered, non-directive counseling approach. These three counselors appeared to have well developed generic counseling skills, including skills in active

listening, paraphrasing content, paraphrasing feelings and being comfortable with silence. Of the other three counselors, two were person centered but one started out with many confrontative directives and the other seemed less comfortable in the counseling role. The sixth counselor had a much more directive, behavioral approach. By the end of this study the counselors displayed increases in the amount of directness to their style by taking more leadership in setting the conversational tone of the sessions; i.e., who talked and the topic being addressed. Only one counselor went from confrontative and confident appearing in first semester, to hesitant and less confident appearing second semester. The two counselors with the most experience seemed to have the most difficulty making a shift in their counseling approach. One remained nondirective, child focused and continued to do individual counseling in a family setting. The other experienced counselor seemed to become more hesitant and uncertain of her style. Although there was a shift in their approaches, all of the counselors retained, to differing degrees, the person centered individual counseling format.

Initially, all of the counselors also began the year attempting to solve the families' problems in the first two sessions. These counselors had a set format of giving a homework assignment to the family three quarters of the way into the counseling session. The homework assignment had not been practiced in the session, so there was no evidence that the families could accomplish the task. The process of assigning the homework stopped after the first semester. The

counselors appeared to be less driven to solve the problems immediately and had slowed their pace of problem solving for the families.

#### Flanders analysis.

Five of the counselors increased their direct behaviors anywhere from 0% to 34%. Only one of the five dropped from 19% in the fall to 2% in the spring. Overall, the counselors focused more on content than feelings across the year, but this varied within each counselor depending on the nature of the families problems and the severity of the problems. The more severe the family problems, the more emotionally laden issues, the more tension or intensity in the room, the more likely the counselor was to focus on content. For example, Counselor 1's focus changed from 47% on feelings to 20% on feelings when she went from a cooperative, verbally facile family to a negative, angry family with a threat of violence at home. Severity of the families problems and emotional intensity particularly involved with anger influenced the kinds of questions the counselors used. All but one of the counselors changed their focus after supervision as they attempted to implement the instructors' directives.

#### Structural analysis.

Structural Assessment: Based on the counselors' responses to questions 1-4 on the "before" session responses forms, the conceptualizations of the structure of the families initially appeared to lack depth and understanding. Five of the counselors used the following words to describe the families: problems with "enmeshed boundaries," usually between mother's and sons "; "disengaged

boundaries between father's and children"; hierarchies in which "mothers need to be empowered to take control" or both parents were not in control; the "children were in charge" and "parentified"; and "intact spousal and parent subsystems". All of the counselors started with a superficial assessment of the spousal system usually perceiving it as "stressed but strong". There was little elaboration with regard to describing the families' developmental stage nor did they translate these terms into relational words. For example, they did not describe what was meant by such terms as "weak control". One counselor described the members of the family for the first semester rather than the structure of the family. By the second semester this counselor was starting to describe the structure.

As the year progressed, the counselors increased the complexity of their descriptions by expanding them and adding new dimensions to them. Four of the counselors developed a greater understanding of the interactional meaning to the terms and changed their behavior accordingly. It is interesting to note that often they changed their behaviors more than the words they wrote. One of the counselors did not change her descriptions or behaviors. She remained focused on an individual perspective. The other counselor seemed to have lost confidence in any approach and seemed to be more confused both on paper and in the sessions.

First semester all of the counselors' seemed to accept the reason for referral as the problem needing to be addressed by counseling. They accepted the generally intrapsychic description of the problems without translating them to interactional terms. For example, the most common reason for referral was that

the children were diagnosed as ADHD and were described as out of control. From the 16 families in this study, 10 of the children had the diagnosis ADHD and were on medicine. The medical definition, the schools' definition or the parents' definition of the child as being the problem in the family was generally accepted. Even their views of the family's strengths were limited to such things as they are "committed to coming to counseling", "parental unit appears intact and they love and care for their children". As the year progressed five of the counselors became better at redefining problems into more relational terms which helped them to conceptualize better. However, they remained somewhat limited in seeing a variety of strengths in the families.

The responses of the counselors' to the "after" session assessment of the family, indicated some increasing awareness of the complexity of people's lives , but only two actually changed their structural assessment, at least in writing. Their conceptualizations of the nature of family counseling and their assessment of families became more multifaceted. One counselor wrote, " I realize that the program is not in a strict continuum. As family makes changes, there will be relapses into the old habitual behaviors and resistance". This same counselor noted that "the family remains static when responding to me, but comes alive when members interact with each other". Another counselor noted, "the family's problems are much more complex" and "it is difficult to stay away from content". Another theme of what was learned after a session for three of the counselors was an awareness that they wanted to have "fewer people in the room in order to focus" on the spousal or parental unit. During the first semester the counselors

developed more awareness of the difficulty of orchestrating counseling with more than one person in the room. Second semester the counselors became more aware of the history of the family and the emotional intensity of the problems.

With regard to self awareness and the impact of learning family counseling on the novice family counselor, only one counselor shared her in-depth reflections on the process. Two others rarely shared any reflections.

*Systemic Hypothesis:* Because of the limited somewhat simplex conceptualizations of the structural assessments, the counselors had difficulty expressing a systemic hypothesis in interactional terms across both semesters. The most frequent responses to questions 5-7 on the before session form described the children as being caught in “a dysfunctional triangle between the parents which resulted in the parents not dealing with their marital problems” or a “parent being enmeshed with a child and the child was in charge”. One counselor described the systemic hypothesis as the “family is out of balance”. A number of the counselors also described the function of the behavior of the referred child as “helping the family to stay in counseling”. One counselor did not attempt to write a systemic hypothesis until second semester, and another wrote “see question 2” which was about structure for the first two videotapes.

Second semester three of the counselors used the phrase “patterns of communication more frequently in writing their systemic hypothesis but did not clearly articulate the relational communication patterns. They continued to use vague descriptions such as “the negative communication pattern maintains the presenting problem by creating a high level of chaos and focus on the negative

aspects of the family so the positive communication" ..or "productive interactions are eliminated". Another more simply put example from a different counselor was "The family's negative focused communication pattern (modeled by the mother) maintains messages of disrespect and chaos in the family". Finally, there was also a tendency to blame the parents such as " the mother's enmeshment with child weakens the marital subsystem".

The responses of the counselors to the "after" session forms indicated that across both semesters four of the counselors did not change their systemic hypothesis based on new information even though they did perceive additional information and included it into the picture of the family's problem.

#### Restructuring plan and interventions.

Since the counselors lacked a clear systemic hypothesis, and their themes were centered on control, most of their goals and intervention plans related to limit setting rather than nurturance. The Counselor's responses to question 8-10 on the before session form and questions 4-5 on the after session form indicated they used isolated techniques and strategies which were unconnected to a conceptual map or understanding of the interactional difficulties in the family.

"Developing clear boundaries between parental and child subsystem" in order to facilitate limit setting through behavior plans were the most frequent responses to question 8-10. Establishing boundaries took the form of delineating rules for the children or having the parents communicate their expectations for the children. Some of the counselors mentioned enactments as

their intervention strategy but more than anything else “educating parents in parenting skills” was mentioned as the strategy of choice. These responses remained fairly consistent across both semesters. One counselor wrote, “structural family therapy” as the strategy and intervention plan for all of the first semester families. Second semester this counselor was able to delineate use of an enactment or clarifying boundaries as a strategy.

All of the counselors were able to join with the families. However, when the families were of a different race or when the families had a high degree of negativity or threat of violence, particularly directed toward the children, the counselors had more difficulty becoming connected with the families. It took more supervision and more sessions to overcome these difficulties.

All of the counselors attempted to use enactments which involved having the families converse with each other. Four of the counselors did not seem to know what to do with the feelings that emerged once the families were talking. Two of the counselors had enactments which seemed directly related to a structural map or plan that they followed. Both of these counselors wrote about what they were doing and it was also observed on the videotapes. One of these counselors made a dramatic shift in her conceptual understanding and use of the enactment. Another counselor, who was directed by the instructor all year to become more active, employed a role playing strategy in the last videotape which was a dramatically different change for this counselor and an excellent use of an enactment. However, it was not clear that the counselor had a conceptual map about where the enactment should go.

The counselors' responses to question 4 on the "after" session form which addressed how well they felt they did, indicated that they were aware that they did not intervene enough in the patterns of communication or stop children's interruptions. Another frequently mentioned theme was that they became too focused on the content of what was said rather than the process of how and to whom conversations were addressed. A few were worried that they talked too much. These reflections about themselves seemed to be fairly accurate with regard to their behaviors on the tapes, but did not seem to influence their conceptualizations of their systemic hypothesis. This is curious since they perceived a need to block interactions, but did not fit this into a pattern of interaction which they could be observing to block.

The counselors' most frequent responses to question 5 on the after session form indicated that the reason their strategy did not work was because of the "resistance of the children or the parents". Only one counselor reported that they "did not understand what they were doing" or something about themselves blocked their strategy. This is surprising given that they had answered question 4 saying that they had not intervened enough to block communication patterns.

Question 11 on the "before" session response forms asked if the counselor had received supervision and what were the directives given. When the counselor had received supervision from their instructor, there was a greater likelihood that their behavior on the videotape appeared more focused and their conceptualizations about their strategies were more clear. Only one counselor did not seem to make adjustments after supervision or at least acknowledge the

directive of the instructor.

Question 12 concerned the assessment of the severity level by the counselors. Most of them either agreed with their supervisors or changed their assessment to agree with the instructor after supervision. The impact on the counselor's behavior of the severity level of the family was more apparent on the videotapes than the response forms. Of the counselors who had families with severe problems all of them made statements such as "can I help this family?", "Help! Get me out of here" or "can I save this marriage", "I was alarmed at what I was hearing". It appeared that the severity of the problems actually made the counselors' question their effectiveness. All of these counselors were referring to their experiences with families who were rated as severe. The two most experienced counselors responded less intensely to the severity of family's problems. For example, one of the experienced counselors who had a very severe family mentioned that she was "a little overwhelmed by the hopelessness of the father". This statement seemed to minimize the extent of the problems of this family.

Question 13 on the "before" session form and question 6 on the after session form asked the counselors to reveal more personal thoughts and concerns. Very few actually responded with anything personal to item 13, "how was your day". They said such things as "very busy" or "productive". Only one counselor said "my schedule would choke a horse" in response to that question.

To question 6, which asked about their thoughts in the session, the counselors gave more responses. The majority of responses both spring and fall

were related to their thoughts about the family and what was occurring to the family in the room. In the spring a few of the counselor's admitted to being frustrated, confused and concerned that they might not be able to "save a marriage" or help the family and stressed by their schedules. The counselors' thoughts were very much tied to the mechanics of being in the room with the families rather than on reflecting upon their emotional responses to being in the room with the families.

The instructors' responses mainly dealt with two themes they wanted the counselors to work on. One related to the counselors' "simplistic conceptualizations" relative to thinking systematically and need to "leave behind intrapsychic or linear thinking". The other related to attention to being present and attentive to the "process occurring in the room rather than the content". The instructors also commented on the natural tendency for the counselors to "focus on the children" or "go through the children" in the counseling sessions. The instructors kept stressing, "stay focused on the parental or spousal subsystem".

The next chapter presents the interpretations and implications of this analysis. Implications for future research are discussed.

FALL  
Summary of Data

Counselors	Flanders						Structure			Restructure			Discourse		
	D	I	C	F	S	CT	A	Hy	J	R	N	E	P	C	L
Counselor 1 PC	7	47	25	47	25	37	PL	U C	+	1	1	+	2	+	+
Counselor 2 Beh.	23	26	38	13	33	38	PL	U C	+	2	2	+	2	+	+
Counselor 3 Child Focus	1	36	66	22	1	59	L	-	+	1	-	-	-	+	+
Counselor 4 Unclear	6	31	44	11	37	24	L	-	?	-	1	?	1	+	+
Counselor 5 PC	6	34	27	25	26	32	PL	U C	+	2	1	+	1	+	+
Counselor 6 PCSA	19	35	33	35	35	25	L	U C	+?	1	-	+	1	+	+

L= limited

PL= Present but limited

U= unclear to nonexistent

UC= present but lacks clarity

+ = present or attempted

- = not attempted

**SPRING**  
Summary of Data

Counselors	Flanders						Structure			Restructuring			Discourse		
	D	I	C	F	S	CT	A	Hy	J	R	N	E	P	C	L
Counselor 1 Systemic	13	22	37	20	41	28	PL	U C	?	-	-	+	-	+	+
Counselor 2 Systemic	35 34	19 27	37 57	3 27	36 16	47 70	PL I L	U C+ U	+ ?	3	2	+	+3	+	+
Counselor 3 Child Focus	8 0	33 41	32 47	29 4	41 33	41 41	L	U C	+	1	-	+	1	+	+
Counselor 4 Systemic	12 11	22 36	51 40	4 16	37 42	31 34	L PL	U U C	? +	1 2	- 2	- +	+2	+	+
Counselor 5 Systemic	18	19	36	26	30	33	PL I	U C+	+	3	2	+	2	+	+
Counselor 6 Confused	2	41	44	24	31	31	PL	U C	?	-	-	-	-	+	+

## Chapter 5

### Summary and Recommendations

#### Purpose of the study

Research in training family therapists has typically attempted to study the development of novice family counselors by measuring the number of concepts learned, examining the content of the course work and tabulating the number of skills acquired in simulated counseling sessions (Avis & Sprenkle, 1990). The research on the effectiveness of the academic training of family therapists has been equivocal (Anderson, 1992; Avis & Sprenkle, 1990; Kniskern & Gurman, 1988; Liddle, 1991). Both graduate and post graduate training in family therapy have demonstrated improvement in the trainees' conceptual skills (Greenberg & Neimyer, 1986; Pulleybank & Shapiro, 1986; Tucker & Pinsof, 1984), but it is less clear that the trainee's ability to apply these skills to therapeutic interventions also increases (Anderson, 1992; Avis & Sprenkle, 1990). There has been an absence of rich, descriptive data in the family therapy literature which examines the actual experience of being trained as a family therapist (Skovholt & Ronnestad, 1992). The purpose of this study was to provide an in-depth description of the development of novice family therapists in an actual therapeutic environment through observing selected videotapes to study their progress over a nine month internship in a counseling graduate program.

Quantification of the complex process of learning family counseling has resulted in limited information pertaining to their development and growth in the

application of cognitive conceptualizations to therapeutic interventions. The objective of this study was to collect descriptive data which examined the reciprocal interaction patterns between the novice family counselors and all members of the family through observations of videotapes of family therapy sessions, responses to questionnaires by the counselors both before and after their counseling sessions and responses from the instructors who provide clinical supervision to these graduate students. A qualitative, descriptive case method was employed in this study because it was the only method in which such complex information could be thoroughly examined (Creswell, 1994). The use of multiple sources of data provided credibility and trustworthiness to the observations.

This study documented the perceptual-conceptual and therapeutic skills and the application of these skills in a real life therapeutic environment. The research was guided by the following questions with regard to the development of the novice family counselors who participated in the nine month internship class:

- 1.) What do the interaction patterns of the novice family counselor look like and do these interaction patterns change over the period of the internship?
- 2.) How do novice family counselors conceptualize family problems? What hypotheses do they generate with regard to the relational patterns in the family? Do these change over time?

3.) What do the structuring and re-structuring skills of the novice counselor look like in counseling sessions? Do these change over the course of the nine months? How active do the counselors become over the course of their training?

4.) In what ways does the kind of interaction between the novice counselor and the family influence the counselor's behaviors and conceptualizations?

### Counseling Approaches

“The alteration or abandonment of intrapersonal theories of behavior is a major transformational process in the trainee's life” (Liddle & Saba, 1982, p. 65). All of the novice family counselors came to the family counseling internship well schooled in an ideology of intrapersonal pathology which is the dominant theme of the larger mental health community and to some degree the counseling education program at Pine Tree College (Anderson, 1994). This individual pathology model represents a medical model of illness in which it is assumed that something within the individual can be diagnosed, treated, cured and covered under medical insurance in 8-12 visits or less (Shields & Wynne, 1994). Although counselor education programs have historically been less pathology oriented than their relatives in psychology, social work and psychiatry, most counselor education graduate students' livelihoods are predicated on insurance payments. Therefore, training in family therapy must maintain a balance with training in individual pathology in order for the students to be able to communicate with the larger mental health community and in order to avoid a marginalization of the profession (Anderson, 1994; Shields & Wynne, 1994).

Adopting a systemic model, which includes the individual's pathology as

well as the interactional view, requires a counselor to possess complex conceptual skills and flexibility. The counselor in effect must be multi-theoretical (Grunebaum, 1988). Functioning from one model is certainly simpler and creates less dissonance than trying to integrate multiple epistemologies. The magnetism of the individual model is powerful and pervasive within the societal and educational context within which the graduate students exist. It is their reality.

Thus, it is not surprising to find how difficult a task it was for the students in this study to shed their shell which surrounds and nurtures them to grow a new larger shell which could encompass both an interactional perspective while being cognizant of the individual within the interactions. Even the families came with a medical diagnoses already placed on their children. Sixteen of the children were on medication for Attention Deficit Hyperactivity Disorder (ADHD), a medical diagnosis of a problem which interacts with environment. The dominant theme in the mental health community continues to be diagnosis of individual pathology and quick interventions to reduce symptoms.

The primary area of growth for five of the six counselors this year was not that they became expert family counselors but that they had their reality challenged and they grappled with it and overcame their natural resistance. The transformative process that family therapy trainees enter, which Liddle & Saba (1982) described 17 years ago, unfolded through the course of this nine month training program. The growth and development in counseling was represented by an increased flexibility in the counselors' interpretation of what it means to take leadership in counseling sessions, to become directive yet direct through

empowerment of others, to balance and hold simultaneously the perspectives of an individual pathology model and an interactional model. The counselors development in family counseling is represented by a qualitative change in the counselors' willingness to enter into a new reality and to show their courage to experience the reality as the families experience it (Minuchin & Fishman, 1981). It is not enough for the novice counselors to understand the concepts of family therapy, in order to change they must risk moving from the comfortable, well developed generic skills, to untested, new ones (Lawrence & Waters, 1993). The majority of the novice family counselors moved into the realm of implementing new techniques but they did not develop the facility with structural family therapy's theory and application of this theory to function comfortably without continued supervision.

What do the interaction patterns of the novice family counselor look like? Do these interaction patterns change over the period of the internship?

(All inferences in the next sections apply only to the novice family counselors who participated in the study.)

### Initial Interactions

The review of the literature on characteristics of effective family counselors found two important variables, the quality of the global relationship between the counselor and the family based on the counselor's ability to show warmth, humor, support and a non-blaming attitude, and their therapeutic structuring skills which involves actively engaging with the family by blocking and supporting the interactional patterns within the family counseling sessions

(Alexander, Barton, Shiavo & Parson, 1976; Friedlander, Wildman, Heatherington & Skowron, 1994; Scott, Edwards & Russell, 1997). More specifically, within the area of relationship skills, it has been found that more affirming, supportive statements are appropriate in the initial phase of counseling while more challenging statements are effective in the middle phase of counseling (Alexander, et al. ; Friedlander, et al.).

The structuring skills needed appear to be focused on support of the hierarchy to develop less punishing behaviors by reducing blaming while reinforcing family strengths (Alexander, et al.). Increasing the range of structural interventions has also been found to be indicative of growth in novice family counselors (Tucker & Pinsof, 1984). In the Delphi study with the experienced family therapists, once again the importance of the relational skills and structuring skills were emphasized for novice family counselors. It appeared that novice family counselors need to develop both set of skills which are referred to as generic counseling skills (empathetic listening, reflection of feelings, clarifying thoughts and feelings ) with structuring skills in order to be able to be effective (Figley & Nelson, 1989,1990).

Another variable found to influence the outcome of family therapy is whether the counselor directs their interactions to the parental dyad and encourages a dialogue between family members rather than directing discussion between themselves and the family members (Friedlander, Wildman, Heatherington, & Skowron, 1994). Use of such structuring skills such as enactments bring the problems into the room in order for the counselors to note

the process of the interaction and coach the family in alternative more productive ways to interact (Minuchin & Fishman, 1981).

The novice family counselors in this study began by doing individual, person centered therapy. All of the counselors, to differing degrees, listened attentively and encouraged clients to talk and applied a model of individual therapy in a family setting. They addressed one individual at a time while the rest of the family members waited their turn. The Flanders Scale describes these skills as indirect behaviors because they are more passive and follow the clients' lead for the direction of the conversations. These skills are more representative of a generic counselor role and appear less active on the videotapes.

The counselors were drawn toward interacting with the children. All of the female counselors appeared quite skilled at interacting with children in a nurturing manner, which facilitated their discussions with them. The male counselor seemed less comfortable conversing with both adults and children. When tension was intense or the problems of the family were severe, the female counselors talked more to the children than to the adults. The counselors conversed with the children as if they had equal status in the family hierarchy and asked them to report on their parents' progress or praise their parents, even when this strategy undermined the parents position of authority. This style of counseling was more similar to what Greenstein (Interview, 1998) and Nichols (Interview, 1998) described as the group counseling model of the family therapists in the early 1960's. The instructors' comments on the response forms

noted repeatedly that the counselors delivered messages through the children to the parents rather than through discussions with the parents to the children.

The counselors' concern for the well being of the children was apparent, but they were confused about how to deal with them in the counseling setting. Three of the counselors had the children play in another room or space in the room during the sessions so they could talk to the parents. Most of these children were over the age of 8. Other counselors had sessions with only the parents present and then talked about the children. The counselors appeared distracted by the children's presence and the number of people in the room who could talk at any one time.

The counselors at first began by problem solving for the families before the problems had been defined in interactional terms and before many of the families were ready. The counselors initially assigned homework assignments to the families as part of the standard operating procedure about 3/4th of the way into the sessions. The assignments typically were to have fun together, eat one meal together, or implement a behavior modification checklist. The assignments were not practiced in the counseling sessions and the families often responded to them by giving the reasons why they could not be accomplished.

The counselors focused on the content of the discussion in the room and ignored the processes of what was happening in the family. Children would have temper tantrums, parents would discipline children, children or parents would cry and the behavior would be ignored by the counselor. A number of the counselors would actually respond to such behaviors by increasing their focus on a content

question and talking over the emotions. It appeared to be a challenge for the counselors to maintain their focus in the room with the family and observe the processes or the families' dance which was enacted before them. Discerning the dancer from the dance while in the middle of it was very difficult for the novice family counselors (Minuchin & Fishman, 1981). When emotions became too intense the counselors became distracted and usually tried to avoid an escalation, particularly of anger, by changing the subject to a more pleasant one, or talking to the least threatening person in the room, the child or children.

The content of the questions asked by the counselors was primarily related to how the parents controlled the children's behaviors. The counselors asked about the parents' expectancies, rules, and consequences which were currently in place for the children. When and if the sessions became too negative the counselors changed the focus to ask questions about how the family has fun together.

### Growth and Development

By the end of this study it was apparent that the novice counselors were actively struggling to create dialogues between the family members through enactments and allowing the families to talk to each other rather than just respond to the counselor. For some of the counselors, each session they presented after their first videotape, displayed one or two times in which the counselor purposively tried to encourage an enactment by presenting problematic discussions. The counselors were observed re-focusing families members when the discussion veered from the topic. The novice family

counselors appeared to have some difficulties knowing where they wanted the family to take the discussions and some reported discomfort with the directness of the intervention, but all of the counselors attempted an enactment, some more successfully than others, by the end of the second semester.

The novice family counselors were also observed changing the direction of their attention away from the children to the parental dyad or single parent. Some of the counselors found it necessary to meet alone with the parents in order to maintain their focus on that unit, but all were aware of the need to change their attention away from the children onto the parents and spousal unit.

The variety and breadth of the interventions also increased on the later videotapes and response forms. Earlier in the year the counselors described their intervention strategies as “doing structural family therapy” or changing the “triangulated child”, by the second semester the counselors were able to delineate on paper such interventions as role playing, enactments, working on themes, activities to support the hierarchy, attend to the process rather than the content of the sessions, etc. However, on the actual videotapes, although the counselors structuring skills became more varied, they did not reflect the variety of what was written on the response forms. Thinking about doing interventions and actually executing the interventions were two different matters.

A few of the counselors also changed their focus from talking about control issues with the families to nurturing issues. Many of the families presented with out of control children who had not connected well with the families. The novice counselors, for the most part, stayed with the theme of

control which may have been a metaphor for their own feelings of lack of control in the sessions. However, at least three of the counselors were able to write about the need to support the family to become more nurturing. Once again, the interventions were not visible on the videotapes, but the therapists' written responses became more complex as they conceptualized the families difficulties and what interventions were needed.

Five of the novice counselors' activity level, as measured by their initiation of conversation topics to structuring who was in the session or who was seated next to whom, increased dramatically over the course of the year. For some counselors it took all year to finally shed their non-direct styles while for others they jumped in at an earlier point. This increase in activity was apparent not only on videotapes but also within the written responses of the counselors.

The literature review presented a number of variables which seemed to influence how and if novice counselors' change over the training period. Personal characteristics such as conjugal family experience, prior knowledge of family theory, experience doing individual therapy coupled with the severity of the families accounted for the a large percentage of the variance in learning family therapy (Breunlin, Schwartz, Krause, Kochalka, Puetz & Dyke, 1989). Further, counselors who were trained in individually oriented theories developed more complex conceptualizations earlier in family therapy training and reported less confusion and integration of the concepts but not in the therapeutic interventions or doing of family therapy (Greenberg & Neimeyer, 1986). Although some of these factors were found in the current study, there were also some

differences as well.

Because all of the counselors had only one introductory course in marriage and family counseling, a difference in knowledge base was not expected. However, at least two of the novice family counselors had significantly more experience in individual counseling. These two counselors appeared to have the most difficulties changing their in-session behaviors as well as writing about their conceptualizations. Although they both appeared initially very comfortable with generic counseling skills and confident in their role of counselor, one of them appeared to experience a temporary decline in both her performance and conceptualizations which has been noted in the literature to occur in the first year of training (Greenberg & Neimeyer, 1986; Stolk & Perlesz, 1990). The other experienced counselor did not seem to become uncomfortable enough in her role with families to become confused or to struggle with the new concepts and interventions. The other four novice family counselors did not present an obvious decline in their counseling skills as was noted in the literature (Greenberg & Neimeyer, 1986).

All but one of the counselors have had children and currently live in families. An instructor did note that for one counselor the experience of having children at times seemed to interfere with objectivity with regard to the family in counseling. However, for the majority of the novice counselors, their own family experience did not appear to be a factor in their learning or execution of interventions.

An important factor which influenced the patterns of counselor behavior was the severity of the families' problems. It was evident that even after a counselor had learned to not focus on the children or take a leadership role by asking focused directed questions, if they had a family which seemed hopeless or there was an underlying potential for violence, the counselors reverted to their old patterns of doing individual therapy and talking to the children. One counselor, who particularly did not appear to be open to supervision or to struggle with learning a new paradigm for counseling, started the year with an incredibly difficult family referred by social services for multiple problems. The case was overwhelming and drew her into using her well developed person centered, individual therapy skills. Another counselor became confrontive very early in the counseling with a father whose motivation for bringing his ex-wife into counseling was suspect. His negativity and need to control seemed to reverberate with the counselor and put her rather quickly at loggerheads with him. This challenging behavior was not observed with other less threatening cases.

A factor which also seemed to influence the growth of the novice family counselors in this study was whether they had received clinical supervision on the family before, what kind and if the counselor attempted to follow the directives. If the counselor had supervision and was open to applying the directives to the case and received adequate support, their behaviors changed. This was true primarily for five of the six counselors.

The instructor's supervision coupled with the counselor's willingness to take the supervision seemed to be important factors in changing the interaction patterns of the counselors. When the counselors presented tapes on which they had not had supervision from their instructors, they had difficulty staying focused or sustaining an interactional view. The only time when supervision was not as helpful was the one time that Counselor 6 noted she had received peer group supervision which suggested that she bring a divorcing couple who were battling through their children together as a family. It was also noted by the informant that counselor 6 may not have received enough support from supervision and this may have been related to her seeming like she lost her confidence in herself as a counselor. The informant was interviewing the interns to understand their perceptions of the supervision experience.

Another factor which was not mentioned in the literature but which seemed to influence the quality of the novice family counselors' interventions was the number of sessions with the family. Becoming connected with the families seemed to take a longer time especially if the family had severe problems and/or were perceived as very punitive toward the children or were culturally different from the counselor. Once connected to the families, the counselors seemed less stressed and better able to try new interventions.

The amount of stress experienced by the counselors played a significant role in their interactional behaviors as viewed on the tapes. The amount of supervision and support that they received from the instructors and supervisors obviously helped, but the severity of these real life family' problems as well as

issues which affected connecting with the families such as cultural issues, sexual orientation and domestic violence all were factors which impacted the growth of the counselor in the application of family therapy concepts.

#### How do novice family counselors conceptualize family problems?

The literature review found a number of studies which reported a correlation between higher cognitive development and essential counseling behaviors such as more complex hypothesis formation, higher empathy levels and more complete descriptions of the counselor-client relationship (Holloway & Wolleat, 1980; Martin, Slemon, Hiebert, Hallberg & Cummings, 1989; Morran, 1986; Morran, Kurpius, Brack & Rozecki, 1994). The importance of understanding the complex conceptual skills in family therapy for novice family counselors was also noted in the literature ( Figley & Nelson, 1990; Greenberg & Neimyer, 1986; Tucker & Pinsof, 1984; White, Edwards & Russell, 1997). A shift to more complex conceptualizations concerning family dynamics has been found to be an integral part of the development for novice family counselors and one which creates some disequilibrium for the counselors (Greenberg & Neimyer, 1986). Thinking systemically, learning to identify and understand family patterns, defining the problem through conducting a family assessment were all considered necessary skills.

It was apparent, both from the counselors' behavior on the videotapes and their responses to the questionnaires, that the counselors struggled in the

translation of the conceptual concepts of interactions to the application of the concepts in a real life family counseling session. They appeared to begin the year with only a superficial knowledge of the basic concepts of the structure of families and the normal developmental life cycle they experience. Although they all wrote about supporting the hierarchy in the family or assisting the mother to take control of the children, it was obviously more difficult to align themselves with the parents than the children in the counseling sessions. Similarly, the concept of boundaries was only minimally understood. A frequent answer to the question about the family structure was “the mothers were enmeshed with their children” and the “fathers were disengaged” while “children were parentified” usually by the mothers. The use of these words suggested a somewhat simple, non-systemic view of the structure of families. The counselors were missing a thorough understanding of roles of children in single parent families and the influence of marital disagreements on enmeshment with children. Most of the counselors reported that the “spousal system was intact or functioning well” while the children’s behaviors suggested otherwise. The instructors consistently noted on the response forms that they wanted the counselors to have a more in-depth understanding of the concepts and interactions processes. Thus, when the counselors began the year their conceptualizations of family functioning and structure appeared quite limited which is consistent with the fact that they had only had one survey course.

Because they were not assessing the structure and not perceiving the interactional patterns, the counselors tended to accept the problem definition as

the one presented by the family. This resulted in the child remaining as the problem and the child's work or behavior at school the focus of the counseling. Through the internship class and instructors' directives the counselors became able to revisit and redefine the focus of the problem to take on more relational aspects.

#### What were their systemic hypotheses?

The importance of being able to clearly articulate a systemic hypothesis in interactional terms is related to the fact that the restructuring skills such as creating boundaries, successful enactments and intervening in the cycle of interaction are all predicated on the systemic hypothesis. The counselors had great difficulty on the response forms generating clear systemic hypotheses in interactional terms. Even when given a visual illustration of a sample systemic hypothesis, only one counselor used it as a model. Most referred back to their description of the structure of the family as their hypothesis. Such statements as "enmeshed boundaries", "child shares the control with the hierarchy", "child is symptom bearer of the spousal system" were typical of their descriptions of the interaction patterns which maintained the families problems.

As the year progressed, the counselors did produce more information and asked more questions in response to the questions about patterns of interaction and systemic hypothesis which was noted in the literature on hypothesis development to be indicative of greater conceptual complexity and counselor effectiveness; however, the novice counselors lacked clarity in their descriptions (Morran, Kurpius, Brack & Rozecki, 1994). Greater clarity could have provided

them with clearer conceptual maps from which to create and employ interventions. This is an area in which further instruction is needed prior to starting the internship.

### What do the structuring and re-structuring skills look like?

Finding ways to become connected with the family or joining, distinguishing between the content and process, reframing the problem, eliciting enactments of interaction, intervening in interactions and assigning in session tasks were described in the literature as a basic repertoire for the beginning counselor (Figley & Nelson, 1990; White, Scott and Russell, 1997). However, without a clearly articulated systemic hypothesis and conceptual map of the family structure, the interns were practicing therapeutic interventions without any idea of where they wanted to take the family. If they created an enactment and the family was discussing an important, even volatile issue, the counselor did not know what patterns to block, whether they should be supporting a limit setting enactment or a nurturing enactment, what language to use to get the parents to become firmer or gentler toward the child. The interns were practicing skills in isolation from a conceptual map; however, they were practicing the techniques of structural family therapy. Because they did not enter the internship class with the conceptual knowledge base, learning the techniques and then connecting them to concepts seemed to be the sequence these novice counselors were experiencing.

Joining with the family or becoming connected seemed to be, for the most part, the most accomplished strategy used by the interns. Because of their well developed listening skills, and empathetic stance, joining was the least difficult for them to accomplish. The only problems with joining arose when the differences between the counselor and family were so significant that finding ways to connect became problematic. This occurred when the parents were quite negative or punitive and/or differences in values, culture, and life style existed between the intern and the family.

Reframing the problem to make it more manageable, hopeful, and using interactional terms that did not place blame was generally not used as a therapeutic intervention. All of the counselors accepted the definition of the problem as within the child at face value. None of the counselors wrote about a different version of the problem or behaved on the videotapes as if they had a different vision of the problem. It appeared that their intrapsychic, linear lenses were still in place. However, the counselors did attempt to normalize behaviors as a way to reframe the problem particularly as the counselors became more familiar with the stages of family development. The instructors noted on their response forms directives for the interns which involved explaining to the family the process of becoming a blended family, or the process of divorcing.

The focus for the year appeared to be to learn to do enactments by having the family communicate with each other. As noted earlier, all of the counselors attempted to integrate enactments into their sessions. Given that control and limit setting were stressed by the counselors, it is surprising that they

did not use the parents disciplining the child differently in the room as an enactment or even controlling a temper tantrum in the counseling session as an enactment. The counselors had a very limited definition of what constituted an enactment; i.e., as a dialogue within the family. Only one counselor actually asked to see the child have a temper tantrum in the counseling session, but did not follow through with the request when the child protested that he would be embarrassed.

How active do the counselors become over the course of their training?

As the year progressed the counselors developed more active leadership styles and increased their percentage of direct behaviors. It appeared that the counselors interpreted the instructors' directives to become more active in two ways. They changed the configuration of the family in the room and they delivered more direct messages. The direct behaviors relative to leadership were more likely to be composed of setting the topic of the conversation, and lectures dealing with parenting skills or limit setting. Other direct behaviors usually consisted of changing the seating arrangements in the rooms, having the counselor move in closer to one of the adults to encourage them to express themselves or changing the configuration of who stayed in the room.

Learning to use oneself in counseling, rather than sitting back and paraphrasing the client's feelings and thoughts, is a skill that requires knowledge of one's own strengths and weaknesses as well as an awareness of the impact of the self upon the system. The counselors' reflections solicited on the after session response forms indicated they were able to assess whether they were

able to apply the therapeutic intervention and often were aware of their becoming “lost in the content”, or were confused about when to intervene and when they “talked too much”. Their fears and discouragement were also reported, particularly as the year progressed. However, in response to the question concerning what was blocking or supporting their strategy, the counselors did not apply their self awareness and often blamed the family’s resistance for the failure of a strategy. Awareness of the impact of the self of the counselor on the interaction process was not a priority because of the need to learn basic family counseling skills.

*Another important component of using the self in family therapy mentioned in the literature was relational issues such as supporting family strengths, maintaining a hopeful attitude, tolerating intensity, being quiet and listening (Figley & Nelson, 1990; Alexander, Barton, Schiavo, & Parson, 1976).* The Flanders Scale indicated that most of the interns came with fairly well developed listening skills and were able to be quiet to some degree, but tolerating emotional intensity, supporting strengths and maintaining a hopeful attitude were areas which may have required additional support as well as challenge from the instructors. Most of the interns interpreted being active as becoming more directive, yet using their own strengths to support the families can be just as active as giving lectures or directives. More support and instruction in this area seemed to be needed.

In what ways did the kinds of interactions between the counselor and family influence the counselor’s behaviors and conceptualizations?

As noted above, the novice counselor's behaviors were influenced by the severity of the families problems, the number of sessions the counselor had had with the family, the quality of the connections the counselor and family had developed and the match between the counselor's values, cultural experiences and the family's. The novice counselor's conceptualizations did not seem to change based on their interactions with the families. The counselors noted repeatedly on their written responses that even after additional sessions with the family they did not change their systemic hypothesis. The only thing that changed were their intervention strategies, at least with regard to their written responses. The counselors' behaviors became more content focused, child focused, and either more talkative or more passive depending on the nature of the families problems. When the families did not follow the counselors' lead the counselors conceptualized this as resistance rather than a problem in the interaction or difficulty changing their view of reality.

#### Instructors' Comments

Willingness to take direction or supervision was listed in the Delphi study as a top priority for any novice counselor (Figley and Nelson, 1990). It was obvious that in the beginning the counselors were somewhat fearful of supervision, but as the year progressed they appeared to be making good use of the instruction and supervision provided. All but one of the counselors was observed implementing the directives that were given by the instructors in supervision. All but one of the interns struggled to apply the instructor's directives as evidenced by there attempts to implement them.

The instructor's response forms indicated that the interns continued through the year to have problems conceptualizing an in-depth understanding of the family structure, identifying family interaction patterns, thinking systemically and getting lost in the content of the family's talk. One aspect of this counseling program which may interfere with the assimilation of systemic thinking is that the supervision and instruction is occurring within a program that also teaches a linear model of conceptualization. The students had only the one survey course in marriage and family counseling which only serves to introduce the concepts of systemic thinking as one part of family counseling. A new paradigm may more readily be learned if a novice is immersed in it. These students have compelling course work and instruction as well as prior practicum and internship experiences which may make it more difficult to change perspectives.

The supervision that the instructor's provided played a pivotal role in the development of the novice counselors' progression to a more sophisticated understanding of structural family therapy. The supervision had to balance the amount of support and challenge that the counselors needed in order to not just learn the concepts but be able to implement this complex counseling paradigm. It appeared however, that because of the severity of the families and the limited knowledge with which the counselors started the year, the counselors may have needed additional support and instruction.

### Methodology

The modified Flanders Scale although useful for examining the counselor's behaviors during the videotaped sessions, did not address the

interactions between family members, the context in which the interaction was occurring nor did it provide enough information concerning structural strategies with regard to restructuring interventions. The complex interactions within the counseling session were reduced by the Flanders Scale to an interaction between the counselor and one family member. When other's interrupted or spontaneous discussions occurred, or children had temper tantrums or clients fell asleep, this kind of information was missed. Whenever interactions between more than two people are collapsed into categories, some information will be missed.

The categories of direct and indirect do not aptly describe the behaviors employed in family counseling. Direct behaviors are more than just giving information related to facts, feelings or expressing one's own opinion. Direct behaviors can be punctuating a family's strengths, blocking an ineffective interaction, or praising an effective use of discipline. Creating an enactment can require the setting up a situation for the family to discuss or taming a child who is having a temper tantrum. Indirect behaviors on the Flanders are defined as accepting feelings and content, asking questions about feeling and content and encouragement. While in family therapy staying silent to produce intensity can be a very effective indirect behavior. Allowing a parent to cry without changing the topic of conversation can be indirect but a powerful intervention. There is very limited information with regard to the nature of the family members response to the counselor and to each other. The Flanders Scale basically assesses generic counseling skills rather than skills specific to family therapy.

Delphi Study\_\_\_\_\_

### The modified Delphi experienced family

therapists study was very helpful with informing the interpretation of the behaviors on the videotapes and the response forms. Although the results were quite consistent with the Figley and Nelson study (1990) it also added some new dimensions. Rather than breaking the skills into conceptual, perceptual and therapeutic, the experienced therapists had overlapping categories such as structural/conceptual and relational/structural. Of the 15 final skills agreed upon in the focus group, eight were relational based and seven were based on systemic concepts and restructuring skills. The experienced family counselors discussed at length the importance of relational skills in the execution of the structuring/restructuring interventions. Without the necessary relational skills, the experienced counselors believed that family therapy could not be effective. The focus group defined relational skills more broadly than was noted in the literature review. The focus group defined relational skills as being able to tolerate emotional intensity, being quiet and listening, patience, taking care of oneself, giving a vision of hope for change, willing to take direction or supervision and use of the self in therapy which requires an awareness of one's strengths and weaknesses. The group placed particular emphasis on two of these skills in the discussion. These experienced counselors believed that the ability to provide a vision of hope for change to the family was of paramount importance. They also believed that being willing to take direction and supervision is a life long process if one is to work as a family counselor.

### Discourse Analysis

It appeared that the dominant discourses within the world of the novice family counselors were issues of power and control in order to provide the limit setting which allows the children in the families to progress in school. Perhaps because the success of referrals are all based on school performance the role of the family counselors is interpreted more narrowly to maintaining social control of children. Limit setting or gaining control may also just be a metaphor for the feelings of the novice counselors as they struggle to gain control of chaotic families. The severity of the families and chaos in the homes, the out of control children, the demands of the public schools, which are being held accountable for providing safe schools with high academic outcomes, all could account for the focus on control.

However, in general, family therapy is not apolitical and in fact is not separate from the socio-political discourses of the times (Hare-Mustin, 1994). Given the emphasis today of reducing violent behavior in schools, issues of control and power would naturally be expected. The language with which the family counselors describe the structure of the families best exemplify the dominant discourse used to define family problems and gender roles. The Counselors repeatedly described the mothers as being in low power positions because they were overly involved with their children, particularly their sons, while the fathers' position was one of disengagement and power to control through their absence. Empowering the mothers through supporting them in taking control of the children usually was seen as a primary goal of the counseling. Supporting the parents to develop equal power through negotiations

of their rules and expectancies was the main strategy employed to reach their goals. This latter discourse, which Hare-Mustin (1994) describes as a marriage between equals theme, has many myths which must be examined before it can be resolved. Not only must the parents discuss their expectancies but their roles within the family must be ones with equal status; however, typically in the families presented by the counselors, the women worked, ran the household and completed the majority of the household chores while the men were held to a lower standard. The counselors encouraged the fathers to spend more time with their children but they wanted the mothers to become more strict in enforcing the rules. The mothers were burdened with an additional charge while the fathers were given permission to focus on the children rather than on the spouse. The counselors' responses to the questions of what interfered with their strategies focused on the apparent "resistance" of the families either to expressing their feelings, or the children were stubborn and did not respond to the new controls or the parents (mothers) failed to follow through. The counselors did not reflect upon what had not been addressed in the sessions or that perhaps their strategies were not fitting with where the families were developmentally, emotionally and socially. By focusing on issues of control, the interns missed the other piece to the family puzzle which is the need for everyone to nurture and be nurtured by their families in order to reach their full potential. Control of children is not just accomplished by rule setting or clear expectancies, the needs of the family members to be loved and to love as well as be supported in their own interests must occur as well (Waters & Lawrence,

1993). It is, of course, important for children to learn self control as well as adults, but the presence of such a predominant theme should be examined through the social and political issues within the context of the Pine Tree College. Can we assume that only families who are out of control are referred to the Counseling Center? Is this a skewed population because of the concerns in today's schools for order and safety. Society has a dominant discourse which places women in positions with less power and control. The novice counselors may have inadvertently reinforced this dominant discourse when they described the mothers as enmeshed and the fathers as disengaged. Gender is a fundamental aspect of social relations, one that involves unequal power. The female counselors in this study often turned to the children to nurture them directly rather than work to empower the parents to nurture the children. An awareness of the implications of the gender of the counselor on the family counseling interventions needs to be examined (Coleman, Avis, & Turin, 1990). A more in-depth understanding of the impact of gender, as well as race and social class is needed by the novice family counselors (Avis & Turner, 1996).

The instructors directives to attend to the spousal subsystem rather than the children attempted to redirect the counselors to examine the inequities and unbalance in the spousal system; however, although marriage counseling is often associated with family counseling, they are not one and the same. The counselors may not have felt comfortable dealing with a whole new subsystem of difficulties inherent in a weak marital subsystem. Additional instruction in marriage counseling which

addresses gender role issues may need to be a part of the novice family counselors' repertoire .

Another aspect of the dominant discourse which seemed to impact the family counseling was the influence of the nature of the schools' referrals on the therapy. Control and limit setting are a role that society clearly gives to the schools in order to facilitate instruction and provide safety for the students. However, the novice counselor's overwhelming emphasis on control and limit setting enactments, might be examined with respect to the role of the schools and the school settings played on the goals for the therapy. Empowering mothers to share leadership in a family, which was often used as a goal by the interns, involves more than establishing rules for children. Expectations of gender roles, marital relationships and the families' values, beliefs, culture and history are all intertwined with who has the power to enforce rules and who has the rights of getting their emotional needs met. Schools often only address the mothers taking charge because they are the ones most likely to interact with the school. The Counseling Center on the other hand requires fathers and other family members to be a part of the problem solving. The novice counselors must then be sure to be aware of how they involve the parents in becoming leaders and who is empowered to make that happen within a family.

Placing novice family counselors in public school settings in which they have an opportunity to not only meet with families but also with school personnel appears like an opportunity for orchestrating change across systems for counselors who work from a systemic model. However, since the novice

counselors struggled in applying a systemic model to the family, it was perhaps too much of a challenge to generalize that model to dealing with input from the schools without specific supervision and instruction around the role of the schools in the therapy. The schools represent another hierarchy with its own boundaries and rules. Due to their lack of experience, the novice counselors were vulnerable to induction not just into the families definition of the problem but also into the powerful schools definition. The counselors were influenced by the school systems' expectancies for the referrals.

Another issue which is also relevant and a prevalent trend within the mental health culture today is who or what agencies should be assisting families with multiple needs. The question is why are families with such complex and severe problems being referred to a training institution rather than to experienced experts in the field? The lack of and/or change to short term counseling in mental health coverage for lower middle class families to short term counseling, results in few alternatives for the more severe problems which may take more than 6-8 sessions. Further, the local mental health clinics sliding fee scale does not assist families until they make less than 18-20,000 dollars a year. Because the services of the Pine Tree College Counseling Center are free, they are more accessible to the families who are not able to pay the \$70.00 per hour fee at the mental health center and do not qualify for a reduced fee. Thus, more families with extensive problems are seeking help through the Counseling Center but are being treated by the least experienced counselors.

The Pine Tree College Family Counseling Center appears to be a

mental health clinic within a college environment only without the full time professional staff to run it. The instructors who provide the supervision also teach a full course load and are required to have ongoing research. The burden of the day-to-day operations falls on the shoulders of doctoral students. There is a need for additional staffing and multi-systemic interventions which could include the services and staff of local agencies to assist with the families.

Multi-systemic interventions could bridge the gap between university based counseling programs and their community based counterparts to provide the breadth of services needed by these families (Henggler, Sonja, Schoenwald & Pickrel, 1995). A multi-systemic approach would target inclusion of community services to augment the program at the College Counseling Center. Such an approach would emphasize family empowerment through accessing and utilizing the available community resources. It would include the involvement of other agencies, both public and private to help meet the needs of these. This process would protect the well being of the families as well as the novice family counselors.

#### Implications for Training

A number of authors have recommended that counselors need to be provided with the conceptual skills and cognitive strategies that can enhance their ability to integrate clinical material (Biggs, 1988; Holloway & Wompold, 1987; Lovell & McAuliffe, 1997). The foundation of the Pine Tree Program's Counseling Center teaching philosophy is a cognitive developmental approach with the goal of enhancing the conceptual complexity of their students in order

that they may be better able to process multiple perspectives and make sense of the complex process of family counseling. Other ways to expand and facilitate the translation of the complex conceptual knowledge into applications to family counseling should be explored further through this model.

According to cognitive developmental theory the disequilibrium experienced by the novice counselors could potentially stimulate growth in the development of more complex conceptualizations if a proper environment is provided (Sprinthall & Mosher, 1978 ). The move from a linear perspective to more complex systems thinking appeared to produce a disequilibrium in the novice counselors that could facilitate an active change in their pattern of thinking (Foster & McAdams, 1993). In order to provide such a growth enhancing environment, alternate ways to further punctuate and enhance the pre-existing curriculum framework based on the Deliberate Psychological Education Model (Sprinthall & Mosher, 1978; Reiman & Thies-Sprinthall, 1993; Thies-Sprinthall, 1984) should be explored. Perhaps more experience could be provided with peer role playing, peer observation and team supervision before actually working with real life families as part of the practicum. The additional support at the beginning of the novice counselors' work with families through live supervision or team supervision might also be explored. Many of the counselors noted that they were stressed by the number of families and demands of other course work or jobs. Working with only a few families with more intense supervision and experiencing success before moving on to a larger case load could be another way to reduce the challenging nature of the program and

increase the support. Writing more reflectively about their experiences with the dissonance created by learning a systemic model superimposed upon an individually oriented model and receiving written responses to their reflections from the instructors might also be considered an essential part of the program. Dealing with real life families with the kinds of problems that presented to the Counseling Center may be too challenging initially and may in fact slow the rate of learning for the novice family counselors.

### Academic Course Work

According to research, the best predictor of learning family therapy is prior knowledge (Breunlin, Schwartz, Krause, Kochalka, Puetz & Van Dyke, 1989). However, traditionally, counselor education programs have focused on individual counseling as well as group counseling and the program at Pine Tree College is no exception. Although there is a family counseling center, there still exists only one didactic course offered in the area of marriage and family. The remainder of the courses offered to both the doctoral and master's degree students are oriented toward identifying and treating individual psychopathology. Teaching counselors to incorporate parts of marriage and family training into individual counseling is very different than the training of marriage and family counselors (Home, Dagley & Webster, 1993).

Committing the resources necessary to train marriage and family therapists in a traditional counselor education setting is indeed a challenging task. As noted earlier, the Counseling Center at Pine Tree College is similar to a

mental health clinic without the full time staff to provide the experience and coverage needed by the families. Thus, there are a number of monetary issues. One is staffing the clinic with personnel other than graduate students and part time faculty, the other is training and educating the graduate students in a complex model.

Generic training is not considered adequate to provide counselors with the skills to ethically function as marriage and family therapists (Horne, Dagley & Webster, 1993). These authors suggest systemic content in course work, ethical and professional issues specific to marriage and family counseling and supervised clinical experiences with couples and families as being part of the essentials needed to produce competent marriage and family therapists.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) has recommended the following standards for programs training competent marriage and family counselors: training in the history and organization of the profession, ethical and legal issues and roles and setting of marriage and family therapists; knowledge of family developmental stages, healthy family functioning, socioeconomic status, ethnicity, family of origin , human sexuality, societal trends and alternative life styles; knowledge of family systems theories and applications, interview skills, assessment, case management, prevention research and its applications; a clinical practicum working with couples and families and a 600 hour internship completed primarily with couples and families using systemic approaches ( Horne, Dagley & Webster, 1993).

A three course interdisciplinary sequence was described by Christensen, Brown, Rickert & Turner (1989). The sequence was composed of a family systems process course which covered the family life cycle development, healthy family functioning, issues such as divorced and blended families and an introduction to assessing family system processes. A family assessment, concepts and skills course which covered the major theories of family systems therapy with an emphasis on assessment and treatment and a supervised clinical seminar which provided consultation on family assessment skills to be taken concurrently with a practicum/internship in the students home department were included. Issues relevant to marriage counseling are also included in these courses. The students in the program at Pine Tree College need to be armed with the necessary knowledge and concepts when they start their clinical experience.

### Supervision

Given that there was a noticeable difference in the novice family counselor's performance after the instructor's supervision, it would seem that providing live supervision might add the additional support and an alternative option needed as the counselors begin the first semester's highly challenging experience of being a family counselor. A supervision model that examines the novice counselors conceptual understanding and matches the methods (firm vs. gentle), techniques (directive, reflective) and modalities (live, videotaped, etc. supervision) to construct environments that foster conceptual, perceptual and therapeutic competencies within the novice family counselor has been suggested

as a way to enhance novice counselor development (Rigazio-DiGilio & Anderson, 1994). These authors suggest the amount and type of supervision needs to be tailored to the cognitive developmental needs of the novice family counselors by assessing their preferred operation (sensorimotor, concrete operations, formal operations and dialectic systemic) through specified questioning strategies (Rigazio-DiGilio & Anderson, 1994). Such a model would facilitate collaboration between the instructors and graduate students in the development of a program of supervision individually designed to promote the students cognitive development.

Historically, live supervision has been one of the hallmarks of family therapy and over the last 10 years there has been a dramatic increase in its use by supervisors (Nichols, Nichols & Hardy, 1990). Videotape and audiotape recordings are the most frequently used but live supervision has seen a major resurgence (Nichols, Nichols & Hardy, 1990). However, it should be noted that like most research in family therapy, live supervision along with videotape supervision in family therapy has few systematic studies but has long been used as the supervision method of choice by family therapists (Greenstein, 1998, Interview; Liddle, 1991). Live supervision, particularly for beginners, is considered useful because the supervisor is present during the counseling session and is able to make changes in the session before the supervisee becomes lost or stuck. It also entails a pre-session planning when the goals and strategies for the session are discussed, in session immediate feedback and post session debriefing (Okun & Piercy, 1989). Live supervision provides

additional support for the beginning novice counselor which may prevent them from becoming discouraged and confused. It also provides a safety net for the families involved in the counseling. Research in the isomorphic nature of supervision and counseling has in fact found the relationship between the counselor and supervisor affects the progress in the therapy of the family (Liddle, 1991). The negative part of live supervision is the amount of time and resources needed in the form of instructors and proper setting in order to make it possible. Live supervision might be considered as a way to provide the first year interns with additional support during the stressful time of learning structural family therapy.

#### Severity Level of Families

The severity levels of the families was a definite factor in the development of the novice family counselors in this study. In previous studies it was noted that the severity of families affect learning in two ways: trainees become overwhelmed easily and the instructors can become mired down in the details of case management (Breunlin, et al. 1989). The availability of good training cases is important to programs focused on the training of novice counselors. Establishing criteria or screening referrals in order to match them to counselor skills or to other agencies may need to be considered in order to provide an optimum learning environment for the graduate students and to assure that the families receive the necessary services. Training the counseling students in interagency collaboration in order to create a community of caring for these families is another strategy which should be considered.

### Relational Aspects

One of the skills the focus group struggled to define but believed had a great impact on counseling families, is the counselor's use of self in therapy, or an awareness of one's strengths and weaknesses. The novice counselor's appeared to need a greater awareness of who they are, their values, attitudes, and beliefs, particularly with respect to issues of cultural diversity and gender roles. The influence of the counselor's gender on the family counseling interventions needs to be examined (Coleman, Avis, & Turin, 1990). A clear definition of use of self in the literature is missing. One way to define this concept was offered in an article by Shadley (1987). This author described it as the process of accepting one's self as a fellow human who offers more to their clients than professional expertise. It is the therapists' feeling response to the family members (Shadley, 1987). An awareness of the role of the self in the therapeutic interaction develops over time with input from instructors and other clinical supervisors, but labeling the need for this awareness and pointing out how the self effects the counseling is an important first step in a life time process.

### Summary

The development of the novice family counselors was in a non-linear progression. The novice family counselors were observed struggling with new skills and strategies, being successful and then reverting to old ways when placed under too much stress related to the emotionally laden issues and difficulties of the families. Their development was influenced by the interaction of a number of factors such as the nature of the families' problems, the number of

sessions with the family, the counselors' ability to connect with the families, the amount of instruction and supervision they received, their personal approaches, the public school backdrop, as well as the amount of prior experience with individual theories of counseling. The counselors began the year with relatively strong generic counseling skills and added to these a greater number and breadth of structuring and restructuring strategies, increased the dialogue between family members and decreased the counselor-client dialogue, attended more closely to the parental and spousal subsystems than to the children and generally became more aware of the need to focus on patterns of interactions. The novice family counselors' conceptualizations as represented by their written responses, became more complex but an awareness of the difference between what they were writing about and what they did in actual practice was still missing. All but one of the counselors seemed open to and profited from the instruction and clinical supervision received in the internship class. They attempted to implement the directives noted by the instructors. The counselors began the year with a well learned individual ideology and through the year became more aware of the interactional nature of problems. Integrating both of these paradigms was a challenge for them, but their awareness of a different view of reality was heightened.

A number of the novice family counselors seemed to lose confidence in their counseling role as the year progressed and as their awareness of the complexity of the issues increased. Some appeared paralyzed by the degree of challenge, others moved on to struggle with the concepts and application of the

concepts. Because of the limited course work, the counselors had to struggle with not only learning to be in a room with sometimes chaotic families, but also to learn the concepts and application of the concepts of structural family therapy. These novice family counselors were brave students who placed themselves in vulnerable positions in order to learn. They have my admiration and appreciation.

### Recommendations for Future Research

Research in the area of training in family therapy is far behind that of efficacy studies in family therapy. Studies on the actual experience of learning family therapy in real life counseling settings is even more limited in the family therapy literature. Because this study was restricted to the observation of selected videotapes of the novice family counselor's due to the need to limit the number of researchers interacting with the students, the phenomenological perspective of the interns was not examined. This observational research could be enhanced through studying further the thoughts and experiences of the interns and supervisors through personal interviews. Comparisons of the counselors' and supervisors' thoughts, feelings and perceptions with the behavior on the videotapes would afford a more in-depth and enriched understanding of the development of the counselors. In addition, it would be interesting to question directly the counselors about their structural assessments and systemic hypotheses because it was reported by the instructors that the counselors did demonstrate competency in these areas, at least in class discussions.

Another area which is rich with information is the supervisory process. Research in the area of the supervision of the novice family counselors through the videotaping of supervision would provide valuable information about the interaction process within the supervision setting. Comparing videotapes of the supervision process with the interaction of the novice counselors in the counseling sessions would address a contextual issue which has long been debated in family therapy, the isomorphic nature of supervision and therapy. examined. A comparison of the effects of live supervision versus videotaped supervision also is an area which needs to be studied.

Documentation through observations and interviews of the concepts, percepts and behaviors of experienced family therapists is an area which is missing in the literature. It is assumed that professionals who consider themselves experienced could be distinguished by their in-session behaviors from novice family counselors. Research in this area would increase the knowledge in this neglected area.

#### Personal Statement

The novice family counselors provided me with an extraordinary learning experience both professionally and personally. The nature of qualitative research allowed me to examine more closely the process of learning to apply knowledge to actual therapy while providing me with an opportunity to integrate my professional knowledge to inform the study. The constant presence in the study of the predominant individual pathology model reinforced for me the challenge of developing a conceptual framework, a meta-theory which includes a vision of the

individual within the system. It also has made me more appreciative of the potential of the cognitive developmental theory as a basis for an instructional paradigm.

By observing the novice family counselors' struggles with the slow process of learning to be with families and think systemically, I became more aware of their strengths and courage. I also became aware of my own tendency to look at their progress too critically and not fully acknowledge that learning to be a family counselor is a life time work which starts in small steps though increased awareness of a relational view of problems.

My family reports that I have grown in my confidence with regard to being able to "do research". The qualitative format, although initially uncomfortable, actually seems to match my preference for collaborative work because it allows me to rework my initial evaluations through conferring with other researchers and searching for more in-depth understandings. Working in teams has always been my preferred style because I believe that working in isolation only perpetuates preconceived ideas and does not serve to broaden my perspective. Perhaps that is why family counseling has been my chosen profession since clinical supervision and feedback is a never ending part of the process.

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## **Appendix A. Interviews**

### Interviews

The development of each of these therapists paralleled in some way the development of family therapy. Both Greenstein and Nichols were associated with Salvador Minuchin, who is considered the father of structural family therapy, during important stages in the development of the theory and therapy.

Greenstein after receiving his Ph.D. in clinical psychology in 1968 and completing an internship at the Eastern Pennsylvania Psychiatric Institute (EPPI), worked with Minuchin in the late sixties into the early 70's. Nichols completed his Ph.D. in clinical psychology in 1973 and was employed as a professor at Emory University. He spent the next three years traveling back and forth to the Philadelphia Child Guidance Clinic for summer extern programs to study with Minuchin.

Both men had similar experiences working with families in their graduate school programs and internships. Nichols stated that, although he studied with well known therapists (Lynne Wynne and Rodney Shapiro), what he learned in graduate school, was "to bring the family members together and promote productive conversation. It was believed that the family members would make things happen" (Nichols, 1998, Interview, p.1). Everyone in the family was treated equally and the therapists bent over backwards to sympathize with children and give them a voice which today would be considered very disrespectful of the parents.

While Greenstein described his work with families at EPPI as applying the group theory of Moreno to families with every member of the family given equal time and voice in the discussions. Both Greenstein and Nichols described the early training as lacking any theoretical framework specific to helping families. Both men reported that the structural model made things much clearer with regard to having a framework for actually helping families.

Greenstein described systems thinking, the foundation of structural family therapy, as a belief system and a passion.

It is a religion which says there is a structure to the universe and there is a tune to the pattern in the universe, if you get in sync. There is a God in structuralism, there is that kind of passion to it. There is a meta pattern that governs the world.....It was a revolution.

According to Greenstein, the decision to use live supervision was related to the fact that it was not possible to teach therapists to think in this revolutionary manner through a six week extern class. Minuchin and his team of therapists believed that through live supervision it was possible to teach therapists how to believe in change and the power of the system model to create change (Greenstein, 1998, Interview).

Nichols was a recipient of this training, however, he reported that he only allowed himself to take the courses that Minuchin taught. He had no exposure to the other staff therapists who included many who were famous in their own right such as Carl Whitaker, Jay Haley and Montvalo Bravalio. When Nichols describes his experiences with Minuchin he believed the theory was in place

although in retrospect he sees that it was still evolving. Nichols also described the use of the one way mirror or live supervision as the way that Minuchin not only taught his students but learned what worked.

The roles of the two men were quite different with regard to Minuchin and structural family therapy. Greenstein was a staff psychologist who worked under the leadership of Minuchin and Haley in the creation and application of structural family therapy. Nichols was a student in the extern program who through his writings became a chronicler of the developments of both structural family therapy as well as other models of family therapy. They were also very different in their future roles as well. Greenstein continued in a revolutionary spirit. Because he believed systems thinking was a belief system, he resisted the professionalization of family therapy. He stated "when family therapy became a profession it ceased to be a revolution". He does not describe himself as a family therapist or trainer of family therapists. "I teach people to be creative, not to see the black lines around figures but the blurring between the black lines and the world". Greenstein reported using parts of structural family therapy to train the person of the therapist to do creative therapy. Greenstein also noted that it is necessary for each generation to take responsibility for improving theories because each generation has its own limitations depending on the context within which it was developed.

Nichols is writing another book with Minuchin as co-author which will address the post modern developments in family therapy. He believes that students should be trained to apply the theory to family work.

The student needs to be thoroughly trained in one paradigm through rigorous graduate programs knowing that it takes years of postgraduate work to become a good therapist. Students with personal issues should be screened out before they come to graduate school. The student must understand structure, develop a hypothesis, follow it and take my direction. This is a therapy that can be done thoughtfully.

## **Appendix B**

### **Conditions for Promoting Psychological Growth-Deliberate psychological Education (DPE)-the model used for instruction in the counseling program.**

( The following is taken from the research of Peace, 1995; Reiman & Thies-Sprinthall, 1993; Thies-Sprinthall, 1984; Sprinthall & Mosher, 1978)

1. **Role Taking:** Growth towards more complex levels of development seems to happen as a result of experiencing a qualitatively new role taking experience. The role of a family therapist will be a significantly new role for the participants. The transition from an individual orientation to an interactional one will provide a challenge for the students.
2. **Guided Reflection:** The graduate students are encouraged throughout their internship class to reflect upon their experiences. The instructor of the class encourages discussion about their reactions to their role as family counselors. Written reactions to the internship, supervision experience and training will take the form of responses to structured questions as well as through their individual and group supervision. The supervisors create a personal dialogue between the interns and themselves in order to foster learning.
3. **Balance Between Experience and Reflection:** Independent practice of family counseling, role plays, videotape presentations will always be followed by group discussion and reflection. The course will provide for both experiential application and intellectual analysis – process and content. One will balance the other by not overly concentrating in either domain.

4. **Support and Challenge:** Because the internship will be a new learning experience requiring the participants to acquire a systems model of thinking that can create significant dissonance and disequilibrium, the participants will need personal support. The challenge of the internship will be both at a personal and professional level. The combination of support by the instructor and fellow students combined with the challenge of making sense of this disequilibrium will serve to enhance conceptual growth. Individual support given by the instructor as well as group support will be provided through class meetings, supervision, and a list serve computer network where students can share concerns and questions with other students experiencing disequilibrium. The instructor will provide group clinical supervision and individual clinical supervision while students will provide peer supervision. The amount of support and supervision provided will complement the degree of the challenge the internship is creating for each student.
5. **Continuity:** Within the educational setting, inservice workshops of short duration are known to provide inspiration but little else, if that. One or two sessions, even in therapy, are unlikely to produce significant change in behavior let alone in developmental structures dealing with complex processes. The time for significant change needs to extend over a significant period of time which in this case will be 9 months of training.

### Training Components

The five conditions for promoting psychological growth (Sprinthall & Mosher, 1978) will be used in conjunction with Joyce and Weil model (1980 class handout). The four components in this training approach are the following:

1. describing and understanding the model- Skills will be presented in lectures, written materials, group discussions and video taped examples.
2. viewing the model- Skills will be demonstrated using role-plays, case histories and videotape presentations. Viewing both examples of techniques as well as tapes presented by their fellow peers will serve to demonstrate skills.
3. planning and peer teaching-Participants will practice the skills in the class with each other and at their placement sites. Constructive feedback from peers will be an integral part of the supervision class.
4. adapting and generalizing the model plus post assessment-Participants will implement the skills with families and discuss changes and adjustments in class. ( Reiman & Thies-Sprinthall 1993).

The combination of the DPE and the Joyce-Weil training components integrates thinking, feeling, and teaching into the learning process and creates an optimal environment for promoting psychological growth.

**Appendix C**

August 27, 1998

Dear

As part of the training program during 1998-1999 semesters, family counselors are being asked to participate in a number of research studies. I am writing to invite you to participate in my research project as part of my doctoral dissertation titled "Growth and development of novice family counselors: Theory to practice".

Research on the development of beginning family counselors as they participate in the counseling process is very limited (Avis & Sprenkle, 1990). The purpose of this study is to document the experiences of novice family counselors as they apply the concepts and techniques of family counseling in actual counseling sessions. You will be asked to provide two videotapes of family counseling sessions each semester along with your responses to questionnaires to be answered before and after the counseling sessions. In addition, you will be asked to provide the case presentation material based on your class presentation. The videotape sessions would be the ones you will be presenting in class for supervision. It is anticipated that the results of this study will provide important information to trainers and clinical supervisors as well as to novice counselors with regard to the challenges of the process of learning family counseling.

I would greatly appreciate your help in this study. I have tried to design this study so that you would not need to do any tasks beyond the class expectations. If you are willing to participate, please indicate on the postcard provided and return to me or call me at 757-898-0379 and leave a message. I will then send you an informed consent form and additional information concerning the study.

This study is being conducted through the Pine Tree College, Department of Education under the direction of Jill Burruss, Ph.D. ( 757-221-2361) and Victoria Foster, Ed.D. (757-221-2321) Chairpersons.

Thank you so much for considering my request. I look forward to hearing from you.

Sincerely,

Denyse Doerries

Doctoral Candidate

## Informed Consent and Information: Counselor Interns

Project Title: You are invited to participate in a research project as part of a doctoral dissertation conducted by Denyse Doerries titled “ Growth and development of novice family counselors: Theory to practice”. The study will be conducted through the Pine Tree College, Department of Education under the direction of Jill Burruss, Ph.D. ( 757-221-2361) and Victoria Foster, Ed.D. (757-221-2321) Chairpersons.

Purpose of the Research and Methodology: The research on the development of novice family counselors as they participate in the therapy process is very limited ( Avis & Sprenkle, 1990). The purpose of the study is to document the experiences of novice family counselors as they apply the concepts and techniques of family counseling in actual counseling sessions. Each participant will be asked to share with the researcher their case presentations which are required in the internship class at least twice a semester, including the videotapes of the counseling sessions, the case description and responses to a before and after session questionnaires. The researcher will not be present in the internship class, but viewing the videotapes and written material after they have been already presented to the class and supervisor. The supervisors will be asked to collect the data and give it to the researcher. It is anticipated that the results of this study will provide important information to trainers and internship supervisors as well as to novice counselors with regard to the challenges of the process of learning family counseling.

Risks and Procedures: If you choose to participate in this study all reasonable efforts will be taken to decrease any risk to you. Participation in the study is completely voluntary. Although potential psychological risk is minimal, the names of appropriate therapists will be made available to you if necessary.

Confidentiality and Anonymity: Individual privacy will be maintained for all participants in the written material resulting from this study. Identifying personal characteristics that might lead to recognition will be changed. However, there cannot be a one hundred percent guarantee someone would not recognize themselves or a student in the study because the Pine Tree College is a small population. Only the principal investigator and the dissertation chairpersons and the intern supervisors will have access to the names of the participants.

Videotapes will be destroyed after the analysis of data is completed.

Voluntary Participation: Although your participation in the study is greatly appreciated, your participation is voluntary. You may withdraw from the study at any time, with no impact upon your grades or other evaluations. There will be no negative consequences in your college career as a result of your withdrawal.

You have the right to refuse to answer any question (s) for any reason.

Questions or Concerns: If you have concerns or complaints about how you were treated during this study please contact Tom Ward, Ph.D., Chairperson, Human Subjects Review Committee at the Pine Tree College, 757-221-2358.

Exceptions to Confidentiality: There are exceptions to the promise of confidentiality. If information is revealed concerning suicide, homicide, or child abuse and neglect, it is required by law that this be reported to the proper

authorities. In addition, should any information contained in this study be subject of a court order or lawful subpoena, the Pine Tree College might not be able to avoid compliance with the order of the subpoena.

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I have read and understood the descriptions of the study to be conducted by Denyse Doerries :” The growth and development of novice family counselors: Theory to practice”. I have asked for and received a satisfactory explanation of any language that I did not fully understand. I agree to participate in this study. I understand that I may withdraw my consent to be a part of the study at any time. I also agree to be videotaped. I have received a copy of this consent form.

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Signature

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Date

Information concerning research project: For families

The Pine Tree College provides family counseling through the family counseling Program as a service to the community, as well as for education, training and research purposes. The Family Counseling Center is staffed by counselors who are receiving training in family counseling from faculty and advanced graduate students. As part of the training process during 1998-1999 semesters, the family counselors are participating in a research study entitled "The development of novice family counselors: Observation research". This study is documenting the experiences of the beginning family counselors as they learn to apply family counseling concepts and interventions in the counseling sessions. As part of this study the researcher will be viewing selected videotapes for analysis of the counselors' interactions with the families in the counseling sessions. It is anticipated that this study will provide much information to instructors and trainers in family counseling about the developmental of family counselors. If you have any questions about this research project, please contact Victoria Foster, Ed.D., faculty director of the Family Counseling Program at 757-221-2321.

FAMILY COUNSELING CENTER  
AT  
THE PINE TREE COLLEGE  
School of Education

**AUTHORIZATION FOR AUDIO/VIDEOTAPING/OBSERVATION**

The Family Counseling Center is staffed by counselors who are receiving training in family counseling from faculty and advanced graduate students. The Center is a teaching and research facility. For training purposes and those listed below, we request your permission to audio/videotape counseling sessions and/or to have live observation.

I (We) authorize Family Counseling Center to use any audio/videotaped recordings of myself (us) and my (our ) family for the purpose of: 1. evaluation by the counselor, 2. evaluation of the counselor, 3. supervision by the counselor's supervisor, 4. consultation with peers, 5. research, 6. teaching.  
Upon written notice I (we) may have any or all audio/videotaped recordings erased, and/or restrict their use to one or more of the above stated purposes.

Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Others in family: \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Witness to signature (s) \_\_\_\_\_ Date \_\_\_\_\_

**Appendix D -Responses Forms**

Questions for interns

**Demograhpic Information****Please complete information below.**

Name: \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Location of session \_\_\_\_\_

Are you currently living in a family? \_\_\_Yes\_\_\_No If yes, what is the make up  
of your family? \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_M\_\_\_F

Degrees \_\_\_BA. \_\_\_M.A./M.S \_\_\_Ed.S. \_\_\_Other \_\_\_\_\_

Number of courses in family counseling \_\_\_\_\_

Number of courses completed in counseling program \_\_\_\_\_.

Other practicum or internship experiences? \_\_\_\_\_.

What is your work experience in the counseling profession?

Occupation(s) \_\_\_\_\_ Years experience \_\_\_\_\_.

Race or nationality \_\_\_\_\_.

**Revised 2-15-99**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Time \_\_\_\_\_ Location of session \_\_\_\_\_

Name of family \_\_\_\_\_

**For each videotaped session you present in the family therapy internship class, please answer the following questions. These questions should be answered before the counseling session is videotaped.**

1. Number of sessions you have had with this family \_\_\_\_\_.
2. Describe the structure of the family. For example who is in charge, what is the nature of the boundaries between subsystems, where do they lie on the continuum of enmeshed versus disengaged, nurturance -limit setting etc.?

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3. What do the family members see as the presenting problem? \_\_\_\_\_

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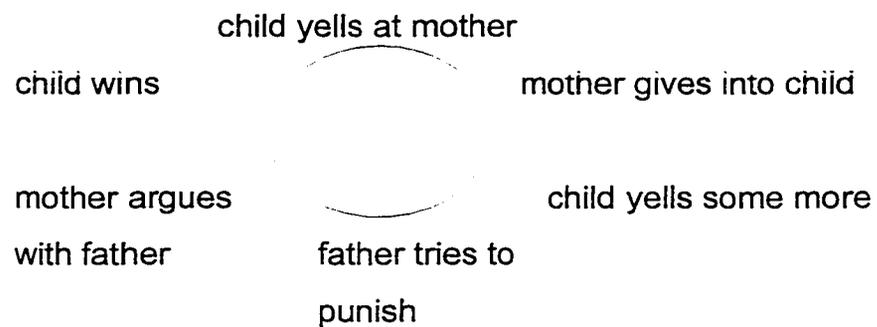
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4. What are the family's strengths? \_\_\_\_\_

\_\_\_\_\_

—

5. What is your systemic hypothesis? How do the family's patterns of interaction maintain the presenting problem? For example --a child yells at the mother; mother gives into the child; father tries to punish child; mother protects child; child yells some more; father tries to discipline child; mother and father fight; child does what he wants.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

—

6. In what way are the presenting problems helpful to the family?

\_\_\_\_\_

—

7. What intervention strategies have you considered? \_\_\_\_\_

---

—

8. Describe your strategy for today's session. \_\_\_\_\_

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—

9. What are your therapeutic goals? \_\_\_\_\_

---

---

—

10. Have you received supervision on this family? Yes\_\_\_ No\_\_\_ If yes, what suggestions were you given? \_\_\_\_\_

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—

11. How severe do you consider this family's problems? Check one of the following: \_\_\_Mild\_\_\_Moderate\_\_\_Severe

12. What kind of day has this been for you up until this point? \_\_\_\_\_

---

---



**Revised 2-15-99**

Name \_\_\_\_\_ Date \_\_\_\_\_ Name of  
family \_\_\_\_\_

**Please answer these questions after the videotaped therapy session.**

1. What did you learn from this counseling session? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

—

2. Did your systemic hypothesis stay the same? If not, how did it  
change? \_\_\_\_\_

—

3. Did anything occur which made you reconsider your goals or strategies with  
this  
family? \_\_\_\_\_

\_\_\_\_\_

—

4. How well do you think you implemented your strategy(ies)? what did you do  
well and what did you need to improve? \_\_\_\_\_

\_\_\_\_\_

—

5. What circumstances supported your strategy and what blocked your  
strategy? \_\_\_\_\_

---

6. What thoughts and feelings were going through your mind during the session?

---

7. Were there any major themes which occurred in this session? \_\_\_\_\_

---

8. What are your plans for the next session? \_\_\_\_\_

Name of supervisor \_\_\_\_\_ Date \_\_\_\_\_  
 Name of intern \_\_\_\_\_ Family \_\_\_\_\_

**Please answer the following questions concerning your supervision of this intern.**

1. Has this intern received supervision about this family from you before?

Yes \_\_\_ No \_\_\_. If yes, what were your previous directives? How has the intern responded to past directives? \_\_\_\_\_

---

2. What were your directives today concerning the present session and future sessions with this family? \_\_\_\_\_

---

3. Do you expect the intern will be able to follow the directives.? Yes \_\_\_ No \_\_\_.  
 If no, what do you think the problem will be? \_\_\_\_\_

4. What theme or areas have you been working on with this intern? \_\_\_\_\_

\_\_\_\_\_

—

5. Have these areas changed since the interns last presentation?

Yes \_\_\_\_\_ No \_\_\_\_\_. If they have changed, please describe how they have

changed. \_\_\_\_\_

\_\_\_\_\_

—

6. How severe do you consider the family's problems? \_\_\_\_\_

7. How would you describe this intern's conceptualizations of the family's

problems? \_\_\_\_\_

—

**Appendix E. Delphi Study****Round 1.**

Name: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone: W \_\_\_\_\_

H \_\_\_\_\_

Date: \_\_\_\_\_

List the ten most important skills that you believe beginning family therapists should learn.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Round 2.**

Name \_\_\_\_\_ Date \_\_\_\_\_

From the following list, please number in order of priority, with 1 being the most important skill to 20, the top 20 skills or strategies you believe are the most important for **beginning** family counselors to learn.

1. \_\_\_ Recognize the structure of the hierarchy
2. \_\_\_ Set up simple enactments
3. \_\_\_ Read closeness and distance in relationships
4. \_\_\_ Sit quietly with tension
5. \_\_\_ Map family/family of origin-genograms
6. \_\_\_ Read metamessages, body language
7. \_\_\_ How to deliver clear, concise directives and assessments/messages
8. \_\_\_ Balance nurturing/support and accountability
9. \_\_\_ Unbalancing the status quo/ interfere in the patterns
10. \_\_\_ Intervene directly whenever abusive behaviors occur
11. \_\_\_ Learn about balance between control and nurturance
12. \_\_\_ Identify family process--read the family--identify patterns in family
13. \_\_\_ Find ways to connect-join
14. \_\_\_ Be able to take direction-supervision
15. \_\_\_ Look for themes in families/develop themes
16. \_\_\_ Develop a hypothesis about the family functions
17. \_\_\_ Identify consequences for the family if changes occur.
18. \_\_\_ Have compassion for family (not a skills but important)
19. \_\_\_ Be able to be quiet and listen
20. \_\_\_ Learn how to move a family around
21. \_\_\_ Skillful listening
22. \_\_\_ Empathy
23. \_\_\_ Giving a vision of hope that it is possible to change
24. \_\_\_ Skillful use of humor
25. \_\_\_ Open ended questions--good use of
26. \_\_\_ Validating feelings
27. \_\_\_ Assessing and Planning
28. \_\_\_ Theory based--how does this apply to family
29. \_\_\_ A clear sense of therapy stages, beginning--middle --end. What does it look like.

30. \_\_\_\_ Safety--How to plan for that for self and for family
31. \_\_\_\_ Use of self in therapy --strengths and weaknesses
32. \_\_\_\_ Awareness of importance of breath
33. \_\_\_\_ Working with resistance
34. \_\_\_\_ Staying of focus
35. \_\_\_\_ Ability to work at one's own issues
36. \_\_\_\_ Opportunity for on going supervision
37. \_\_\_\_ Aware of being inducted
38. \_\_\_\_ Thinking systems/systemically
39. \_\_\_\_ Patience
40. \_\_\_\_ Taking care of one's self
41. \_\_\_\_ Establishing boundaries
42. \_\_\_\_ Ability to sit and be with someone
43. \_\_\_\_ Recognizing alliances/coalitions
44. \_\_\_\_ Establishing leadership in the room
45. \_\_\_\_ Effective use of silence
46. \_\_\_\_ Decision making in how to deal with presenting problems
47. \_\_\_\_ Process versus content
48. \_\_\_\_ Sense of comfort in receiving supervision
49. \_\_\_\_ Ability to see strengths in the midst of weaknesses
50. \_\_\_\_ A kind, strong voice
51. \_\_\_\_ Humility
52. \_\_\_\_ Tolerate intensity
53. \_\_\_\_ Be directive to change patterns
54. \_\_\_\_ Willing to look at self and how you engage in process
55. \_\_\_\_ Understanding that you are a beginner and the only way to learn is by doing
56. \_\_\_\_ Flexibility
57. \_\_\_\_ Clarity
58. \_\_\_\_ Persistence
59. \_\_\_\_ Caring
60. \_\_\_\_ Fully present to listen
61. \_\_\_\_ Being aware when their intervention plan is incompletely or unsuccessfully executed because of their personal issues
62. \_\_\_\_ Gathering each family member's definition of the problem, attempted solutions, frame of other members and self in such a way that members feel heard and validated.
63. \_\_\_\_ Bring the problem into the room and offering alternative transactions among family members (enactment)
64. \_\_\_\_ Taking leadership
65. \_\_\_\_ Understanding systems thinking
66. \_\_\_\_ Conducting a structural assessment with restructuring goals
67. \_\_\_\_ Reframing in such a way that the family is challenged to think and act differently congruent with restructuring goals

68. \_\_\_\_ Take action both verbally and in the room , based on restructuring goals.
69. \_\_\_\_ Engage the family in a mutually agreed upon contract for treatment
70. \_\_\_\_ Offer hope, goals and a direction for change
71. \_\_\_\_ Be willing to show humanity and to be connected with the client's struggle--open hearted, empathic, warm, sharing of self

November 11, 1998

Dear Family Counselor,

Enclosed is the list of skills which were generated from the Quinn/Greenstein supervision group in October. As you can see, it was a large list. I now need you to rank from most important to least important the top 20 skills you think it would be important for a **beginning** family counselor to master. Place your number to the left of the item in the space provided.

Thank you so much for your assistance. If you could bring the completed form to the supervision group on November 18th and give it to me or Julia Canestrari I would be most grateful. I would like to meet for a short time after the January supervision meeting to discuss these results and get any other suggestions.

See you in November.

Sincerely,

Denyse Doerries

### Round 3 Focus Group

- **Directions for discussion**

- I would like to brainstorm with you the skills and concepts that are necessary for novice family counselors to learn. Please describe what skills and concepts you think are most important for novice family counselors to learn. How would they appear in a counseling session?
- We will discuss the pros and cons after we have everyone's ideas. Feel free to piggy back on someone else's suggestion.
- From this list please rank order the top ten skills you think are needed by novice family counselors.
- Can we come to a consensus about the top five skills that novice family counselors need to learn and what it would look like in a counseling session?

Basic Skills –Delphi round 2 results

P=Personal variables C-Concepts Pp-process variables

1. Tolerate Emotional Intensity (7) -P
2. Thinking systemically (6) -C
3. Giving a vision of hope for change (6)-Pp
4. Conducting a structural assessment (5)-C
5. Identify and understand the families' patterns (5)-C
6. Find ways to join or connect with the family (5)-Pp

7. Willing to take direction or supervision (4)-P
8. Identify themes in families/develop themes-C
9. Develop systemic hypothesis about family functions (4)-C
10. Be able to be quiet, sit with someone and listen (4)-Pp
11. Use of the self in therapy; awareness of one's strengths and weaknesses (4)-P
12. Taking Care of oneself (4)-P
13. Patience (4)-P
14. Establish boundaries (4)-C
15. Enactments—bring the problem in the room and offer alternative methods of transation-C

### **Final List**

#### **Conceptual Skills**

1. Thinking systemically
2. Identifying and understanding family patterns
3. Conducting a structural assessment
4. Identify themes in families/ develop themes

#### **Structural (Doing) Skills**

1. Develop a systemic hypothesis about family functions

#### **Structural and Conceptual**

1. Establishing Boundaries
2. Creating Enactments

#### **Relational**

1. Tolerate emotional intensity
2. Be able to be quiet, sit with someone and listen
3. Taking care of oneself
4. Patience

**Relational/structural**

1. Giving a vision of hope for change
2. Find ways to join or connect with the family
3. Willing to take direction or supervision
4. Use of the self in therapy; awareness of one's strengths and weaknesses

## **Appendix F - Flanders Scale**

Flanders Scale: Interactional Analysis Adapted for Counseling (Fowler & Devivo, 1988)

Items 1-4.B. are considered indirect

Items 5.A.-7.B. are considered direct

Items 8-9 are client responses

1. Accepts Feelings: Accepts and clarifies the feeling tone of the clients in non-threatening manner.
2. Praises or encourages: Uses facilitative comments to keep talk going; e.g. "um-hum, go on, That's good".
3. Accepts Content: Clarifies the content and helps client extend the meaning.  
Open ended paraphrasing of the meaning.
4. A. Asks content questions-Probes for facts
4. B. Asks feeling questions-Probes for emotions.
5. A. Information giving—states own facts, opinions, ideas, rhetorical questions or interprets content.
5. B. Information giving- states own feelings or interprets feelings.
6. Gives directions-states procedures
7. A. Positive confrontation—I message designed to change behavior, ideas and feelings
7. B. Criticism-put downs-justifies authority-you messages
8. Client talk: Response to counselor questions

- a. content

- b. feelings

9. Client talk: Initiation by client

- a. content

- b. feelings

10 Silence

- a. working silence

- b. confusion or dead air

## Appendix G. Tables

Table 1. Fall, Counselor 1  
Family R. 2 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1	4	3		1	5	1					4b	b	1
2	4	10		1	4						2b	3a1 b	
3													
4a				1	3						5a 1b		
4b		2		1	2	2					4b		2
5a	1			1		1	1	1			a	a	
5b						1	1						
6											a	b	
7a													
7b											i		
8	3	5		1	1	1		1			a 2b	6a 4b	
9	4	5			1					1	4b	4a 5b	1
10		1		2	1							1	5
T	16	26	0	8	17	6	2	2	0	1	26	27	9
%	11	18	0	.05	12	.04	.01	.01	0	.00 7	18	19	.06

\*a= content

b=feeling

total observations: 140

Total Content responses =25%

Total Feeling responses= 47%

Direct: . 07

Indirect: 47%

Silence: 25%

Client Talk: 37%

Counselor Talk: 37%

Table 2. Spring, Counselor 1  
Family Q-2 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1	1							1			a	b	
2			1	1	2			1			3a 3b	ab	2
3				1									
4a		1		4		1				1	3a 1b	2b	
4b								1			2a		
5a	1					1		1		1			2
5b													
6	2	1				1		3	1		2a	b	1
7a				1					1				
7b										1	2a		
8		3		2		2		2			14a 3b	4a 3b	7
9		3	1		2			3			b	3a 3b	7
10	1	3		6	1						3a	2a 7b	24
T	5	11	2	15	5	5	0	12	2	3	38	28	43
%	.02	.05	.01	.08	.02	.02	0	.07	.01	.01	.22	.16	.25

Total: 169

Total percentage responses content:37%

Total percentage responses feelings:20%

Direct: 13%

Indirect: 22%

Silence of counselor: 41%

Client Talk: 39%

Counselor Talk: 28%

Table 3. Fall Counselor 2  
 Family H-1 session  
 Family R-1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1													
2				1		111							
3				1				1			aa		
4a			1	4		1					9a 2b		
4b											4b 2a		
5a				1		5	2	4	2		3a 1b	b	3
5b													
6						5		17		1	3b 1a	a	1
7a					1				1		2b		
7b											2a		
8		3		7	2	1		4	1		8a 6b	a	25
9						11							11
10		1	4	4	1	3		4	1		6a 4b	ab	62
T	0	4	5	18	4	20	2	30	5	1	55	5	70
%		.01	.02	.08	.01	.09	.009	.13	.02	.004	.25	.02	.31

Total: 219

Percentage Indirect: 23%

Percentage Direct: 26%

Percentage Silent: 33%

Percentage Content: 38%

Percentage Feelings: 13%

Client Talk: 27%

Counselor Talk: 38%

Table 4. Spring, Counselor 2  
 Family J-one session  
 Family H-one session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1													
2		3		2	2	1					a	2a	4
3						1							1
4a		1		5	1	2	1	1			6a 1b		2
4b													
5a		1		3		10		2	1		6a 1b		
5b				1									
6			1			1		32	1		2a	2a	2
7a						1							
7b													1
8		3	1	2		1		1			4a 1b		14
9		1				1		11				b	2
10		6		4		5		3			2a	a	28
T	0	15	2	17	3	23	1	41	2	0	23	6	53
%	0	.08	.01	.09	.01	12	.005	.21	.01	0	.12	.03	.28

Total : 187

Percentage Indirect: 19%

Percentage Direct: 35%

Percentage Silent: 36%

Percentage Content: 37%

Percentage Feelings: 3%

Client Talk: 16%

Counselor Talk: 47%

Table 5. Counselor 2 Spring  
Family B -1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1	1						1						
2						1							
3											2a		
4a				7		1		2			8a		
4b				1	2		2				4b		
5a				2	1	2		1					
5b						1	5	7	1				
6	1				2	1		3	1		2b 1a		2
7a													
7b													
8			2	4	2	1	2	2			2a, b		6
9					1						2a		
10		1		2				2			3a		8
T	2	1	2	16	8	7	10	17	2	0	24	0	16
%	.01	.009	.01	.15	.07	.06	.09	.16	.01	0	.22	0	.15

Total: 105

Percentage Indirect Response: 27%

Percentage of Direct Response: 34%

Percentage of Content Talk: 57%

Percentage of Feeling Talk: 27%

Percentage of Counselor Silence: 16%

Percentage of Counselor Talk: 70%

Percentage of Client Talk: 22%

Table 6. Counselor 3, Fall  
Family P-2 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1				1							2b		
2		3		1	1	1					2a		
3				1							2a		
4a		2		3	5						6b, 41a	a	
4b											3a		
5a												a	
5b													
6													
7a													
7b													
8	5	3	2	22	#11	2					28a 14b	2a	1
9		1		3								3a	
10				1									2
T	5	9	2	32	17	3	0	0	0	0	98	7	3
%	.02	.05	.01	.18	.09	.01	0	0	0	0	.55	.03	.01

Total: 176

Indirect Percentage: 36%

Direct Percentage: .01%

Content: 66%

Feelings: 22%

Silence: .01

Client talk: 59%

Counselor Talk: 33%



Table 7. Counselor 3, Spring  
Famiy H--2 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1											a	b	
2	2	1	1	1							6a, b	a	5
3		1									b		
4a					2			2			7a, 3b		1
4b					1					1	10b 2a	2b 1a	
5a				3		5					a		
5b					1								
6											bb		
7a													
7b				1									
8		9	1	6	8	2		1			9a, 6b	5b, 3a	4
9		4		2	4						2a	4a 1b	5
10		6		4	1	2	1	1			2b 1a	2b	14
T	2	21	2	17	17	9	1	4	0	1	54	20	29
%	.01	.11	.01	.09	.09	.06	.00 5	.02	0	.01	.30	.11	.16

Total: 177

Indirect Percentage: 33%

Direct Percentage: 8%

Content Percentage: 32%

Feeling Content: 29%

Silence: 28%

Client Talk: 41%

Counselor Talk: 41%

Table 8. Counselor 3. Spring  
Family P-1 ( 3rd viewed of this family) session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1													
2				1								2a	3
3													
4a		1		1							4a 3b		
4b				1	1						a		
5a													
5b													
6													
7a													
7b													
8				4							3a 2b	a	5
9		2		1	1							b	
10		3		5								2b	3
T	0	6	0	13	2	0	0	0	0	0	13	6	11
%	0	.12	0	.23	.04	0	0	0	0	0	.26	.12	.22

Total: 51

Indirect Percentage: 41%

Direct Percentage: 0

Content: 47%

Feelings: 4%

Silence of Counselor: 33%

Client Talk: 37%

Counselor Talk: 41%

Table 9. Counselor 4, Fall  
Family G. 2 -sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1													
2		4		3	1			1			2a		6
3													
4a				9	1	3	1				25a 2b	2ab	10
4b				1							2a 2b		11
5a				2	1	3					3a 3b		
5b		1		1		1					b	b	
6													1
7a													
7b													
8		3		#11		1	1				ba	5b 5a	15
9		2		5	11	1		1				2ba	10
10		8		24	1	3	2				2a	2ba	21, 31
T	0	18	0	56	6	12	4	2	0	0	44	20	96
%	0	.06	0	.22	.02	.04	.01	.00 7	0	0	.17	..07	..37

Total: 258

Percentage Indirect: 31%

Percentage Direct : 6%

Percentage Content: 44%

Percentage Feelings: 11%

Percentage Counselor Silent: 37%

Client Talk: 24%

Counselor Talk : 31%

Table 10. Counselor 4, Spring  
Family F.-3 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1													
2		5	2	3		2					2a 1b		8
3		1		1		1					a		2
4a		1		7		1					59a 2b, b		6
4b													
5a				3		24		1			15a 2b,		2
5b													
6				1							b	b	
7a													
7b													
8	1	2		22		10		1			4a 1b	7b 14a	38
9				6		11					2a 1b	1b 3a	12
10		14	2	32	1	6		1			2b 4a	ba	103
T	0	23	4	75	1	55	0	3	0	0	98	28	171
	0	05	008	16	002	12	0	006	0	0	21	06	37

Total: 458

Percentage Indirect: 22%

Percentage Direct: 12%

Percentage Content : 51%

Percentage Feelings: 4%

Percentage Counselor Silent: 37%

Percentage Client Talk: 27%

Percentage Counselor Talk: 31%

Table 11, Counselor 4. spring  
Family C-1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1				1									
2		4	1	4	2	2						b	6
3				1							3a 1b		
4a				1		1					11a 2b		
4b						1		1			5b 1a		
5a		1				8		1			2a 2b		
5b													
6											b		1
7a													
7b													
8		5	4	5	4	2					ba	a	8
9													2
10	1	9	1	11	11								21
T	1	19	6	15	8	14	0	2	0	0	30	2	38
%	.00 6	.14	.04	.11	.05	.10	0	.01	0	0	.22	.01	28

Total: 135

Percentage Indirect: 36%

Percentage Direct: 11%

Percentage Content: 40%

Percentage Feelings: 16%

Percentage Counselor Silent: 42%

Percentage Client Talk: 23%

Percentage Counselor Talk: 34%



Table 12. Counselor 5. Fall  
 Family R. - 1 session  
 Family H.- 1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1		1									7b,		
2	2	#11	3	6	1	1					10a 7b,	3b, 1a	#11
3		1		1							3a, 2b,		
4a			1	3		2					13a	2a	1
4b						1					4b	2b	
5a		1	1			2		1			a	b	
5b							3				2b	b	1
6								1			2a		
7a													
7b													
8	2	23	1	6	2	1	1				3a 7b,	5b 2a,	17
9		2		2			2				2b	2b	12
10	4	15	1	4	3	2		1			5b 4a,	3b	34
T	8	54	7	22	6	9	6	3	0	0	72	22	76
%	.02	.18	.02	.07	.02	.03	.02	.01	0	0	.25	.07	.26

Total: 285

Percentage Indirect: 34%

Percentage Direct: 6%

Percentage Content: 27%

Percentage Feelings: 25%

Percentage Silent: 26%

Percentage Client Talk: at least 32% higher because of arguing. Arguing increased all of the response rates.

Percentage Counselor Talk: 21%

Table 13. Counselor 5. spring  
 Family H-1 session  
 Family BB.-1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1					1						2b		1
2	1			1		1					3b 3a		3
3			1			1					b		
4a		1		2	1	1		1			12a 3b	a	3
4b							1				1a 4b		
5a						14	2		3		2a	3a	
5b							8				2b	b	
6				1				2			2b		
7a		1							1		2b		
7b													
8	1	4		6	3		3	1			3a 5b	4b 6a	12
9		2		8	2	2						2b 2a	12
10	2	2	2	5	1	2		1			1a 3b	4a 5b	44
T	4	10	3	23	8	19	14	5	4	0	49	28	75
%	.01	.04	.01	.09	.03	.07	.05	.02	.01	0	.20	.11	30

Total: 242

Percentage Indirect: 19%

Percentage Direct: 18%

Percentage Content: 36%

Percentage Feeling: 26%

Percentage Counselor Silence: 30

Percentage Client Talk: 31% at least. Arguments increased client talk

Percentage Counselor Talk: 33%

Table 14. Counselor 6, Fall  
Family M-2 sessions

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1	2	1		1	2						3b 2a		3
2	4	6	1	2	1	1				1	6b 1a	b	5
3					1								
4a	1	2		2	2						5a 1b		
4b				1	1					1	1a 6b		1
5a				3	1	4		2	1		a		1
5b	2			1	1		1			2	2b 2a		
6				1	1			6			ba	a	
7a						1			2		2a		
7b				1						3	2b 1a		
8	5	12		3	2	2	7	1	1		4b		9
9		1				1							
10		6		2	1			2	1	.	6b 2ab		22
T	12	29	1	17	13	9	8	11	5	7	49	2	41
%	.05	.14	.004	.08	.06	.04	.03	.05	.02	.03	.24	.009	.20

Total: 204

Percentage Indirect Responses: 35%

Percentage Direct Responses: 19%

Percentage Talk Content: 33%

Percentage Feeling Talk: 35%

Percentage Counselor Silent: 35%

Percentage Client Talk: 25%

Percentage Counselor Talk: 40%

Table 15. Counselor 6. Spring  
Family C-1 session

	1	2	3	4a	4b	5a	5b	6	7a	7b	8	9	10
1				1							a		
2		1		2	2						3a 1b	a	3
3											a		1
4a	1	1	1	1							1b 3a	b	
4b		1			4						5a	2a	1
5a					3	1					2a		
5b													
6													
7a													
7b													
8	1	6	2	4	3						2a	2b	6
9				1	2	1					3a		3
10		3		1							4a	2a 3b	5
T	2	12	3	10	14	2	0	0	0	0	26	11	19
%	.02	.12	.03	.10	.14	.02	0	0	0	0	.26	.11	.19

Total: 99

Percentage Indirect Responses: 41%

Percentage Direct Responses: 2%

Percentage of Content Responses: 44%

Percentage of Feeling Responses: 24%

Percentage of Counselor Silence: 31%

Percentage of Client Talk: 37%

Percentage of Counselor Talk: 31%

## Vita

Denyse B. Doerries

Birthplace: Stoneham, Massachusetts

## Education:

- 1996-1999 The College of William and Mary  
Williamsburg, Virginia  
Doctor of Philosophy
- 1968-1970 University of Rhode Island  
Kingston, Rhode Island  
Master of Science
- 1964-1968 University of New Hampshire  
Durham, New Hampshire  
Bachelors of Arts
- 1973-1999 York County Schools  
Yorktown, Virginia  
School Psychologist