QUANTITATIVE AND QUALITATIVE DIFFERENCES BETWEEN THE REFLECTING TEAM MODEL AND THE STRATEGIC TEAM MODEL IN FAMILY THERAPY: A COMPARATIVE STUDY

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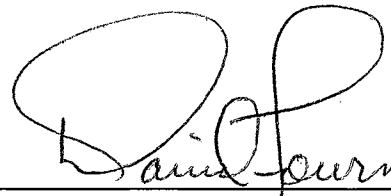

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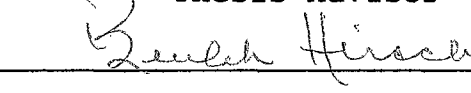

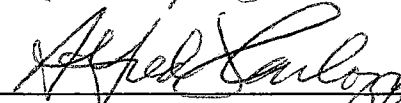

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CHAPTER I

INTRODUCTION

With our continually evolving society, families are presented with difficult challenges to not only survive but to maintain their integrity and values. Over the past three decades in response to our evolving society, we have seen the family change and adapt to include not only the nuclear family but many "non-traditional" family forms as well, such as divorced-remarried families, single parent families, and same sex couple families. In actuality, many of these alternative ways of being a family have been present in our society for a number of decades (Walsh, 1991). However, as the family responds to our changing society and culture, and as it simultaneously moves through its own family life cycle, families have naturally encountered stress and problems (Carter & McGoldrick, 1989). In response to this stress and the problems it causes within the family, some families have sought out family therapy. With this constant change in our society and the resulting stress this places on families, there is a definite role that family therapy plays in helping families to respond and adapt to our changing society.

The field of family therapy developed as new theories

such as general systems theory (Bertalanffy, 1968) and cybernetics (Wiener, 1967) became more available to psychotherapists in the 1940's and 1950's (Guttman, 1991). During the early years of the family therapy field, the adaptation and use of these theories to conceptualize and treat human problems was quite innovative due to the predominance of the psychodynamic model in the 1940's and 1950's (Haley, 1976).

Need for Research on Emerging Models of Family Therapy

Since its conception, the family therapy field has developed many models of family therapy which suggests continued inventiveness and innovation but this also calls out for the continued need for ongoing evaluations on these new and evolving models of family treatment (Gurman & Kniskern, 1978).

In this research study, the author describes one of these new and innovative models of Systemic Family Therapy called the Reflecting Team Model. (Systemic Family Therapy is a model of family therapy that was originally developed by Selvini Palazzoli, Boscolo, Cecchin and Prata [1978, 1980] and is also known as the Milan Systemic Family Therapy Model. Since the development of this family therapy model, other practitioners have used and refined these original theoretical and clinical ideas as well. These family therapy practitioners that use Milan or post-Milan concepts

in their therapy are considered to be using a Systemic Family Therapy Model.) The conception and clinical application of the Reflecting Team Model is relatively recent (Andersen, 1987, 1990; Davidson, Lax, Lussardi, Miller, & Ratheau, 1988; Griffith & Griffith, 1992; Hoffman, 1991; Parry & Doan, 1994; White, 1995). However, practitioners of Systemic Family Therapy are interested in the potential of the Reflecting Team Model to help families change themselves so that they can evolve to a preferred level of family functioning (Andersen, 1987, 1990; Hoffman, 1988; Tomm, 1988b). These systemic theorists/practitioners see the potential for this model to be nonintrusive and liberating for families experiencing problems. Liberation in the sense of opening space for the generation of new ideas which may lead to the self-discovery of new solutions by the client system in question (Tomm, 1988b).

These practitioners (Hoffman, 1991; Tomm, 1988b; White, 1995) have suggested in workshops and in the literature that the Reflecting Team Model seems to fit well with some of the current guiding theoretical frameworks in the family therapy field, namely Bateson's (1972) cybernetic epistemology and Maturana's (1975) theory of structure determinism. From Bateson's (1972, 1979) cybernetic epistemology, the Reflecting Team Model draws on the concept that the therapist and the therapy team are part of an observing system that includes the clients where no one part of the

treatment system has unilateral power or control over another part of that system. In drawing on Maturana's (1975) theory of structure determinism, the Reflecting Team Model offers clients a variety of ideas that could possibly be helpful to clients in the resolution of their problems. However, it is the clients who choose which if any ideas from the reflecting team are helpful or useful to them in their efforts to resolve the presenting problem.

However, in reviewing the literature, there are only a handful of research studies in the family therapy literature (Griffith, Griffith, Krejmas, McLain, Mittal, Rains, & Tingle, 1992; Hoger, Temme, Reiter & Steiner, 1994; Sells, Smith, Coe, Yoshioka & Robbins, 1994; Smith, Sells & Clevenger, 1994; Smith, Winton & Yoshioka, 1992; Smith, Yoshioka & Winton, 1993) designed to verify and validate that the Reflecting Team Model actually does operationalize what its adherents claim. Since this is a new and promising Systemic Family Therapy Model for treating clinical family systems, it is useful to conduct studies that would examine the perceptions of the family therapy process by all subsystems involved. The subsystems involved in this family therapy process would include the clients, the therapist and the observing therapy team. This strategy of studying the perceptions of the reflecting team members, the family members, and the therapist during the course of family therapy is precisely what Smith et al. (1992, 1993, 1994)

have begun tracking. (The tracking refers to the initial studies on the reflecting team process that have been completed to date by Smith et al. [1992, 1993, 1994].) This is particularly important because the Reflecting Team Model is being guided primarily by theory alone without much empirical validation. Further research in this area is necessary to adequately document the effectiveness of this approach. The participating systems in this therapy process include the clients, the therapist(s), and the observing therapy team (i.e., the reflecting team).

Issues Affecting Research on Family Therapy Process

It is proposed that the perceptions of the therapy process by the participating systems (i.e., couple/family, therapist, and the observing team) when the Reflecting Team Model is used, will be different from the perceptions of the therapy process by the participating systems when the Strategic and Solution-Oriented Family Therapy Team Model is the treatment modality. The Strategic and Solution-Oriented Family Therapy Team Model is defined here as a family therapy team that uses theory and techniques from the Structural Family Therapy Model (Minuchin, 1974), the Strategic Family Therapy Model (Haley, 1976, 1980, 1987; Madanes, 1981), or the Solution-Oriented Family Therapy Model (DeShazer, 1985, 1988, 1991). These are models of family therapy that look at structural and hierarchical

imbalances in the family system as leading to the development of problems in the family (Minuchin, 1974; Haley, 1976, 1980). These models intervene to help families change by interrupting problematic patterns in families and by giving directives and tasks for families to do that focus on the development of solutions in order to change these structural and hierarchical imbalances (DeShazer, 1985, 1988, 1991).

Clearly, the perceptions and experiences of the family therapy process by the clients is important and should be given priority in studies in this area. However, since this model impacts on the therapist(s) and the observing therapy team as well, it is also useful to study the impact of the Reflecting Team Model on these other interdependent subsystems in the family therapy process. These systems are interdependent because the family, the therapist(s), and the observing therapy team are focused on a common goal of solving the problem that the clients bring to treatment and because information is exchanged between these various subsystems. In essence, there could be two different research projects with one focusing on the clients perceptions of the therapy process and one focusing on the therapist(s) and the observing team's perceptions of the therapy process. Due to the interdependence between the clients, therapist(s), and the observing therapy team in the reflecting team therapy process, this study will compare the

perceptions of the therapy process by all of the subsystems involved.

Currently, there are only a few studies that compare the perceptions that clients have of the family therapy process when an observing therapy team is part of the treatment approach. Green and Herget (1989a) suggested in their research, on the use of a Milan Systemic Family Therapy Team Model (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978, 1980) that there has not been any empirically sound studies that have examined the process or the outcome of the Milan Family Therapy Team Model. The Milan Systemic Model of family therapy was developed in Milan, Italy during the 1970's by Selvini Palazzoli et al. (1978, 1980). This model became very popular with family therapists due to its use of a family therapy team in the treatment process and its efforts to operationalize such theoretical constructs as hypothesizing, circularity, and neutrality in the therapy process. The Reflecting Team Model is a derivative of this Milan Systemic Family Therapy Model.

Green and Herget (1989a) developed their own outcome study contrasting regular family therapy without the use of a family therapy team with a treatment group that received a Milan Systemic Family Therapy team consultation interview in addition to their regular family therapy without the use of an observing therapy team. Green and Herget's (1989a, 1989b, 1991) results indicated that the treatment group

which had received the therapy team consultation in conjunction with the regular family therapy did better at attaining their main treatment goals at follow-up periods of one month and three years than the comparison treatment group of families that did not have the consultation interview with the therapy team.

In another study, Coleman (1987) examined a group of clinical families that received family therapy using an observing therapy team model and this treatment group was compared to a group of families that received family therapy without the use of an observing therapy team. In this study, the treatment group was given family therapy based on the Milan Systemic Family Therapy Model (Boscolo, Cecchin, Hoffman, & Penn, 1987; Selvini Palazzoli et al., 1978, 1980) where an observing therapy team was employed as part of the treatment model. The results suggested that the Milan Systemic Family Therapy Team Model was not as effective as their comparison group that received Structural/Strategic Family Therapy (Minuchin, 1974; Haley, 1987). They also noted that families receiving the Milan Systemic Family Therapy Model generally did not like the approach or feel a strong therapeutic alliance with the therapist or the observing therapy team.

Mashal, Feldman, and Sigal (1989), in an outcome study of the Milan Systemic Family Therapy Model, found more promising outcome results than Coleman's (1987) study, but

also reported the lack of a strong therapeutic alliance for the families with the therapist and the observing therapy team. In response to the less than favorable alliances of the clients with the therapists and the observing therapy teams in these studies, Green and Herget (1991) developed a process and outcome study of a revised Milan Systemic Family Therapy Model which placed more emphasis on therapist warmth and therapist activity rather than the standard therapist stance of neutrality in the original Milan Family Therapy Model. Green and Herget's (1991) results suggested that families were more likely to achieve their main treatment goal in a therapy team approach to family therapy when the therapist was active and warm during the therapy session as perceived by the client families.

More recently, two quantitative studies (Griffith et al., 1992; Hoger et al., 1994) and four qualitative studies (Sells et al., 1994; Smith et al., 1992, 1993, 1994) examined the reflecting team therapy process. Griffith et al. (1992) compared client communication processes during the therapy session prior to and immediately after the reflecting team intervention. The results showed an increase in interactional sequences indicating more trust, comforting, and nurturing for client families after the reflecting team intervention. Hoger et al. (1994), in an outcome study on the Reflecting Team Model, found that two thirds of the families at follow-up (15 months) reported a

decrease in symptoms and 80% of the families were satisfied with their treatment. The studies by Smith et al. (1992, 1993, 1994) used qualitative methods to study clients' and therapists' perceptions of the reflecting team process.

Statement of the Research Problem

This current study intends to add to the research on the Reflecting Team Model by including both quantitative and qualitative methodologies in the study design and by describing and contrasting two observing therapy team models, the Reflecting Team Model and a Strategic and Solution-Oriented Team Model of practice. This was accomplished by assessments from all contributing members of the therapy process and by use of self-report, observational, and qualitative data collection strategies.

Purpose and Objectives

This study examined the perceptions and experiences of all subsystems involved in the Reflecting Team Model (Andersen, 1987, 1990). In this study, the clients' perceptions and experience of the therapy process will be examined using two different family therapy team treatment models. The family therapy team treatment models are: X1-clients receiving therapy using the Reflecting Team Model and X2-clients receiving therapy using a Strategic and Solution-Oriented Therapy Team Model.

Some of the previous studies (Coleman, 1987; Green &

Herget, 1989a, 1989b, 1991) have compared a Milan Systemic Family Therapy Team Treatment Model to family therapy without the use of an observing therapy team where the therapist worked with clients alone without the use of an observing therapy team. In comparison, this current study contrasts and compares two different family therapy team treatment models.

It will become evident in the upcoming literature review chapter for this study that there is not one model or type of Systemic Family Therapy. Systemic Family Therapy is practiced differently by a variety of family therapy clinicians and theorists. Some practitioners were particularly influenced by the original developers of the Milan Systemic Family Therapy Model (Selvini Palazzoli et al., 1978). However, as Hoffman (1988) indicated, other important practitioners (Anderson, Goolishian & Winderman, 1986; Keeney, 1983; McCarthy & Byrne, 1988; Tomm, 1987a, 1987b, 1988a; White, 1986) developed their own versions of Systemic Family Therapy. As will be noted in the upcoming literature review chapter, these models of family therapy have drawn on the theories of Bateson (1972, 1979) and Maturana (1975) to guide their clinical work.

The Reflecting Team Model (Andersen, 1987, 1990) is an example of one of these systemic, second order cybernetic concepts that have been operationalized for the family therapy process. It is considered a second order cybernetic

process because the reflecting team is considered to be one part of a larger client-therapist-therapy team treatment system where information is exchanged in a recursive manner by all of these components of this larger treatment system. In contrast, a first order cybernetic model of therapy is one where the therapy team is viewed as separate and not a part of the client-therapist system. Therefore, the therapy team can intervene into the therapist-client system directly by calling in interventions to the therapy room or by giving clients tasks to do at home in between therapy sessions (Keeney, 1983). A description of Bateson's (1972) definitions for first and second order cybernetics will be given in the literature review chapter.

Clinicians (Tomm, 1988b) who have used a Reflecting Team Treatment Model suggest that it is an interesting, respectful, and enjoyable way to conduct therapy. It is the perception of those who have used the Reflecting Team Model that it is less directive in the way it intervenes in working with the family system and more likely to generate the family system's own solutions than the Strategic or the Milan Systemic Therapy Team Models (Hoffman, 1988; Parry & Doan, 1994; Tomm, 1988b; White, 1995). Tomm (1988b) argued that besides being a less directive approach to family therapy, he also indicated that families may feel less of a sense of manipulation when the Reflecting Team Model is used in comparison to when a Strategic or a Milan Systemic Family

Therapy Model is used with clients. However, proponents of the Strategic and Solution-Oriented Family Therapy Models (DeShazer, 1988, 1991; Haley, 1987) would probably take issue with the above description of the therapy process by arguing that Strategic and Solution-Oriented Models are respectful of clients. At times, Strategic and Solution-Oriented therapists can be directive in therapy but would argue that they do not manipulate clients any more than any type of psychotherapy does (DeShazer, 1988, 1991; Haley, 1976, 1987).

The Reflecting Team Model utilizes a procedure where the therapist and the clients are sitting together to observe and listen to the reflecting team's comments about the current therapy session. This contrasts with the consultative model where the therapist leaves the room to consult with the observing therapy team behind the one-way mirror (as Strategic and Milan Systemic Family Therapy Treatment Models do). It is hypothesized that the Reflecting Team Model may strengthen the therapist/family alliance and facilitate a more egalitarian relationship for clients with the therapist and the therapy team. In theory, from a reflecting team perspective, this egalitarian relationship is more likely to occur in the Reflecting Team Model than in the Strategic Team Model because of the different ways the therapy team is used in these two models. However, it is argued that both of these different therapy

team models help families develop alternative ideas and behaviors but the process of how it happens is different for each model.

Prior to the reflecting team's conversation, the team members sit quietly behind the observation mirror and listen to the therapist/family conversation in order to come up with their own alternative ideas about what they are observing in the therapy interview. Theoretically, this is intended to reduce potential contamination by preventing the therapy team from coming up with just one hypothesis or idea about the family's situation. The therapist/family system hears a number of different ideas rather than any single pre-planned idea (which usually occurs on a Strategic or a Milan Systemic Family Therapy Team). In addition, during the actual reflection by the team, an idea of one member may trigger a new idea in another team member that he/she had not considered prior to hearing the other member's reflection or comment (Andersen, 1987, 1990; Tomm, 1988b). In contrast to this, in the Strategic Team Model, the therapy team purposefully talks together to provide clients with one or two ideas or tasks so that the clients have a specific direction to follow that will help them resolve their presenting problem.

Some of these ideas about the possible impact of the reflecting team on the therapy process are primarily theoretical assumptions that have only begun to be validated

by research (Griffith et al., 1992; Hoger et al., 1994; Sells et al., 1994; Smith et al., 1992, 1993) into the effect of this Systemic Family Therapy Model and process on the family system, the therapist, and the therapy team. Initially, as is the history with most of the family therapy models and their subsequent therapeutic techniques, the Reflecting Team Model was derived only from theory rather than from a combination of theory and empirical research findings. The Reflecting Team Model is being advocated by many systemic family therapists (Andersen, 1987; Hoffman, 1988; Tomm, 1988b) because of its fit with the theoretical foundations of Systemic Family Therapy which includes cybernetics (Bateson, 1972, 1979) and constructivism (Efran, Lukens, & Lukens, 1988). However, the question of whether there is an empirical fit between the model's theoretical assumptions and its actual clinical outcomes has only begun to be known. It is hoped that researchers and therapists will continue to develop research instruments that are designed to elicit perceptions of the therapy process by the participants involved (this includes families, therapists, and the therapy teams). Bringing forth these perceptions in conjunction with outcome results will allow further steps to be taken to validate the preliminary assumptions of this new Systemic Family Therapy Model.

This study is a limited and far from comprehensive attempt to empirically study the impact of the Reflecting

Team Model on a small sample of families, therapists, and therapy team members. The families' perceptions of the reflecting team therapy process will be compared to the perceptions of the therapy process by another small group of subject families using a Strategic and Solution-Oriented Family Therapy Team approach. The therapists and team members will be exposed to both family therapy team models and will be asked to compare and contrast their experiences using the two different models. As Gurman and Kniskern (1978) suggested, this study will employ multiple measures of the therapeutic process and will measure the perceptions of the process from both the insider and outsider perspectives. The insider perspective is the perspective of the therapy process that any part of the therapy treatment system (i.e., clients, therapist, and the therapy team) would have. An outsider perspective comes from someone who is not part of the therapy treatment system such as independent raters who would code transcripts or videotapes of the therapy process.

Hypotheses for the Clients Stated in the Null Form

1. There will be no difference in the perceptions of the therapy process between couples/families in the two treatment groups X1 and X2, where X1 is the Reflecting Team model and X2 is the Strategic and Solution-Oriented Team Model.

2. There will be no difference among the two treatment groups in the couples'/families' ability to find and use their own solutions to the presenting problem.

3. There will be no difference between the two treatment groups in the couples'/families' sense of hopefulness that the presenting problem will be resolved.

4. There will be no difference between the two treatment groups in the perceptions by the couples'/families' that they are united with the therapist in solving the presenting problem.

5. There will be no difference between the two treatment groups in the couples'/families' level of interest and cooperation in the therapy process.

6. There will be no difference between the two treatment groups in the couples'/families' ability to change their original view of the problem.

7. There will be no difference between the two treatment groups in the couples'/families' perception of being manipulated by the therapist.

Hypotheses for the Therapists/Team Members Stated in the Null Form

1. There will be no difference in team members' preferences for using a Reflecting Team Model or a Strategic Team Model.

2. There will be no difference in team members' ability to focus on clients' strengths, exceptions to the problem, and on solutions to the problem when either a Reflecting Team

Model or a Strategic Team Model is used.

3. There will be no difference in team members' awareness of and focus on clients' problems, and problematic patterns when either a Reflecting Team Model or a Strategic Team Model is used.

4. There will be no difference in team members' perceptions of how their ideas/interventions for clients are listened to in the therapy process whether a Reflecting Team Model or a Strategic Team Model is used.

5. There will be no difference in team members' perceptions of cooperativeness among the team members whether a Reflecting Team Model or Strategic Team Model is used.

6. There will be no difference in team members' perceptions of their effort to attend to and focus on the family therapy interview whether a Reflecting Team Model or a Strategic Team Model is used.

7. There will be no difference in team members' perceptions of the pressure or anxiety that they feel to come up with ideas/interventions for clients whether a Reflecting Team Model or a Strategic Team Model is used.

8. There will be no difference in team members' experience of any hierarchical differences or professional distance between the therapy team and clients whether a Reflecting Team Model or a Strategic Team Model is used.

9. There will be no difference in team members' experience of themselves as active participant observers in the therapy

process whether a Reflecting Team Model or a Strategic Team Model is used.

10. There will be no difference in the therapists' perceptions of being supported and not judged by the therapy team whether a Reflecting Team Model or a Strategic Team Model is used.

11. There will be no difference in the therapists' perceptions of being connected to and aligned with clients whether a Reflecting Team Model or a Strategic Team Model is used.

12. There will be no difference in the therapists' perceptions of the clients' ability to focus on their own ideas and solutions to their problems whether a Reflecting Team Model or a Strategic Team Model is used.

13. There will be no difference in the therapists' perceptions of the clients' comfort level and ease with the therapy team process whether a Reflecting Team Model or a Strategic Team Model is used.

14. There will be no difference in the therapists' or the team members' perceptions of the usefulness and effectiveness of the therapy team process whether a Reflecting Team Model or a Strategic Team Model is used.

Assumptions

Given concerns about mortality of subjects while the study was being conducted, it will be assumed that couples/families will have had enough treatment sessions

with the therapists after the fourth therapy session to respond to the multiple measures of the dependent variable. Therefore, it is assumed that in the two treatment groups, after four therapy sessions, the therapists will be able to join with the couples/families initially, will be able to develop a clear understanding of the problem for both the therapist and the family, and will have discussed some possible solutions to the problem.

For the population from which the sample will be drawn, originally the author attempted to use subjects from several counseling centers including the clinic employing the author. This was proposed in an effort to strengthen the generalizability of the results from the study. However, the study was turned down by the other clinical sites contacted. Therefore, subjects were solely drawn from the clinic site where the author worked and generalizability of the results would have to be limited to sites with similar client demographics. For a copy of the solicitation letters to the proposed clinical sites and to prospective clients for the study, see Appendix A.

Limitations

Since this study draws from a client population of mostly self-referred couples/families that are seeking marital/family therapy, it was difficult to develop a large sample for the study. The small sample size is a potential threat to the internal and external validity of the study.

Given that this is a self-referred population, random selection of subjects for the study was not possible because many of the clients seeking marital/family therapy at the clinic site chose not to participate in the study. This ruled out the use of a true experimental design and called for the use of an exploratory design with an emphasis on descriptive and comparative analyses.

Given the recent development of the Reflecting Team Model of systemic family therapy practice and the limited number of empirical studies on this model, it is argued that an exploratory/descriptive research design is warranted. With the proposed dependent variables emanating from the couples'/families' and the therapists'/team members' perceptions of the therapy process. It is also important to use quantitative and qualitative instruments that measure the therapeutic process from the multiple perspectives of the subsystems involved in the therapy (i.e., clients, therapist, and therapy team).

In a review of the therapeutic process and therapeutic alliance literature, the author decided to use the family version of the Integrative Psychotherapy Scales developed by Pinsof and Catherall (1986). Use of other scales for the study are reported in Chapter III. However, as noted in Chapter III, some of the quantitative instruments used in this study had to be rewritten to reflect a systems or family focus rather than an individual focus. This may

affect the validity and reliability of these instruments.

In Chapter III, two other measures of the clients' part of the dependent variable (i.e., face to face interviews by the researcher with the couples/families asking open-ended and closed-ended questions about the therapy process and independent raters viewing videotapes of the therapy sessions for the two treatment groups) are used to strengthen the study design by using multiple measures from both the insider and outsider perspective. However, the observational coding system was developed by this author and validity and reliability had not been established on an adequate sample prior to this study.

Qualitative interviews and a quantitative instrument are employed to measure the therapists'/team members' part of the dependent variable. Due to the unique aspects of this study, the quantitative instrument for the therapists/team members was developed by this author and validity and reliability were not fully established. These reliability and validity issues for both clients and therapists/team members are limitations in this study.

Measurement issues will be carefully addressed and qualified during the discussion of the design and the results from this study. In short, the exploratory and qualitative features will be highlighted within the context of its potential for further study. Another limitation is the aspect of the researcher's bias as to the outcome of the

study due to the author's personal training, study, and use of the Reflecting Team Model for about seven years now. The Reflecting Team Model was adapted as a clinical and training tool in the clinic one afternoon/evening a week, where the author worked at the study site. The equivalence of the researcher being the therapist for some of the families in the study and, also, a participant on the observing therapy team, creates potential bias problems. Gurman and Kniskern (1978) point out how a study's research design is strengthened when the therapist is not in the role of the researcher as well. But the clinical and practical context of the study site did not permit this split between the therapist and researcher. Coders, other than the author, were used and consultants were used at all phases of the study.

Other limitations in the design of the study include the possibility of the existence of extraneous and intervening variables that were difficult to control in the study design. Clearly, having a self-referred sample of clinical couples/families leads to the possibility of the two treatment conditions not being similar on demographic variables, functioning level, organization of the families, and on the presenting problem bringing the families into treatment. Other potential problems in the study's design include the differences in the training and expertise of the therapists and team members for the two treatment groups.

As Gurman and Kniskern (1978) point out, the inability to control for these extraneous variables in family therapy outcome studies are common methodological flaws in past family therapy research studies.

Definitions

A Reflecting Team Model is defined as a model of therapy where therapy team members observe the therapist-client session quietly from behind a one-way mirror. At a certain point in the therapy session, the therapy team goes into the interview room and the therapist and the clients go to the team observation room where they listen to the therapy team have a conversation (reflection) about their ideas of the therapist and the client(s) discussion up to that point in the therapy session. After the team conversation, the team goes back to the observation room and the clients and therapist go back to the interview room and resume their therapy conversation. The focus for the therapy team, in the Reflecting Team Model, is to offer a variety of ideas to clients in a respectful and tentative manner and to take a curious rather than a judgmental stance towards the clients' situation.

A Reflective Therapy is a type of therapy that involves seeing the therapist as a co-participant in the therapy process with families or clients. As a co-participant, the therapist and the family engage in a conversation around the presenting problem (Anderson & Goolishian, 1988). The

therapist and the family both offer ideas about the problem situation. The therapist is not viewed as having more expert knowledge than the family, just a different kind of knowledge than the family. The therapist takes a curious stance with the family about their problem situation and offers ideas in a tentative manner that lets the family decide whether the ideas that are offered are useful to them.

A Reflecting Team is an observing therapy team where the team members sit quietly and do not share their thoughts while they observe a family therapy session with a therapist and a family. At a certain point, in the therapy session, the reflecting team members have a conversation where they talk about the ideas that they had while watching the therapy session. The therapist and the family observe the conversation that the team members are having. In the team members' conversation, they offer the ideas that they think may be useful for the family or for the therapist, and this is done is a tentative manner so that the team members are not seen as the experts on the family's situation. After the team's reflection or conversation, the therapist and the family resume the therapy session and they may comment on some of the ideas that were discussed by the reflecting team.

A Reflecting Process is a part of the therapy process where the therapist or the therapy team offer ideas that

they have about the family's problem situation. The ideas are offered in a tentative manner so that the therapist or the therapy team is not viewed by the family as the expert(s) on their situation. It is the family that decides whether any of the ideas that are offered are useful to them in their efforts to resolve their problem situation. This reflecting process can occur when the treatment involves an observing therapy team or when the therapist is working with a family without the use of a therapy team.

A Strategic and Solution-Oriented Family Therapy Team Model is defined in this study as a method of family therapy treatment that uses an observing team of therapists and students behind the one-way mirror who view the therapy session that involves the therapist and the family. The observing team is active and participates in the therapy process by calling in questions or interventions for the therapist to ask the family during the interview. Towards the end of the session, the therapist will usually go back and consult with the observing team and will bring back closing comments or homework for the family to do during the intersession. The Strategic (Haley, 1976, 1987) and Solution-Oriented (DeShazer, 1985, 1988, 1991) Models of family therapy will be the primary models used by the observing team when this treatment approach is used in the study. The Strategic Model of family therapy assesses the family's structure and hierarchy. This model believes that

problems occur for families when the family is in a transition phase in the family life cycle where the family is moving from one stage of the life cycle to another stage of the life cycle that is unfamiliar to them (such as the leaving home stage of the life cycle when young adults move out of the family home and become independent) (Haley, 1980). Problems also arise in families when strong alliances occur that interfere with the normal hierarchy within the family. The therapist intervenes by helping the family to regain its normal structure and hierarchy through in-session interventions and planned tasks to do at home in between the therapy sessions.

A Solution-Oriented Model of Family Therapy actively looks for exceptions to the problem behavior in the family (i.e., the times in the family when the problematic behavior is not occurring). As the therapist talks with the family about the exceptions to the problem, the therapists works with the family to find ways to continue and expand these non-problematic patterns (i.e., solutions to the problem) so that the solution behavior is occurring more than the problem behavior in the family. The therapist verbally reinforces the family in their efforts to eliminate the problem behavior and offers suggestions and tasks for the family to follow at home in between the therapy sessions. (DeShazer, 1985, 1988, 1991). The Strategic and the Solution-Oriented Models of family therapy can be used with

an observing therapy team or can be used by a therapist without the use of an observing therapy team.

A Milan Family Therapy Model is defined as a type of family therapy based on the concepts developed by Selvini Palazzoli et al. (1978, 1980) which include hypothesizing about the reasons for the clients' problems, taking a neutral therapeutic stance, and intervening with clients through the use of circular questions. The model tends to use an observing therapy team as well.

Systemic Family Therapy refers to models of family therapy that have been derived from the original Milan Systemic Family Therapy Model (Selvini Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G., 1978). These models of family therapy use a second order cybernetic perspective which implies that the therapist, in working with a clinical family, temporarily joins the family to form a new system called the therapist-family treatment system. In this new treatment system, the therapist and the family interact with each other in a recursive manner with neither having unilateral control over the other (Keeney, 1983). Due to their own participation in the treatment system, the therapist can not take a truly objective position because they are part of treatment system and are influenced by the recursive interactional process that occurs between the therapist and the family. This implies that the therapist is not separate from the family in therapy. Therefore, the

therapist can not intervene in the family system in an objective manner. When the therapist intervenes with a family, the family decides whether the intervention fits for them or not. Basically, the family gives its own meaning to behaviors and they are the experts in deciding what behaviors are useful for their family. Since its inception, with the Milan Systemic Family Therapy Model, Systemic Family Therapy has been further developed by other practitioners as well (Hoffman, 1988; Tomm, 1987a, 1987b, 1988a). The Reflecting Team Model as developed by Andersen (1987) is an adapted version of the original Milan Systemic Family Therapy Model.

A First Order Cybernetic Perspective is defined as a type of family therapy that sees the observing therapy team as separate and distinct from the therapist-client system. By being separate, a first order perspective suggests that the therapy team can observe the therapist-client system and suggest interventions that would help change the client system in a positive manner.

A Second Order Cybernetic Perspective is a term used by models of family therapy that closely try to operationalize Bateson's (1972, 1979) cybernetic epistemology in actual family therapy practice. These are models of family therapy that attempt to deemphasize the hierarchical difference between the therapist and the family, that do not attempt to use directive techniques or interventions with clients, and

try to avoid using the therapist's power to bring about change in clients. However, these models of treatment view the therapist's role as one of a catalyst that helps the family to come up with their own solutions to the problem (Keeney, 1983).

A Cybernetic Epistemology stems from Bateson's (1972, 1979) interpretation of cybernetic theory (Wiener, 1967). Bateson examined the patterns that are similar for all living systems and looked at how information is exchanged for living systems within their environment. Bateson looked at how information was communicated and exchanged within families, so that families could be both stable and also change and adapt, when it needed to in response to its environment or to the developmental needs of the members of the family. Bateson believed that the concept of mind involved the recursive interchange of information for the living system with its environment. This implies that the living system becomes part of a larger system when it interacts with its environment. In the application of a cybernetic epistemology to family therapy, the therapist is seen as involved in a recursive process of exchanging information with the family where the therapist is not seen as separate from the family system but becomes part of a new treatment system that involves the therapist and the family. From this perspective, with the therapist being a part of the treatment system, the therapist can not be fully

objective in how it views the family since he/she is also part of the same system as the family. It is argued that both the therapist and the family have information and ideas but the therapist's ideas are not given a greater value than the family's ideas (Keeney, 1983).

Liberation is defined as the family's ability to change their view of the presenting problem so that they can see alternative causes or reasons for the problem (Tomm, 1988b). Generally, the family moves or shifts from a blaming posture where one family member is identified as causing or having the presenting problem to a posture where they see everyone's participation in the problem behavior or are able to see a less blaming reason for why they have the problem. Liberation also refers to the family's ability to see alternative solutions for the resolution of the problem.

Empowerment is defined as the experience that clients have when they have some control over the presenting problem and are able to use their own ideas and solutions to reduce or resolve the presenting problem rather than seeing the choices and control of their situation in the hands of the therapist or some other outside party.

CHAPTER II

REVIEW OF LITERATURE

This literature review begins with a discussion of the underlying conceptual frameworks for Systemic Family Therapy from which the Reflecting Team Model evolved. General systems theory (Bertalanffy, 1968) is included because of its importance as a theoretical framework for the family therapy field as a whole and because of its use by the Milan Family Therapy Team (Selvini Palazzoli et al., 1978) who were the original developers of the Milan Systemic Family Therapy Model.

General systems theory was most influential as a guiding conceptual framework for the originators of the Milan Systemic Family Therapy Model in their early stages of development (Boscolo et al., 1987). The clearly predominant conceptual framework used in Systemic Family Therapy is cybernetic theory as interpreted by Bateson (1972, 1979). More recently, systemic theorists/practitioners (Andersen, 1987; Cecchin, 1987) have also used Maturana's (1975, 1980) structure determinism as a theoretical framework for Systemic Therapy. This biologically based theory has been in the forefront with the theorists/practitioners using constructivism as their guiding framework (Efran, Lukens, &

Lukens, 1988; Hoffman, 1990; Tomm, 1988b). However, constructivism has at times been confused with social construction theory by family therapy practitioners (Hoffman, 1991). Social construction theory is another theoretical framework that is currently guiding some models of Systemic Family Therapy (Gergen, 1985; Goolishian & Anderson, 1988; Hoffman, 1991).

Theoretical Underpinnings of Systemic Family Therapy

Using the metaphor of a newly constructed house to describe the various models of family therapy, one would probably be accurate to describe their foundations as being made of general systems theory (Bertalanffy, 1968). Continuing this metaphor for only Systemic Family Therapy, one could probably get the sensation from touching its inside and outside walls and its roof that these quite noticeable components came from cybernetic theory. Looking through the windows of this newly constructed house, one would probably see that the glass comes from the theory of structure determinism (Maturana, 1975, 1980) and social construction theory (Gergen, 1985). The following sections in this chapter will provide an overview of these conceptual frameworks that have influenced the theory and practice of Systemic Family Therapy.

General Systems Theory: A Conceptual Framework for Systemic Family Therapy

As most practitioners of family therapy know, the Systemic Family Therapy Model (Selvini Palazzoli et al., 1978, 1980) is one of several major models or schools of family therapy. The common thread through most of the major models of family therapy is their use of general systems theory (Bertalanffy, 1968) as their underlying conceptual framework. General systems theory (Bertalanffy, 1968) can be viewed as a universal theory that can use its theoretical umbrella to understand and describe all living systems from an individual cell to the biosphere.

According to Bertalanffy, "general systems theory is intended to elaborate properties, principles, and laws that are characteristic of 'systems' in general, irrespective of their particular kind, the nature of their component elements, and the relation of 'forces' between them" (cited in LaViolette, 1981, p. 109). In describing the living organism as a system, Bertalanffy (1968) stated that "any organism is a system, that is a dynamic order of parts and processes standing in mutual interaction" (p. 208). And, as a living system, the organism is inherently active in that it seeks out active interchange with its environment. From this perspective, the living organism maintains its stability and growth within its environment by using such systemic properties as wholeness, goal-directedness,

organization, hierarchical order, regulation, and other systemic properties in its interaction with its environment which is comprised of other smaller and larger systems with similar properties.

Discussions of systems distinguish between open and closed systems, with living systems (such as a family system) being characterized as open systems. Bertalanffy concluded that open systems are "maintained in import and export, building-up and breaking-down of material components; in contrast to the closed systems of conventional physics which do not exchange matter with the environment" (cited in LaViolette, 1981, p. 112). Bertalanffy pointed out that closed systems move towards entropy while in living systems (such as family systems) movement is towards states of higher order which Bertalanffy called "anamorphosis". According to LaViolette (1981), who edited a collection of Bertalanffy's papers, Bertalanffy conceptualized general systems theory as a unifying theory that gives us a coherent view of the world that allows all disciplines to fall into a logical and coherent place within the overall framework of general systems theory.

Constructivist Thinking and Systemic Family Therapy

Ellis (1987) defined a conceptual framework as "a framework of concepts held together by a set of assumptions about human behavior" (p. 4). These concepts and assumptions help us organize reality by focusing on some

phenomena which also implies that certain other phenomena is not focused on (Ellis, 1987). Becvar and Becvar (1982) suggested that we "invent" the notion of a system so that we can understand recurring patterns that we see in the world around us. Becvar and Becvar stated that "it is useful and simplifies our understanding of the world to conceptualize a given pattern of relationships as a system. . . .Systems theory is a unifying theory. Instead of studying objects and people discretely, we now have a means of studying them in relationships" (Becvar & Becvar, 1982, p. 5). They indicated that we have "invented" other systems also by the way we punctuate and organize our environment, these other systems include the solar system, culture, neighborhoods, etc. (Becvar & Becvar, 1982).

This notion of "inventing" a system can be seen in Systemic Family Therapy's current emphasis on the use of constructivist thinking and its application to family therapy. Constructivism stems from philosophy and has its origins in the work of Immanuel Kant in the 18th century. According to Efran, Luken, R., and Luken, M. (1988), Kant "regarded knowledge as the invention of an active organism interacting with an environment" (p. 28). Efran et al. (1988) further stated in their comparison of Lockean and Kantian philosophy that:

> The card-carrying Lockean regards mental images as basically representations of something outside the

> organism; while the Kantian assumes that mental images are wholly creations of the organism. . .the images of the objectivist can be thought of as discoveries about the outside world, and the images of the constructivist are more like inventions about what is out there. (P. 28)

As much of the family therapy literature (Gurman & Kniskern, 1981) indicated, most of the models of family therapy used general systems theory as the theoretical framework in which to view interactions within the family. Since family therapy grew out of the study of culturally determined behavioral pathology within the culturally defined social unit called the family, family therapists found systems theory to be a more useful conceptual framework than the predominant conceptual framework (i.e., psychodynamic theory) used in the mental health field when family therapy began to develop in the 1950's. In essence, it was more useful for therapists with a social, interactional, and a family perspective to view behavioral problems within the context in which it occurs (the family) and less useful to view it from the intrapsychic context. (It should be noted though that some family therapists [Nichols, 1987] have begun to rediscover the "self" as an important component in the family system). In doing so, general systems theory became the natural theoretical framework to guide the family therapy field since it is a

conceptual framework that can be generalizable to all living systems. The emphasis on the usefulness rather than the correctness of using systems theory to study the family is important from a constructivist position.

For a family therapist, a systems perspective of the maintenance of human problems is more useful than a psychodynamic perspective of human problems. (Obviously, for the psychodynamic therapist, the psychodynamic perspective is viewed as more useful.) For a true constructivist, neither conceptual framework is more correct or valid than the other and the differing positions taken tell more about the "observers" than they do about "reality". (Even though a constructivist family therapist would probably still view the family as seen from a systems perspective as more useful than the perspective that is given when one looks through a psychodynamic lens).

Cybernetic Epistemology: A Framework for Systemic Family Therapy

Burbatti and Formenti (1988), in their book on Milan Systemic Family Therapy, suggested that Milan Systemic Family Therapy has its origins in general systems theory and Bateson's (1972, 1979) cybernetic epistemology. They state that "general systems theory is an integrated and interdisciplinary holistic approach to the most disparate fields of human knowledge. It is based on the concept of a system, namely of an organized unit determined by the

reciprocal interaction of its components" (Burbatti & Formenti, 1988, p. 7). These authors suggested that our defining families as systems led to viewing families as open systems that interact with their environment through the exchange of energy (i.e., information).

In Burbatti and Formenti's (1988) discussion of Bateson's seminal work, they emphasized Bateson's ideas on the pattern that connects. With this idea, Bateson (1972, 1979) examined the patterns that connect or are universal to all living systems that interact with their environment including the family system. Bateson held that the concept of "mind" was not an organ within the human skull but is the pattern of interaction that a system had with its environment that allowed for the continued existence of the living system in its environment. From this definition, all living systems were said to have "mind". In essence, Bateson (1979) looked for the pattern of life common to all organisms. This focus on the "pattern that connects" stems from Bateson's interest in biology, anthropology, and the new disciplines that emerged in the 1940's (general systems theory and cybernetic theory). Bateson was keenly interested in cybernetic theory. Norbert Wiener (1967) is commonly known as the founder of cybernetics; he was interested in the flow and exchange of information in living and nonliving systems. Burbatti and Formenti (1988) indicated that:

> Wiener proposed to revolutionize the scientific world by diverting scientific attention from the study of quantity, causes, and substances-typical of classical physics and of the disciplines inspired by it-to the study of relations, organizations, and form. The general principle of cybernetics was, and is, that of information. (p. 7)

Bateson (1979), in his paper on the criteria of mental process, stated that:

> 1) A mind is an aggregate of interacting parts or components. 2) The interaction between parts of mind is triggered by difference. . . . 3) Mental process requires collateral energy. 4) Mental process requires circular (or more complex) chains of determination. 5) In mental process, the effects of difference are to be regarded as transforms (i.e., coded versions) of events which preceded them. . . . (p. 102)

Bateson suggested that all living systems had these and other characteristics. These characteristics are similar to some of the concepts in general systems theory in which Bateson also had more than a passing interest.

In contrasting general systems theory and cybernetic theory, Keeney (1983) discussed some of the differences between the two theories. For Keeney, a "systems" or "circular" epistemology may not actually be a cybernetic epistemology. Keeney (1983) stated that:

> In family therapy, for example, a "systems epistemology" is often used simply to indicate a holistic view, for example, working with families rather than individuals. Cybernetics, however, is principally concerned with changing our conceptual lens from material to pattern, rather than parts to wholes. Thus, in the world of cybernetics, both parts and wholes are examined in terms of their patterns of organization. (p. 95)

Keeney argued that Bertalanffy's (1968) general systems theory stems from the tradition in the physical sciences which uses "metaphors of force rather than pattern" and he suggested that Bertalanffy misunderstood the concept by mistakenly believing that cybernetics takes a mechanistic approach (Keeney, 1983, p. 62). For many non-cybernetic systems theorists, this is a common concern that cybernetic theory reduces the processes involved in a living system (such as a family) to mechanistic-like processes that are usually attributed to machines which take away the human qualities from the family system. Keeney argued that this stance is a misunderstanding of Bateson's (1972, 1979) cybernetic theory. He pointed out that mechanistic explanations, in cybernetic theory, are explanations derived from pattern and structure whereas explanations in general systems theory are derived from energy or force. Therefore, one could argue that general systems theory hasn't fully

taken off its Lockean glasses, as of yet, at least from Keeney's perspective.

From a Kantian or constructivist perspective, an "observer" with a cybernetic perspective, will look for patterns and structures that connect the living systems that we distinguish out in the world. Whereas the "observer" with the traditional perspective that comes out of western science will look for a real objective reality that is made up of matter, energy, force, etc. . . . Disciplines such as physics and modern medicine are examples of this perspective. Keeney (1983) suggested that "seeing a cybernetic world does require changing our habit of viewing material exclusively. . .it means avoiding any lineal dichotomies between material and pattern or mind and body" (p. 64). Keeney uses the analogy of a Japanese garden to explain cybernetic thinking, where the foreground becomes the overall pattern of the garden rather than the individual plants in the garden which in Bateson's (1979) language implies a "pattern that connects".

First and Second Order Cybernetics

Another way to discuss these important distinctions is to examine the differences between first order and second order cybernetics or the cybernetics of observed systems and the cybernetics of observing systems, respectively (Keeney, 1983; Sluzki, 1983). Most of the major models of family therapy can be described as first order cybernetic models

(e.g. Strategic and Structural Family Therapy Models). From this perspective, the family system is seen as a separate and distinct system that can be "observed" by another system (the therapist) and this other system can use therapeutic interventions to alter, shift, redirect, or change the separate "observed" system (the family). This implies that the therapist has knowledge of how families should be organized in terms of their structure and hierarchy.

Those familiar with Structural and Strategic Family Therapy interventions are aware that these interventions are designed to shift and alter what is observed by the therapist to be problematic patterns that prevent the family from functioning optimally. In contrast, from a second order cybernetic view, the therapist while working with the family system is viewed as part of a new system that includes the family and the therapist. "The therapist, at a higher order of recursion, is part of a whole system and subject to its feedback constraints. At this level, the therapist is incapable of unilateral control and can be seen as either facilitating or blocking the necessary self-correction" (Keeney, 1983, p. 74). This is in contrast to Haley's (1980) view that the Strategic family therapist needs to take a lot of the responsibility for changing the family system.

In his later years, Bateson (1979) became concerned about the use of directive techniques by family therapy

models that were based on first order cybernetics. He argued against the use of power and positive manipulation (directive interventions) in family therapy believing that this did not fit with a cybernetic epistemology that respects the autonomy and self-corrective nature of systems (Bateson, 1972; Keeney, 1983). The first order cybernetic view also implies that there is a distinct system out there in reality that can be observed in an objective manner. However, a second order cybernetic view argues that the observer (therapist) is part of the system (therapist/family system) being observed. Therefore, the therapist by being another component of the new larger system is subject to the same recursions as the family in this newly formed system. The implication is that the observer (therapist) can not take a meta-position if it is really part of and not separate from this recursive process (Bateson, 1972; Hoffman, 1988; Keeney, 1983). Basically, the therapist is one part of an "observing system". From a Strategic Family Therapy perspective, Haley (1980) would argue that the role of the therapist implies some power and expertise and it is the responsibility of the therapist to use this power in a responsible, ethical, and helpful way with clients.

Bateson (1972, 1979), Maturana (cited in Simon, 1985), and Gergen (1985) have argued that there is no one objective reality that can be perceived by an individual or family. What we perceive and respond to in the environment is based

on our internal maps, our personal epistemology, our nervous system, and our sociocultural biases and influences. So, there is no one correct way of being for a system; it is a matter of what is useful for that system in the given context in which it finds itself. The implication, from this theoretical position, is that the therapist's view of how the family should organize itself and respond to their problems is only one of many possible options that may be helpful for the family in resolving their problem.

Structure Determinism: A Framework for Systemic Family Therapy

To be a Systemic family therapist, with a second order cybernetic perspective, implies embracing the work of Maturana and Varela (1987). Within recent years, much attention within the family therapy field has been placed on the work of these neurobiologists (Dell, 1985; Efran & Lukens, 1985). Maturana's (1975) theory of structure determinism has become one of the conceptual frameworks from which current Systemic Family Therapy thought is guided. Structure determinism is an ontological theory that attempts to encompass and define the nature of existence for both living and non-living organisms and can be viewed as complementary to Bateson's cybernetic epistemology (Dell, 1985).

In comparing Bateson's and Maturana's theories, Dell (1985) stated "in Bateson's view, all living creatures are

connected by, and constitute the epistemic. He believed that there is a 'sacred unity of the biosphere' which possesses the properties of mind" (p. 2). Whereas Maturana (1975) holds that "the fundamental feature that characterizes living systems is autonomy, and any account of their organization as systems that can exist as individual unities must show what autonomy is as a phenomenon proper to them, and how it arises in their operation as such unities" (p. 313). For Maturana (1975, 1980), the core characteristic of autonomy in living systems is "autopoiesis" (i.e., self-production/self-creation). Dell (1985) argued that Bateson's cybernetic epistemology is incomplete as a conceptual framework for guiding family therapy (just as Keeney [1983] argued that general systems theory is also incomplete) because it lacks a "corresponding ontology" (p. 1). Dell (1985) stated that "the biological ontology implicit in Bateson's writings and explicitly delineated in Maturana's (at long last) provide a sound foundation for the social and behavioral sciences" (p. 1).

According to Dell (1985), Maturana's work focuses on two primary questions: "a) What takes place in the phenomenon of perception? and b) What is the organization of the living" (p. 5). Dell (1985) said that Maturana viewed these phenomena (i.e., cognition and the process of living) as being identical. From this perspective, a living organism is said to have knowledge because it is connected

to and surviving in its environment. Efran and Lukens (1985) stated that one of the propositions of this theory is that "living systems are structure determined" (p. 24). This implies that any possible behavior or interaction by a living system is dependent on and determined by the structure of the system (Dell, 1985). This proposes that other living systems or the environment (medium), in general, can not determine the behavior of a living system (individual, family, etc.). The environment (medium) or another system in the environment may "trigger" another system to respond but the particular response or behavior by that system is determined by that system's unique structure (Efran & Lukens, 1985).

Another proposition of the theory is that "living systems are 'informationally-closed'. Their autonomous organizations can not be described as being simply 'caused' by or directly 'instructed' by outside forces" (Efran & Lukens, 1985, p. 24). Efran and Lukens (1985) suggested that this eliminates the argument between linear and circular causality in family therapy, since this proposition holds that there is no direct causality. However, Dell (1985) pointed out that there is circularity within the organization of the system and according to Maturana it is this circularity that "makes a living system a unit of interactions, and, it is this circularity that it must

maintain in order to remain a living system" (Dell, 1985, p. 5). Dell (1985) further stated that:

> Maturana noted the following: if the organization of a living system is circular, then that organization is a closed organization-not thermodynamically closed but organizationally closed. The significance of organizational closure is that it directly implies autonomy. . . .Because interactions with the environment cannot specify how an organizationally closed living system will behave, it therefore must be the case that such systems do not have inputs [and outputs]. (p.6)

From this perspective, living systems (including individuals and families) do not receive information which implies that information, in this manner, does not exist (Dell, 1985). At first glance, this seems to be in contrast to the general systems theory concepts of input to the system from the environment and feedback from within the system. As Dell (1985) suggested, people or systems receive the same information differently because each person or system will behave or respond differently. In general systems theory (Bertalanffy, 1968), this is explained by the system's individual or family maps and by the specific characteristics that make the system unique and separate from other systems in the environment. Dell (1985) argued that:

> This is precisely Maturana's point. It is the system that specifies how it will behave, not the "information". The information has no existence or meaning apart from that given to it by the system with which it interacts. The system specifies not only what is an interaction (for it), but also what kind of interaction that a given interaction is. Thus, information can have no objective existence. And, because objectivity is intrinsic to our conventional understanding of the term, "information", Maturana claims that there is no such thing as information. (p. 6)

Andersen (1987), who originally proposed the use of the reflecting team as a family therapy intervention, indicated that the main contributors to his version of Systemic Family Therapy have been Bateson (1972, 1979) and Maturana (1975).

Andersen (1987) stated that "Maturana speaks not of the universum but of the multiversa-the many possible meanings that constitute our many possible worlds. That is why he puts the word 'objectivity' in parentheses" (p. 416). The theory of structure determinism suggests that the system determines what it perceives in its environment and it determines how it understands and interprets and ultimately how it responds to its environment as well. Given this assumption, it does become difficult to state that there is an objective reality out there that everyone can see since

every system sees differently due to its organization as an autonomous living system. However, Maturana does admit that we have some shared meanings or consensus that help us drift in the same environment (medium) with other autonomous systems (cited in Simon, 1985).

Social Construction Theory as a Framework for Systemic Family Therapy

In a shift from a modernist perspective to a postmodernist perspective, the family therapy field has followed the larger sociocultural shift from modernism to postmodernism that has occurred in such diverse fields as philosophy, physics, literary criticism, semiotics and cultural anthropology.

Sprenkle and Bischof (1994) concur with Hoffman (1990) that this important theoretical and clinical movement in the family therapy field towards a postmodernist type of therapy can be viewed as occurring under the general term 'social construction theory'. In contrasting social construction theory with constructivist theory, Hoffman (1991) stated that "the social construction theorists see ideas, concepts and memories arising from social interchange and mediated through language. All knowledge, the social constructionists hold, evolves in the space between people, in the realm of the 'common world' or the 'common dance'" (p. 5). From this perspective, our inner world is actually socially constructed through human conversations and our

interpretation of the world is deeply influenced by the sociocultural structures that are all around us (Gergen, 1991).

From a social constructionist perspective, a sense of self develops not in the individual's personality but in the constant conversations that individuals have with significant others in their life. This fits well with Bateson's (1972, 1979) concept of mind which develops not inside one's head but in the constant recursive interchange with one's environment. Ideas and beliefs are formed through the process of human communication. Anderson and Goolishian (1988) drew from Hermeneutics, which comes from the field of literary criticism, to develop their model of Systemic Family Therapy. Anderson and Goolishian (1988) see therapy as conversation where ideas and beliefs about human problems develop and form in the course of conversation and that new ideas and beliefs about problems can form during 'therapy conversations' so that the problem can 'dis-solve' within the family system. In their overview of social construction theory, Sprenkle and Bischof (1994) stated that "Problems are conceptualized as stories that people agree to tell themselves and others" (p. 10).

Postmodern ideas and concepts from social construction theory have provided the foundation for the narrative therapy movement (White & Epston, 1989; White, 1991, 1995) within the family therapy field. These postmodern ideas

have been adapted and fit well with the Reflecting Team Model (White, 1995) even though Andersen originally used as his conceptual frameworks Bateson's (1972, 1979) cybernetic epistemology and Maturana's (1975) structure determinism.

Review of Systemic Family Therapy Literature

Now that the guiding conceptual frameworks for Systemic Family Therapy have been discussed, the literature review will be expanded to include the model or school of family therapy called Systemic Family Therapy. From the conceptual underpinnings of general systems theory, cybernetic epistemology, structure determinism, and social construction theory, we have current Systemic Family Therapy as a mid-range theory as it is applied to living systems (i.e., individuals, couples, and families) that are experiencing some form of distress.

For most people familiar with family therapy, Systemic Family Therapy tends to connote the type of therapy derived from the developers of the Milan Systemic Family Therapy Model in the 1970's (Selvini Palazzoli et al., 1978). These original developers of Systemic Family Therapy primiarly used general systems theory (Bertalanffy, 1968) and Bateson's (1972, 1979) cybernetic epistemology as their guiding conceptual frameworks, with most of their ideas coming from Bateson's work in studying cybernetics and human communication. In the 1980's, various systemic family therapists (Andersen, 1987; Dell, 1985; Cecchin, 1987; Tomm,

1987a, 1987b) began to see the relevance of Maturana's theory of structure determinism for family systems. As stated previously, in the 1990's, some systemic theorists/therapists (Dickerson & Zimmerman, 1992; Hoffman, 1991; Parry & Doan, 1994; White, 1991, 1995) have moved towards the use of social construction theory in their clinical work as well.

Historical Development of Systemic Family Therapy

The Milan group (i.e., Selvini Palazzoli, Boscolo, Cecchin, and Prata) developed their ideas during the decade of the 1970's and their theoretical approach changed and evolved over time (Tomm, 1984a; Boscolo et al., 1987). (The Milan group refers to the original developers of the Milan Systemic Family Therapy Model which includes the following family theorists/therapists: Selvini Palazzoli, Boscolo, Cecchin and Prata.) Initially, the Milan group studied the work developed at the Mental Research Institute (MRI) (Fisch, Weakland, & Segal, 1982) that had evolved originally from Bateson's original research team of the 1950's. Due to the influence of the MRI group, the Milan Systemic Family Therapy Model had a strategic as well as a systemic flavor to it. Boscolo et al. (1987) indicated that:

> In their therapeutic techniques, the group took some of the methods pioneered by the Mental Research Institute and expanded them. The therapeutic double bind, or, as the Milan group called it, 'counterparadox' became the

> heart of their approach. The entire problem situation would be positively connoted, for instance, and the family warned against premature change. (p. 6).

During this early period, the Milan group began to use a team of therapists behind the one-way mirror as part of the therapy process which was in contrast to the MRI group's use of a team which was for research purposes (Boscolo et al., 1987). During this stage of the group's development of Systemic Family Therapy, Tomm (1984a) pointed out that the families that they saw clinically were viewed more as stuck homeostatic systems than as growing, changing, and evolving systems. In this punctuation of the system, they looked for redundant patterns that maintained the problematic behaviors and used interventions that were sometimes paradoxical in nature that were designed to disrupt the redundant patterns (Tomm, 1984a). Due to the early influence of Strategic models, such as the MRI Model (Fisch et al., 1982) and Haley's Strategic Therapy Model (1980), the Milan Systemic Family Therapy Model became grouped with these models and was thought of as a Strategic Model (McKinnon, 1983). The Milan group's early interventions which were strategic in nature invited this model to be classified as a Strategic model of family therapy. During this period, the model was definitely more of a first order cybernetic model (Keeney, 1983).

During their next stage of development, the Milan group

began to study Bateson's ideas directly in Bateson's (1972) book, "Steps to an Ecology of Mind" as opposed to studying how others interpreted Bateson's ideas (i.e., MRI group and Haley). They were impressed with Bateson's (1972) concept of a model for living systems that employed the concept of cybernetic circularity. Boscolo et al. (1987), in their book on Milan Systemic Family Therapy commented about this period and stated that:

> Although germs of Bateson's momentous and complex ideas were present in much of the original Milan thinking, especially in the systemic notion of positive connotation, a new round of invention was now set off. The model that Boscolo and Cecchin were beginning to teach as early as 1977 was becoming in some respects almost diametrically opposed to its early "strategic" legacy. (pp. 9-10)

Part of this shift away from a Strategic Model (first order cybernetic model) to a more Systemic Model (second order cybernetic model) included the development of circular questioning. Tomm (1984a) noted that the Milan group shifted their view of families experiencing problems from seeing them as locked into interactional patterns that maintained the problematic behaviors to seeing families continually evolving and changing even though they had problematic patterns within the family. Interventions were designed in the form of questions (circular questioning)

that hopefully allowed the family system to pick up new information (Selvini Palazzoli et al., 1980). In discussing this process, Tomm (1984a) stated that:

> No matter how the new "information" was introduced, it was oriented to stimulating the family to create new patterns for themselves. The therapist did not break up maladaptive patterns but acted more like an "enzyme" which triggered the family to experience greater freedom for spontaneous change in their continuing evolution in patterns of behavior and belief. (p. 116)

Tomm (1984a) noted that, at this point, the Milan team began to see themselves as part of an "observing system" and began to move towards a therapy with a second order cybernetic perspective. During this phase of their theoretical development, the Milan group (Selvini Palazzoli et al., 1980) published an important paper entitled "Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session". This paper indicated a way to conduct therapy that more clinically delineated concepts from Bateson's (1972) cybernetic epistemology. In commenting on this paper, Boscolo et al. (1987) indicated that:

> The three categories addressed by the article represent a brilliant attempt to translate the implication of Bateson's idea of cybernetic circularity into the day-to-day work of consulting with human beings and their

> families. "Hypothesizing" translated the concept into an assessment process; "circular questioning" translated it into an interviewing technique; and "neutrality" translated it into a basic therapeutic stance. (p. 10)

In 1980, the Milan group separated into male and female teams, with the two different teams pursuing different interests. The women of the group (Selvini Palazzoli and Prata) focused their efforts on research with families that had strong problematic patterns and began to develop an "invariant" prescription or single, universal intervention that they used with clinically difficult families. The Boscolo and Cecchin team (called the Milan Associates) focused their efforts on training other therapists in their Systemic Model of family therapy. This training experience caused an emphasis not only on family systems but also on the larger systems in which their trainees worked and practiced. This developed into a therapeutic focus on the "significant system", Boscolo et al., (1987) stated that:

> The significant system includes all those units (persons or institutions) that are activated in the attempt to alleviate problems brought to professionals for a solution. Adding the professionals, including the Milan professionals, to the treatment picture was a major step in conceptualizing the problem in terms of

"observing systems" rather than "observed systems". (p. 23)

As noted earlier, the Milan group (Selvini Palazzoli et al., 1978) was the first to use the therapy team behind a one-way mirror for therapy purposes rather than for research purposes. As the popularity of the Milan Systemic Family Therapy Model spread, the use of the therapy team spread as well due to its potential therapeutic use with families and its use as a training vehicle. Boscolo et al., (1987) stated that:

> The one prerequisite for a therapeutic team seemed to be that it fulfill some version of Bateson's idea of binocular vision. As long as there was one person who could be immersed in the family and one person who could watch-one who leaned out the window and one who sat on that person's feet-a depth dimension could be achieved. (p. 24)

As will be pointed out later in this chapter, the observing therapy team continues to change and evolve in the way it works. Andersen's (1987) Reflecting Team Model is an example of a recent change in the operation of a family therapy observing team.

Neutrality and Curiosity as Systemic Stances

Cecchin (1987) in a paper entitled "Hypothesizing, Circularity, and Neutrality Revisited: An Invitation to Curiosity", continued to move Milan Systemic Family Therapy

in a direction that Bateson would probably have seen as a useful direction. In this paper, Cecchin pointed out that "neutrality" originally meant being open to everyone's view of the situation and not aligning with one particular view over another view in the family system. By doing so, the therapist was able to take a more constructivist view that there are many possible alternative views of the problem situation. This therapeutic stance of "neutrality" implied an acceptance on the part of the therapist that the family system could not be organized or behave differently than it had in the past up to the time that the family system sought therapy. This acceptance leads to a respect for the family system as a living organism despite the fact that we may view some of its behaviors as socially unacceptable (i.e., such as when domestic violence or child abuse occurs in some families). This stance of acceptance hopefully invites the family system to feel less blamed in the therapy process and, therefore, may invite the family system to evolve into a more socially adaptable form, perhaps more readily than a family system that feels blamed.

Cecchin (1987) made the point that many therapists in the family therapy field interpreted this therapeutic stance of neutrality to mean acceptance of such non-socially desirable behaviors as domestic violence and sexual abuse. From this perspective, the systemic therapist was viewed as not taking a stand against these types of undesirable and

unlawful behaviors that occur in some family systems. Cecchin (1987) suggested that:

> We describe neutrality as the creation of a state of curiosity in the mind of the therapist. Curiosity leads to exploration and invention of alternative views and moves, and different moves and views breed curiosity. In this recursive fashion, neutrality and curiosity contexualize one another in a commitment to evolving differences, with a concomitant nonattachment to any particular position. (p. 406)

This type of acceptance and curiosity can also be seen in the Systemic Family Therapy intervention, the reflecting team. Some systemic thinkers (Tomm, 1988b) believe that Boscolo and Cecchin have continued to evolve in a more truly systemic manner (continuing a second order cybernetic perspective) while they perceive that Selvini Palazzoli has evolved in a more strategic direction with her "invariant prescription" and in her concepts from her paper about "family games" (Selvini Palazzoli, 1986). Hoffman (1988), in her paper entitled "A Constructivist Position for Family Therapy", pointed out that Boscolo and Cecchin have left the strategic road for a more systemic one and this can be seen in the shift away from the end of session interventions towards a belief that the questions asked during the session are indeed interventions in their own right, in the sense that they may stimulate new information for the family

system. Proponents of the Strategic Therapy Model would argue that there is value in giving clinical families interventions and end of session tasks to do at home because these interventions help the family interrupt problematic patterns and allow families to try out and practice more useful behaviors and patterns.

Ideas Derived from the Milan Systemic Family Therapy Model

When one discusses Systemic Family Therapy, it becomes evident that there are many systemic practitioners in the field and that the ideas of the Milan group (Selvini Palazzoli et al., 1978, 1980) have spread and have been changed by various other practitioners in Europe, North America and Australia. In general, as noted in the previous sections of this chapter, Systemic Family Therapy hopefully operationalizes the theoretical work of Bateson's (1972) cybernetic epistemology and Maturana's (1975) theory of structure determinism. Hoffman (1988) and other systemic theorists would also argue that this implies taking a constructivist stance in how we view the world and punctuate a family system. Some authors (Efran, Lukens & Lukens, 1988) suggested that the constructivist thought has always been with family therapy because of the seminal influence of Bateson's ideas on the field since its inception and this constructivist view has grown recently due to the work of Maturana and Varela (1987). Hoffman (1988) suggested that these new ways of viewing Systemic Family Therapy have

evolved in a variety of family therapy training centers throughout the world; she described these various systemic practitioners as "post Milan teams".

Tomm (1987a) has suggested a fourth guideline, Strategizing, be added to the original clinical guidelines (i.e., hypothesizing, circularity, and neutrality) proposed by the Milan group (Selvini Palazzoli et al., 1980). He suggested that these are actually "conceptual postures" that can be used in a therapy session by the therapist. Tomm describes the overall process of using these postures as "interventive interviewing" and defines it as "an orientation in which everything an interviewer does and says, and does not do and does not say, is thought of as an intervention that could be therapeutic, nontherapeutic or countertherapeutic" (Tomm, 1987a, p. 4).

The idea seems to be that the therapist, as part of the recursive, circular system (therapist/family system) is always responding to the family system's responses and the family system, in turn, is continually responding to the therapist's responses. This implies that the therapist is one component of a larger system (i.e., therapist/family system). With this view, the therapist's own behavior influences the larger systems' direction, but the family's behavior also influences the larger system as well. This suggests that the therapist needs to be in tune with their own behavior as well as the family's behavior. These four

conceptual postures, which the therapist consciously and unconsciously adopts during the therapy session, help the therapist maintain a second order cybernetic perspective (i.e., observing system perspective). When a therapist intervenes by purposely adopting a specific conceptual posture and asks a question from that conceptual stance, Tomm (1987a) pointed out:

> That the actual effect of any particular intervention with a client is always determined by the client, not by the therapist. The intentions and consequent actions of the therapist only trigger a response; they never determine it. . . .Listeners hear and experience only that which they are capable of hearing and experiencing [by virtue of their history, emotional state, presuppositions, and so on]. (pp. 4-5)

It is evident that Bateson's (1972, 1979) and Maturana's (1975) ideas form the underlying theoretical framework for "interventive interviewing". Tomm (1987a) believed that the type of questions the therapist asks (based on the conceptual posture the therapist is in when asking a specific question) can be therapeutic or interventive in the sense that it may open space for new information to enter the family system (which is similar to the logic behind the Milan group's circular questioning). Tomm (1987b, 1988a) has delineated four different categories of questions that can be used by a therapist during a

therapy session. These include lineal questions, strategic questions, circular questions, and reflexive questions.

It is believed that during an interview that all four types of questions are asked by the therapist, whether the therapist is aware of it or not. However, Tomm (1987b) believed whenever possible the therapist should adopt a conceptual posture that brings forth reflexive questions, he stated that:

> Reflexive questioning is an aspect of interventive interviewing oriented towards enabling clients or families to generate new patterns of cognition and behavior on their own. The therapist adopts a facilitative posture and deliberately asks those kinds of questions that are liable to open up new possibilities for self-healing. (p. 167)

It is apparent that this line of systemic thought is similar to Cecchin's (1987) description of neutrality where the therapist takes a stance of curiosity which suggests acceptance of the present family system and opens the door for future change by the family system.

Hoffman (1991), in discussing a reflexive stance for family therapy, indicated that this movement, in part of the family therapy field, has paralleled the shift in our society from a modernist to a postmodernist view. Hoffman (1991) pointed out that the shift at the larger sociocultural level was initiated in semiotics and literary

criticism. In the process of shifting from a modernist to a postmodernist stance in family therapy, Hoffman believed that the field confused constructivist thinking (von Glasersfeld, 1984) with social construction theory (Gergen, 1985).

In Hoffman's (1991) interpretation of the differences in the two theories, it was pointed out that both challenge and question the notion of one true objective reality but the reasons for the challenge to an objective reality are quite different. Constructivism takes a more biological challenge where reality is determined by the structure and organization of the living system (a la Maturana). Whereas social construction theory challenges the modernist view of reality by suggesting that reality develops in the social interchange between living systems and is bounded by the limitations of language (i.e., reality is socially constructed through language). As Hoffman and some other systemic theorists (Anderson & Goolishian, 1988; White, 1993; White & Epston, 1990) have noted, a social constructionist view of therapy is more appealing to these theorists/practitioners than the more biologically based constructivist view of therapy. (Strategic family therapists would probably find a first order cybernetic model more appealing to them in their work with clinical families who want and expect the therapist to be active, possibly directive and, also be able to give them

information based on their professional knowledge.)

Recent Variations on the Milan Systemic Model

Hoffman (1988), in a discussion of post Milan teams, indicated that Penn and Sheinberg of the Ackerman Institute have been studying how the questioning process is interventive in and of itself through their use of future and hypothetical questions (Penn, 1986). And, Hoffman (1988) noted that Draper, Campbell, Little and Lang have been experimenting with using the Milan Systemic Family Therapy Model in London with various social agencies in the public sector. Byrne, McCarthy and Kearney have adapted the Milan Systemic Family Therapy Model to work with incest families and the larger systems involved with them in Dublin (Hoffman, 1988). She pointed out that other therapy teams in Sweden, Norway, Germany and Finland have been adapting systemic, constructivist ideas to their own particular therapy settings.

In the U.S., Systemic Family Therapy teams have developed in the 1980's, in such places as Atlanta (Southeastern Institute for Systemic Studies) and Vermont (Brattleboro Family Institute) where systemic ideas were being used to work on family violence and incest, respectively (Hoffman, 1988). In the closing discussion of post Milan teams, Hoffman (1988) indicated that Keeney while at Texas Tech University in the 1980's and Goolishian at the Houston-Galveston Institute both made significant

contributions to operationalizing second order cybernetic and social construction ideas at their family therapy programs.

Another current significant contributor to Systemic Family Therapy and thought is Australian family therapist, Michael White. White's model of Systemic Therapy (1986, 1990, 1991, 1995) was not influenced by the Milan group. His conceptual and clinical ideas stem from his efforts to operationalize Bateson's (1972) cybernetic epistemology, Foucault's (1980, 1988) theory of the practices of power, Bruner's (1986) use of narrative structure, and Bourdieu's (1988) deconstruction of knowledge practices. White's (1995) work has evolved from an emphasis on cybernetic epistemology to a focus on the text or narrative metaphor for the therapy process. White's (1986) earlier work, as indicated above, was primiarly influenced by Bateson's ideas. At that time, White (1986) suggested that:

> Cybernetic theory provides a negative explanation of events in systems. According to this theory, events take their course because they are restrained from taking alternative courses. . . .From this perspective, habitual family interactions or the specific behaviors of family members are best explained negatively by the analysis of different kinds of restraints. (p. 169)

White proposed that families are restrained from finding workable solutions to their problems due to a variety of

patterns of interactions in the family system. These restraints "include the network of presuppositions, premises, and expectations that make up the family members map of the world..." (White, 1986, p. 169). The family's internal maps and their view of the world prevents the system from what Bateson (1972) called that trial and error search that is needed to find and try out new solutions to the family's problem. Instead, the family's internal maps which restrain and block the finding of alternative solutions, keep the family trying solutions that do not work (White, 1986).

According to Tomm (1988b), White's model, suggests that the symptom/problem inhibits the evolutionary growth of the family system and that the symptom is actually a restraint that prevents the natural growth of the system (morphogenesis). However, what is unique to this model is that the symptom does not serve any useful or positive function for the family system which is in contrast to the view of the presenting problem in most other models of family therapy. From this perspective, when the symptom first occurred in the family system, the family tried solutions that didn't work and was restrained from trying solutions that do work, and over time, the family adapted to and learned to live with the symptom despite the discomfort the symptom probably caused family members (White, 1986).

In White's (1991, 1995) more recent work, the metaphor

of the family being negatively restrained from noticing and finding solutions has evolved to a metaphor of the family being restrained by a dominant story about their lives that focuses too much on their problems and not enough on their strengths, abilities and resources. In this metaphor, which draws on literary criticism, cultural anthropology and philosophy, the dominant problem story influences what events are selected from the environment to become integrated into this dominant story that individuals and families have about themselves.

One of the key elements in this model is the concept of externalization (White, 1988-89). This is operationalized by the efforts of the therapist to separate the problem from the identified patient. White (1988-89, 1991, 1995) believed that various cultural practices (such as the diagnostic and labeling process in mental health) have the impact of isolating the person with the problem to the extent where the identified patient may focus and identify him or herself by the problems that they have and forget about their own strengths and personal resources. By externalizing or separating the problem from the person, through ongoing externalizing conversations in the therapy sessions, it invites the identified patient, his/her family, and the therapist system to see the identified patient as a whole human being rather than a person who's identity becomes wrapped up in culturally defined symptoms.

As noted earlier in the chapter, it is clear that there is no one model or type of Systemic Family Therapy. Systemic Family Therapy is practiced differently by various family therapy clinicians and theorists. Some practitioners were particularly influenced by the Milan group (Selvini Palazzoli et al., 1978, 1980) but as Hoffman indicated some other major practitioners (Anderson & Goolishian, 1988; Keeney, 1983; White, 1986, 1991, 1995) developed their own versions of Systemic Family Therapy. Irrespective of which road was taken to reach the systemic path, it is evident that Batesonian (1972, 1979), Maturanaian (1975), constructivist (Efran, Lukens & Lukens, 1988), and social constructionist (Gergen, 1985) ideas have been present theoretically and specific clinical techniques have been designed to operationalize these ideas.

Conceptual Literature on the Reflecting Team Model

One such Systemic Family Therapy Model that has attempted to operationalize some of Bateson's and Maturana's ideas is the work of Andersen, Hald, Flam, and others in Tromso, Norway (Andersen, 1987, 1990). This family therapy group, headed by Andersen, has developed the therapeutic technique called the "Reflecting Team". From this perspective, a family system that seems or appears to be stuck in problematic patterns, needs new information or new ideas so that it can "broaden its perspectives and its

contextual premises" (Andersen, 1987, p. 415). In using this method, a therapy team behind a one-way mirror observes and listens to a therapist, who is having a conversation with a family that has come in for family therapy. At certain points, during the therapy session, the team or the therapist can invite the therapist and the family (therapist/family system) to observe and listen to the ideas and comments that the team (reflecting team) has about the conversation that the therapist and the family were having. After the reflecting team has finished their discussion of the therapist-family discussion, the therapist invites the family to comment on their observation of the reflecting team's discussion. This reflecting team discussion can take place towards the end of the therapy session or at various times throughout the actual interview.

Autonomy of the Family System with the Reflecting Team

As indicated in Bateson's (1972, 1979) cybernetic epistemology and Maturana's theory of structure determinism (1975), the autonomy of the living system is clearly evident and needs to be respected. The reflecting team process makes an effort to be respectful of the family system's autonomy because of these theoretical underpinnings. Given this assumption, the family system's autonomy is respected in a number of ways and these show the theoretical influences of structure determinism (Maturana, 1975) and a cybernetic epistemology (Bateson, 1972, 1979) in the

reflecting team process. One such way is that the family is always asked first if they want to hear the team's comments. Another way is that the family is always given the "last word" in the sense that they are asked whether they have any comments on the reflecting team's comments. Another way of showing respect for the family system is that the family becomes "observers" of the so-called "experts" (i.e., therapists behind the mirror) which tends to imply a more egalitarian hierarchical stance than the Strategic Family Therapy Team that the family doesn't actually see during the therapy session.

Strategic and Solution-Oriented therapists would argue that clients come to therapy because of the expert knowledge and experience that therapists have in dealing with human social problems. These two models would propose that the reality of therapy is that there is a hierarchical imbalance due to the role that society puts therapists in. However, this hierarchical difference between the therapist and clients actually helps facilitate change because clients will be more likely to listen to the therapist and try out the therapeutic interventions because of the knowledge and expertise that the therapist has (Haley, 1976, 1987).

Hoffman (1988), in discussing the Reflecting Team Model, suggested that "this powerful idea has extended the 'conversation' model for therapy in the direction of a less hierarchical and genuinely recursive dialogue" (p. 15).

Tomm (1988b) indicated that the implication is not just that the team is not the "experts" on the family problem, it is that the family members are the "experts" on their own system. The reflecting team offers new ideas or possibilities but does not know whether any of these will be useful, only the family system knows. By not stating opinions as facts, the reflecting team takes a constructivist position (Efran et al., 1988) where the team realizes that their view of the situation comes from their own position as observers in the treatment system. The comments and ideas that the team shares with the therapist and the family are stated in question form in order to maintain a constructivist position (Andersen, 1987; Tomm, 1988b; Davidson et al., 1988). At the University of Calgary, their reflecting team's goal is to value diversity rather than homogeneity and they invite the family to see different alternative understandings or views of their situation by use of the reflecting process (Tomm, 1988b).

Whether or not the family sees any of the reflecting team's comments as useful depends on the family system not on the therapist or the reflecting team. This implies Maturana's idea that it is the system that decides whether it will respond and that the system's structure and organization decides how it responds (Tomm, 1998b). Andersen (1987) commented on this process stating that "the reflecting team has to bear in mind that its task is to

create ideas even though some of those ideas may not be found interesting by the family, or may even be rejected. What is important is to realize that the family will select those ideas that fit" (p. 421). Davidson et al.(1988) of the Brattleboro Family Institute stated that:

> The reflecting team emphasizes the central position of the client's belief system in the therapy process. The therapist's role is to help generate ideas and possible solutions while maintaining a respectful, non-hierarchical position in the therapeutic system. None of the alternatives and constructions that emerge in the dialogue between therapist and clients are considered more "right" than any others-the only relevant criterion is what "fits" the system and is acceptable to it. (p. 44)

Andersen (1987) and Tomm (1988b) pointed out that the process of having the therapist and the family observing the reflecting team's discussion tends to amplify the team's comments more so than if the same comments were heard in an ordinary conversation. Due to this amplification process, Andersen (1987) warned that:

> It must be emphasized that connotations must always be positive and never negative. . . .The screen [the process of observing] tends to magnify criticisms and remarks of the 'why-did-they-do-this-or-that' category . . . .The team must remain positive, discreet,

respectful, sensitive, imaginative, and creatively free" (p. 424).

In its efforts to maintain respect for the family system, Andersen (1987, 1990) noted that the team may not comment on some of the nonverbal behavior that it observed during the therapist and family conversation because the team may believe that the family system is not ready to talk about whatever that underlying issue may be. However, if the team does decide to bring up some analogic information that it observed then it is done in a very tentative tone. Andersen (1987) stated that "it is important to respect the stuck system's resistance to that which is too unusual. The only way to know if one is on the right side of this boundary is to be sensitive for signs the system itself gives us when it closes itself to our questions" (p. 417).

In this process of being respectful, the reflecting team is observing not the family system but the therapist/family system and the team is commenting on the recursive, circular process that it is observing from behind the mirror. This implies that the team may choose to comment on the behavior or comments of the therapist, also. If, this occurs the same ideas hold for the therapist as those that were indicated for the family. The team does not try to alter the therapist's direction if they believe that the therapist is pursuing a nonuseful line of inquiry with the family. Instead, the team may offer some alternative

avenues or ideas for the therapist to consider but, like the family, it is the therapist's choice whether to follow the alternative ideas during the remainder of the therapy session (Tomm, 1988b).

Concepts of Empowerment and Opening Space in the Family System

Tomm (1988b), in his version of Systemic Family Therapy, talked about the idea of "opening space" for the possibility of new ideas or alternative views for the family system. And, if this therapeutic space is opened, the family system may discover some alternative views of the problem or alternative solutions to the problem. Tomm (1988b) pointed out how a system that discovers its own ideas feels empowered from his perspective. From Tomm's (1988b) perspective, this sense of empowerment is an important part of the therapy process because it opens space for self-discovery by the family system and is in line with the views of Bateson (1972, 1979) and Maturana (1975). Tomm (1987b) worked on using reflexive questions by the therapist to enable more of a sense of empowerment by the family system; he also noted that the reflecting team may also invite a sense of empowerment for the family system if it opens space for the generation of new ideas by the family system that had previously focused on recurring problematic patterns.

This can also be applied to the therapist, in the sense

that empowering and liberating ideas may be given to any part of the therapist/family system. In addition, a therapist who feels stuck during the therapy session may ask for the reflecting team's comments to help the therapist to pursue a more useful line of questioning with his/her clients. (Tomm, 1988b). With this issue, Strategic and Solution-Oriented Therapy Models would believe that a positive outcome for clients is liberating and empowering because the family gets assistance in moving away from problematic patterns. In this process, the family discovers patterns of behaviors that are more productive and useful for them in their lives. Strategic and Solution-Oriented therapists would argue that this change is empowering and liberating for clients and helps them to continue to change on their own as problems arise in the future.

Observations of the Reflecting Team Model by Clinicians

The reflecting team is one of many systemic, second order cybernetic concepts that have been operationalized for the therapy process. Clinicians, who have participated on a reflecting team, suggest that it is an interesting, respectful and enjoyable way to conduct therapy (Hoffman, 1991; Tomm, 1988b; White, 1995).

The process of the therapist and the family sitting together and watching the reflecting team's comments, rather than the therapist leaving the room to consult with the therapy team behind the one-way mirror (as the Strategic,

Milan Systemic, and Solution-Oriented Therapy Team Models do), may strengthen the therapist/family alliance. Strategic therapists would argue that they must form a positive alliance with clients in order to get clients to follow through with the strategic interventions or tasks in the therapy process (Haley, 1976, 1987).

Proponents of the Reflecting Team Model (Andersen, 1987, 1990; Hoffman, 1988, 1991; Tomm, 1988b) believe that the process of generating new or alternative ideas occurs not only for clients and therapists but, also, for the reflecting team members as well. While observing the therapist/family conversation, each reflecting team member sits quietly and listens in an effort for each team member to come up with their own alternative ideas about what they are observing. Andersen (1987, 1990) believes this helps prevent the team from coming up with just one common hypothesis or idea and the result is that the therapist/family system gets to hear a number of different ideas rather than one preplanned idea (which usually occurs on Strategic, Milan Systemic, and Solution-Oriented Therapy Teams). During the actual reflection, an idea of one member may trigger a new idea in another team member that he/she hadn't thought of prior to hearing the other member's reflection (Andersen, 1987, 1990; Tomm, 1988b). The Strategic and Solution-Oriented Models argue the opposite, that giving families too many ideas will be confusing and

lead to the family having difficulty remembering what they are supposed to work on in between their therapy sessions (Haley, 1976, 1987).

Some clinicians (Parry & Doan, 1994; White, 1995) have added to Andersen's (1987, 1990) original ideas of how to implement and use the reflecting process. Parry and Doan (1994) use the narrative or text metaphor to describe their therapy process where the therapist and the reflecting team are viewed as "re-visionary editors". The reflecting team is used as an "editorial committee" which keeps track of a possible "hidden text" in the family which the family may be reluctant or fearful to bring up during the therapy conversation.

White (1995) has made efforts to make his model of therapy more "transparent" where the therapist shares his or her ideas, theories, and thinking with the family system in order to make the therapy process more egalitarian and less hierarchical from his perspective. White's notion of transparency suggests that therapists need to share more of their underlying premises and beliefs with clients, so that clients can know where the therapist is coming from with the questions they ask clients in therapy. This concept of transparency comes from Foucault's (1980) concern about the misuse of power that can occur when the underlying sociocultural biases of expert knowledge is not revealed to clients.

Again, Strategic therapists would argue that the role of therapist implies some power and that it is better to accept this reality rather than pretend that it does not exist (Haley, 1976, 1987). Along with this theoretical line of thinking, the therapist's responsibility is to use this power in a responsible manner to help clients change in a positive direction.

White (1995) has adapted this stance of transparency to the reflecting team process as well. This is accomplished during the team's reflecting conversation by the team members asking each other questions about the origins of their comments during the reflecting conversation. The idea is for the team members to situate their comments in their personal experiences so that their comments are more "transparent" to the family system listening behind the one-way mirror. For example, if team member A makes a comment during the reflecting conversation, team member B may ask team member A where the idea/comment came from in terms of did it arise from team member A's personal life, his/her professional theories, or from work with other clients/families. Team member A then shares where his/her idea came from.

Research on the Reflecting Team Model

As noted in Chapter I, there have only been a few research studies on the use of the Reflecting Team Model. Two quantitative studies attempted to measure the

effectiveness of the Reflecting Team Model. One of these studies (Griffith et al., 1992) measured the ability of the reflecting team intervention to change the family's communication before and after the intervention. This study used the observational coding system known as the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974) to measure the families communication before and after the reflecting team intervention. The results indicated an increase positive communication as noted by more coding of trusting, comforting, and nurturing codes after the intervention and less coding of negative codes such as controlling, blaming, monitoring, and belittling. The other quantitative study (Hoger et al., 1994) used a single-group design to measure the outcome effectiveness of the Reflecting Team Model fifteen months after treatment had ended. In this study, 35 families responded at follow-up, two thirds of this group believed that their symptoms had improved and 80% of this group were satisfied with the reflecting team treatment.

Two of the qualitative studies of the Reflecting Team Model in the literature focused on clients' and therapists' perceptions of the reflecting team process (Smith et al., 1992, 1993). Other qualitative studies used qualitative analyses to elicit the domains of practice in the Reflecting Team Model (Sells et al., 1994) and to do a content analysis of clients' and therapists' perceptions of the reflecting

team process (Smith et al., 1994). For a comparison of the Reflecting Team Model studies in the literature, see Appendix B.

Review of the Therapeutic Alliance Measurement Literature

Since this is a process-oriented study that examines the perceptions of the therapy process for the clients, therapists, and team members, it is hypothesized that an important indicator for perceptions of the process would include measures of the therapeutic alliance between the clients and the therapists/team members. However, most of the literature on the therapeutic alliance comes from the individual psychotherapy process literature. Saunders, Howard, and Orlinsky (1989) pointed out that across many psychotherapy research studies it has been found that the quality of the psychotherapeutic relationship is strongly related to successful outcomes in psychotherapy. Part of their concern is that measurement of the quality of the therapeutic relationship between the client and the therapist comes from a "non-participant observer perspective" (Saunders et al., 1989, p. 323). These authors developed the Therapeutic Bond Scales which attempts to measure the quality of the therapeutic relationship through a self-report instrument. The instrument has the following dimensions: working alliance, empathic resonance, and mutual affirmation. These dimensions form the three scales for the instrument. The items for the three scales of the

instrument were taken from the patient version of the Therapy Session Report (TSR) questionnaire (Orlinsky & Howard, 1967). There are 50 items in the three scales and there is a Global Bond Scale which is a composite of the three scales.

Tracey and Kokotovic (1989) examined the factor structure of the Working Alliance Inventory (WAI) which was developed by Horvath and Greenberg (1986). This inventory examines the perception of agreement on therapeutic goals by the client and the therapist, the perception of agreement on how to reach these goals, and the perception of the strength of the personal bond between the client and the therapist. Tracey and Kokotovic (1989) indicated that the WAI is a useful instrument because the self-report instrument can be given to both the client and the therapist, because it can be used to assess the therapeutic relationship regardless of the theory base of the therapist, and it is designed to be given during the early stages of the therapy process. The Working Alliance Inventory is a 36 item questionnaire that has three 12 item subscales which consist of Task, Bond, and Goal and it also provides an overall score.

Marmar, Weiss and Gaston (1989) designed a study to test the validity of the California Therapeutic Alliance Rating System (CALTARS). This instrument was developed to measure the therapeutic alliance between the client and therapist by using trained raters who view videotaped

therapy sessions. In this study, the treatment modality was short-term dynamic psychotherapy. This instrument, rated by non-participant observers, includes 41 items of which 20 are therapist items and 21 are client items. There are four dimensions to the instrument which include: therapist positive contribution, therapist negative contribution, patient positive contribution, and patient negative contribution.

Within the family therapy research literature, Joanning, Newfield and Quinn (1987) designed an interesting study that examined both the effectiveness or outcome of treatment as well as the ongoing therapeutic process. This study involved using both quantitative and qualitative measures to examine the effectiveness of three different treatment modalities with families that have adolescent drug abusers as members of their system.

Pinsof and Catherall (1986) developed the Integrative Psychotherapy Scales which have been adapted from Bordin's (1975) concept of the working alliance and includes a systems orientation so that the strength of the therapeutic alliance can be measured in marital and family therapy. Since this is a systems measure of the therapeutic alliance, it will be used as one of the measures in this study. This systems self-report instrument is made up of three separate alliance scales that measure the individual's, the couple's, and the family's perceptions of the therapeutic alliance;

the couple (CTAS) and family (FTAS) scales have 29 items each. Each of the scales has three subscales which include tasks, bond, and goals.

In addition to this scale which measured the overall alliance as perceived by the couples/families in this study, the Session Evaluation Questionnaire (SEQ) (Stiles, 1980) was given to the couples/families after their fourth therapy session in the study in order to measure the therapeutic impact of that session. The SEQ uses a semantic differential format and has 22 bipolar adjectives that relate to the client's thoughts, feelings, and perceptions of their just completed therapy session. The therapeutic alliance will also be measured in the study by a qualitative interview with the couples/families after the fourth session as well. Other instruments that are included in the pretest and posttest measurements to compare the subjects in the two comparison groups will be discussed in Chapter III.

Summary

In summary, there has only been a limited number of evaluation studies on the Reflecting Team Model. Griffith et al. (1992) found an increase in positive codes and a decrease in negative codes in subject families for in session communication after the reflecting team intervention. Hoger et al. (1994) found at a fifteen month follow-up period that two-thirds of the respondent families reported improvement in their symptoms and 80% of this group

were satisfied with the Reflecting Team Treatment Model.

Two of the qualitative studies (Smith et al., 1992, 1993) analyzed clients' and therapists' perceptions of the reflecting team process. One qualitative study (Sells et al., 1994) used ethnographic analyses to elicit the domains of practice in the Reflecting Team Model. The analysis indicated six domains of reflecting team practice which included: (a) benefits of its use, (b) effects of gender, (c) recommended use, (d) contraindicated use, (e) creating spatial separateness between clients and reflecting team members, and (f) communication patterns between clients and reflecting team members that bring forth change. Using the same client sample as the Sells et al. (1994) study, Smith et al. (1994) did an ethnographic content analysis of clients' and therapists' descriptions of the reflecting team process during marital therapy. The analysis showed that the clients focused on what they liked about the reflecting team process and how hearing ideas about their problems, in a different manner, were helpful. The therapists focused more on therapeutic outcome rather than on the therapeutic process. In this study, therapists' and clients' perceptions and perspectives of the Reflecting Team Model differed; the clients focused more on the process and therapists were more focused on the outcome.

These initial studies have started the evaluation process on the Reflecting Team Model in family therapy

practice. However, there have been no comparison studies of the Reflecting Team Model with other models of family therapy practice. This researcher plans to continue the evaluation process of the Reflecting Team Model by doing a comparison study of the Reflecting Team Model with a Strategic Team Model that uses strategic (Haley, 1976, 1987) and solution-oriented (deShazer, 1985, 1988, 1991) strategies and intervetions.

CHAPTER III

METHODOLOGY

Overview of Research

In this research study, a descriptive and exploratory design will be employed. As Gay (1987) indicated, for a researcher to use a true experimental design, the study has to include random selection of subjects. However, given the constraints of the setting and the context of where the research was conducted, a true experimental design with random selection of subjects was not possible. Therefore, the design employed in this study used a less rigorous design that will have some sources of invalidity. Sources of invalidity, such as shifting or veering from the study design, will be documented and reported in the study.

Issac and Michael (1983) suggested that descriptive research can be narrowly or broadly defined. In its broad definition, it can include most research designs except those which are historical and experimental in nature. Since there is little empirical research on the Reflecting Team Model, preliminary exploratory and descriptive investigations, such as this study, are necessary to identify potentially relevant variables for consideration in more rigorous designs to be used later. Most of the

published work on the reflecting team (Andersen, 1987 & 1990; Lax, 1989; Miller & Lax, 1988; Roberts, Caesar, Perryclear, & Phillips, 1989) involves theory and practice papers that describe, in a retrospective manner, one or two case studies where the reflecting team has been employed. Smith, Yoshioka, and Winton (1993) in their review of the reflecting team literature pointed out that there has been no empirical study of clients' perceptions of this treatment process or model. In response to the lack of studies, these authors (Smith et al., 1993) did a pilot study using qualitative research methods to begin the process of understanding this model from clients' perspectives. A similiar pilot study on the therapists' perspective was done by these authors (Smith et al., 1992) as well. To date, there are only two studies on the Reflecting Team Model (Griffith et al., 1992; Hoger et al., 1994) that have employed quantitative research measures. Griffith et al. (1992) examined changes in the families' communication style before and after the reflecting team interventions. Hoger et al. (1994) examined client outcomes and satisfaction with the Reflecting Team Treatment Model at a fifteen month follow-up period.

An attempt was made for this study to involve several different counseling agencies, however, delays and the lack of control at other sites led to the decision to use an exploratory and descriptive design for this study. These

other sites turned out to not be available anyway. One of these sites felt that given the amount of data, that was requested from clients, that financial incentives for clients would be needed to recruit subjects. The lack of incentive for clients, such as financial reimbursement for participation, made it less likely that respondents would cooperate. Without resources to provide incentives to clients for participation in the study, only the clinic where the author worked was used as the site for this study.

Description of Research Methodology

The study, as originally designed, used random assignment of couples/families seeking therapy to one of two treatment groups whenever possible. At times, random assignment to groups was not possible given constraints in the study site. The particular constraints on the collection of data in this study are discussed in Appendix C of this paper. Initially, in using descriptive and exploratory research methods, the study started out using a nonequivalent control group design that included not only quantitative but qualitative measures of the dependent variable. As Gay (1987) noted, this quasi-experimental design is similiar to the pretest-posttest control group design with the exception being the lack of random assignment to groups in the nonequivalent design. Using Gay's (1987) symbols, the proposed nonequivalent control

group design for the study was as follows:

O X1 O (Reflecting Team Model)

O X2 O (Strategic Team Model)

Using these symbols, the first column of O's represents the pretest, the second column of O's represents the posttest. X1 is the group of couples/families receiving the Reflecting Team treatment and X2 is the group of couples/families receiving the Strategic Team treatment. With no group of subjects on a waiting list and both groups of couples/families receiving therapy, the proposed design is viewed as one with two different treatment or comparison groups without the use of a waiting list control group. Gay (1987) indicated that in this design, the Strategic Team treatment group (X2) can be viewed as the control group for the new treatment (Reflecting Team Model) but he suggested that the two treatment groups in this study design are more likely comparison groups where each treatment group is the control group for the other treatment group. However, the pretest data will be compared to the larger group of couples/families receiving marital/family therapy without the use of an observing therapy team at the clinic site during the time frame of the study.

In addition to using this nonequivalent control group design when possible, the qualitative research methods employed qualitative interviews to add to the type and variety of information collected from couples/families in

this study. This allows for a broader and richer view of a clinical process that involves not just the therapist and the family system but its interaction with the observing team as well. The intent was to provide multiple measures of the couples/families experience of the therapy process (dependent variable) as Gurman and Kniskern (1978) suggest.

Moon, Dillon and Sprenkle (1991) believe that qualitative and quantitative research methods can be woven together and are complementary. For instance, Joanning, Newfield, and Quinn (1987) performed a large scale process and outcome study on the treatment of adolescent substance abusers and their families using quantitative and qualitative research methods.

Moon et al. (1991) took a synthesist position in the debate over qualitative and quantitative research designs arguing that both methods of research can be employed together. These complementary but different measures provide multiple avenues for the collection of information and data on the couples'/families' perception of the treatment process. Moon, Dillon, and Sprenkle (1990, p. 361) point out that this use of multiple measures in qualitative research is called triangulation which they define as "using multiple data sources, multiple data collection and analysis methods, and/or multiple investigators, in order to increase the 'trustworthiness' of findings." Multiple sources of information fits well with

the purpose of the Reflecting Team Model (Andersen 1987, 1990) of offering multiple ideas to the client family system.

Qualitative research methods have been viewed by some Systemic Family Therapy theorists and researchers as being more compatible with the cybernetic and constructivist theories that underlie some of the recent ideas and current directions of some parts of the family therapy field and the Reflecting Team Model would be included as an example of one such recent approach (Atkinson & Heath, 1987; Moon et al., 1990, 1991).

Within these cybernetic and constructivist ideas, that include the Reflecting Team Model, is the concept that the therapist and therapy team are part of the phenomenon being observed and this includes recursive interactions between the family, therapist, and the therapy team (Keeney, 1983; Tomm, 1988b). As Wynne (1988) indicated, the therapist is not separate from the client system but is one member (a participant) of an observing system that includes the client family system.

Research methods that employ qualitative interview procedures view the researcher as a "participant observer" who not only observes but participates and influences the phenomenon being studied (Patton, 1987). Qualitative methods using these procedures fit well with the Reflecting Team Model where there is a deemphasis on hierarchical

differences between the clients and the therapist/therapy team members. This involves a shift in emphasis to seeing the clients as their own experts on resolving their issues when the normal differences between the clients and therapist are theoretically lessened. (Again, Strategic therapists would propose that this normal hierarchical difference between the therapist and clients is useful in bringing about positive change in clients since clients may be more likely to try out new behaviors due to the expertise of the therapist.) Moon et al. (1990) indicated that the participant observer role for the researcher also has implications for the subjects in the research who take on a less passive and more equal role as participants rather than subjects in the research in question.

Qualitative interviews of couples/families will add and hopefully complement the quantitative data gained from the use of self-report questionnaires. In order to gain more of the multiple views of the participants in the therapy process, qualitative interviews will be used with the observing therapy team participants as well. Although, the main focus of the study still remains on the couples/families experience as participants in the process.

As noted earlier in this chapter, this study can be seen as exploratory and descriptive in nature due to the small sample size and the need to diverge from the original study design in order to gain more sources of data.

Smith et al. (1993) pointed out that researchers need to be open to change as information is received in that recursive process between the researcher and the participants in the study and the researcher needs to be adaptive to such changes. It is argued that a pilot study of this type, though limited in scope, contributes to the existing body of knowledge of the Reflecting Team Model given the sparseness of empirical studies on the model. Cavell and Snyder (1991) maintain that qualitative methods help elaborate and build on theory development in a generative manner but due to difficulty in generalizing the results beyond the study in question, these authors (Cavell & Snyder, 1991) hold that qualitative designs are limited in what they can offer the family therapy field. Just as Cavell and Snyder (1991) indicated, this present study, due to its limitations, may not be generalizable beyond the participants in the study but it hopefully will indicate trends that are similar or dissimilar to the existing research on the Reflecting Team Model. This contribution to a more indepth empirical analysis of the model could be helpful to future efforts. However, given the early stages in the empirical analysis of the Reflecting Team Model, qualitative methods which tend to be exploratory in nature (Moon et al., 1990) will fit with the purposes of this current study.

Included in the multiple measures of the dependent variable will be the observational coding of videotaped

segments of the therapy sessions by two independent raters. This strategy will provide an outsider perspective of the phenomenon being studied which Gurman and Kniskern (1978) consider to be important in family therapy research.

Research Design

Independent Variables

Within this study, the primary independent variable was the type of family therapy treatment that each of the treatment groups received. Other independent or client background variables were collected during a pretest phase when couples/families came to the clinic site and filled out the agency's intake forms and the study's self-report instruments prior to therapy. These instruments measured the couples'/families' current level of stress, their typical responses to stress, their communication, their level of family functioning, their problem-solving confidence, and their sense of hopefulness. Family members twelve years and older were asked to complete the pretest instruments. One of the pretest measures was the agency intake questionnaire which assessed whether the subjects/participants in each of the two groups were similar to each other on a number of extraneous variables such as age, education, socioeconomic status, racial group, sex, family type, presenting problem, and duration of the problem.

The pretest self-report instruments were used to assess

stress level, family functioning, the amount of confidence, and the amount of hopefulness that the couples/families have in resolving their issues/problems prior to beginning treatment. These measures were also used to ascertain if the couples/families assigned to each treatment group were similar on these variables prior to the start of treatment. These measures also indicated whether these two groups were similar to the larger group of couples/families receiving marital/family therapy at the clinic site without the use of an observing therapy team.

In the original study design, the posttest measures were given after the fourth treatment session for each couple/family participating in one of the two treatment groups. The independent variable was duration (the four therapy sessions) with either a Reflecting Team Model (X1) or a Strategic Team Model (X2). The time frame chosen for the posttest is rather short but given the potential of couples/families dropping out of treatment, this is a way of dealing with an important source of internal invalidity, differential experimental mortality (Issac and Michael, 1983). In this study, concern for subject mortality was an issue but the difficulty in getting subjects to participate in the study required changes in the original study design. A combination of factors made it difficult to find subjects who were willing to participate in the study. Given the recent development of the Reflecting Team Model, the limited

amount of empirical research in the literature on the model, and the time constraints for the completion of the study, it was decided to allow changes in the study design. For a detailed description of these study design issues, see Appendix C.

Whenever possible, posttest data were collected at the end of the first four therapy sessions for both treatment models. Posttest data were also collected from couples/families at the study site that were receiving current marital/family therapy by the author or the other staff family therapist; these previous therapy sessions were done without the use of an observing therapy team. Most of these couples/families that were receiving current individual marital/family treatment received usually two to four therapy sessions without the use of a therapy team prior to being assigned to one of the two therapy team treatment groups. At that time, these couples/families received either of the therapy team treatments for at least their next two therapy sessions then posttest data were collected on these couples/families.

Since there were difficulties in recruiting subjects for the study at the pretest period, just prior to the initial therapy session, it was decided to ask as many of the couples/families receiving individual marital/family therapy at the study site as possible to participate in the study after the first two to four therapy sessions with

their individual family therapist. It was hoped that these families felt more comfortable after the initial therapy sessions and it was assumed that the therapist had begun to build an alliance with these couples/families. The assumption was that these couples/families may be more receptive to participating in the study at this early stage of treatment.

When these couples/families were solicited to be in the study, the vast majority of these couples/families chose not to participate in the study. These clients did not participate because of the following reasons: (1) scheduling problems for the family; (2) some anxiety about being in the study; or, (3) a lack of interest in participating in the study. When approached about using a therapy team and being videotaped, many couples/families already in individual marital/family therapy felt uncomfortable with this proposed treatment context and chose to continue in their current individual marital/family therapy. However, a few couples/families did elect the proposed new treatment context and could also rearrange their schedules to be seen on the day that the family therapy team works with families at the study site. (This raises the question about what was different about these couples/families, that they were willing to participate in the study, after they had already begun therapy without the use of an observing therapy team. At this time, it is unclear what if any differences were

present in these couples/families as compared to those couples/families who declined to participate in the study.)

The difficulty in recruiting subjects from the larger population of marital and family therapy clients at the study site needs to be looked at. Did clients choose not to participate in the study due to the amount of data to be collected at the posttest stage, or because being in a study felt like an invasion of privacy to them? Many clients are initially hesitant to participate in family therapy when they are informed that the treatment process involves the use of an observing therapy team. Generally, clients become used to having a therapy team as part of the therapy process particularly when they experience the observing therapy team as being helpful to them in resolving their presenting problem. However, some clients continue to feel uncomfortable with a team of observers. (When this occurred at the study site, these clients were seen by the therapist alone.)

Whenever a large number of clients decline to participate in a study (as happened in this current study), does this imply something about the data being collected or does it say something about the proposed treatment involved in the study? In family therapy, observing therapy teams are primarily used in training settings, not in most community practice settings, with the primary purpose of helping to educate and train family therapy trainees to do

marital and family therapy. As a discipline, it may be useful for the family therapy field to examine the reasons for the use of an observing therapy team given the normal hesitancy of some of our clients to participate in the process when observers are involved. Basically, the question is whether the use of an observing therapy team is more for our benefit (i.e., the family therapy field) or for the benefit of the clients that we work with?

It should also be pointed out that both treatment models involved in this study can be used by therapists without the use of an observing therapy team. The context is somewhat different when there is no observing therapy team but strategic and reflective concepts and interventions can be implemented by a therapist working without an observing therapy team.

The only subjects that received the treatment process differently than in the original study design or altered study design was one couple who were seen for their first two therapy sessions with the family therapy team but then due to scheduling problems, the couple could no longer come in for therapy on the day that the family therapy team met. Posttest data were then collected after the end of the second session and the couple was seen in individual marital therapy in subsequent sessions. The other exception was a family that was terminating family therapy at the end of their twelfth family therapy session. The family therapist

referred the family to the family therapy team for a combination termination session and consultation interview which the therapist hoped would help the family to leave therapy in a positive manner. At the end of their twelfth session and only therapy team session, some posttest data were collected.

Clearly, these shifts in the study design, along with the accompanying confounding variables that these shifts in design introduce, limit the possible impact and generalizability of the study and raise questions about the conclusions that are drawn from the data collected in the study. However, given the preliminary and exploratory nature of the prior research on the Reflecting Team Model, it is again hoped the trends found in this study will still provide a contribution to the existing research on this model. The use of qualitative research methods as part of the multiple dependent variable measures will help in the discovery of any possible trends in the analysis of the data given the introduction of a confounding variable, such as ongoing individual marital/family therapy. The constraints on subject participation and data collection in this study called for flexibility and adaptability which is more accepted in qualitative research methods (Moon et al., 1990; Smith et al., 1992, 1993).

Description of Therapy Treatment

In describing the type of therapy received by each

treatment group, a typology used by Green and Herget (1989a, 1989b, 1991) will be used to explain the differences in the two treatment models used in the study. In general, the therapeutic stance of the therapist(s) was one of empathy, warmth, and active participation with the couple/family during the session. Therapists using the Reflecting Team Model tended to be more non-directive in their interactions in the therapy session. Whereas, when the Strategic Therapy Model was used, the therapist made efforts to be more problem focused (i.e., framing the problem in solvable terms) and more solution focused (i.e., looking for exceptions to the problem behavior and encouraging clients to continue to try out behaviors that involved possible solutions to the problem). Following the results and recommendations from Green and Herget's (1991) study on outcomes from Strategic/Systemic Family Therapy, when the Strategic Model was used, the therapist made efforts to be less directive and hierarchical with the couple/family. When interventions or assignments were given in this model by the therapist or the therapy team, efforts were made to explain any interventions or directives given.

The therapy team operated and made efforts to intervene differently depending on the treatment model being used. With the Strategic Team Model, team members discussed observations, ideas, and strategies behind the observation mirror. The therapy team called in questions, thoughts, and

interventions at least two times prior to the end of session break. The therapy team's phone interventions always began with an acknowledgement and compliment of something that the clients were doing well, prior to making an intervention. Towards the end of the interview, the therapist left the room and joined the therapy team in the observation room where an end of session strategy was designed which the therapist brought back and delivered to the clients. This usually included a focus on current and past functional behavior by the clients as well as some intersession assignments for the clients to do.

In contrast, the reflecting team members generally did not talk to one another while observing the therapy session. Generally, about two-thirds or three-quarters of the way into the session, the therapist would ask the family if they wanted to hear some of the team's comments or ideas about their situation. At that point, the therapist and family would trade rooms with the reflecting team where the family would see the team members and hear their comments. The reflecting team made efforts to intervene by having a reflecting conversation between the team members with the family and the therapist observing the team's conversation about their therapy session. The focus of the therapy team was on looking for family strengths, exceptions to the problem, solution behavior, and a decreased emphasis on examining the problematic patterns that were occurring for

the clients. The therapy team's reflection began by acknowledging the family's strengths and efforts to resolve the presenting problem. Interventions and ideas were introduced by the team through the use of a questioning format where the team members offered ideas in a tentative manner.

Role of the Researcher/Therapist

As Gurman and Kniskern (1978) indicated the role of the therapist and researcher needs to be delineated and separated in order to provide a more objective perspective of the clinical processes being studied. However, research methods involving qualitative interviews suggest that the researcher take on a participant observer role where the researcher not only observes the phenomenon under study but joins in and actually experiences the phenomenon himself/herself (Patton, 1987). According to Patton (1987), qualitative research methods involve choices by the researcher on how to observe and study the phenomenon in question. Patton (1987) views the observational process of the researcher as being on a continuum from active participation on one end to an onlooker who observes the phenomenon as an outsider on the other end of the observational continuum. Clearly, the role of the researcher as active participant in the process fits with the cybernetic and constructivist ideas on which the Reflecting Team Model is based.

This participant observer role may seem in contrast to Gurman and Kniskern's (1978) views on the separation of the roles of the therapist and the researcher. Smith et al. (1992, 1993) worked on combining these researcher perspectives/roles by involving a small research team in the ongoing reflecting team processes for a three month period where the research team observed the therapist-family sessions and participated in the reflecting team discussions and activities. These authors (Smith et al., 1992, 1993) took the stance that the participant observer method provided the flexibility for one of the authors to take on the dual role of research team member and clinical supervisor of the reflecting team in the university based clinic that was the study site. However, it did not appear that this dual role by the faculty member included taking on the role of therapist with the subjects/participants in the study which is consistent with Gurman and Kniskern's (1978) call for separation of the therapist and researcher roles.

In this study, the author also takes on the dual role of researcher and supervisor of the therapy team at the study site. Since the study site is not a university based clinic but a community counseling center with an emphasis on service provision, the researcher also had to take on the role of therapist or co-therapist frequently during the time frame of the study. Other factors involved in the combining of these roles included the lack of family therapy staff at

the clinic site, the lack of clinical experience for some of the trainees on the therapy team, and a concern about the quality of the therapy provided for the couples/families seen by the therapy team.

In an effort to be cognizant of Gurman and Kniskern's (1978) concerns for separation of roles, this author attempted whenever possible to take an observing team member role rather than the therapist role in the clinical work with couples/families. The author also made efforts to separate the roles of therapist and researcher whenever possible. Whenever qualitative interviews were conducted with couples/families where the author was the therapist, a member of the observing therapy team conducted the qualitative interviews with the subjects/participants. There is only one exception to this where the author was the co-therapist and qualitative interviewer for one couple, in the study, due to scheduling demands on the other team members which didn't allow anyone else to perform the qualitative interview with this couple. This blurring of roles was pointed out to the couple in question during the qualitative interview. When the author was a member of the observing therapy team and not the therapist, the author was the participant/conductor of the qualitative interviews with the couples/families in the study. The reasons for this being the lack of a research team or human resources at the study site and the intention by the author to not burden

team members with the author's own research work whenever possible.

The Observing Team

During the sixteen month time period when data were collected, membership of the observing team did not remain constant. The author was the only stable member of the team and was present for all three weekly time slots where the therapy team approach to therapy was used at the study site. A sociology faculty member from a local university was present throughout the study period for one of the three time slots as well. A family therapist colleague from the study site was a team member for five months of the study period. The remainder of the team members were made up of masters level graduate students and one doctoral level graduate student. These students participated in the family therapy team out of either interest in family therapy or as part of their practicum requirements at the study site. The team members ranged in age from 24 to 58 years and included people of various socioeconomic status. The group was Caucasian in racial makeup and generally had more women than men on the team at any one time. The range of clinical and family therapy experience ranged from no prior experience to ten years experience. For the most part, the majority of team members had only limited or no clinical experience. However, two graduate students had experience in chemical dependency treatment and the one doctoral student had some

experience working with a Structural/Strategic Family Therapy team in a university based training clinic. The author had been working with a Reflecting Team Model one day a week for four and a half years when the study began. No other team members had any prior clinical experience in using a Reflecting Team Model before becoming team members except for the local faculty member who had been a member of the reflecting team at the study site for a year prior to the beginning of the study.

Since many of the team members did not have knowledge of the Reflecting Team Model, this author gave the team members frequent theory and practice papers from the literature on this model as well as papers on the Strategic and Solution-Oriented Models of family therapy. Periodically, the author would use didactics and role playing to help initiate team members in the Reflecting Team and Strategic/Solution-Oriented Models. The interest level of the team members in learning more about the Reflecting Team and the Strategic/Solution-Oriented Team Models of treatment varied greatly. Differing theoretical preferences by team members and the feeling that many of the student team members had of being overloaded with readings from their academic courses contributed to this variation.

The actual process and operation of the team varied according to whether a couple/family was receiving the Reflecting Team Model or the Strategic Team Model. The

number of observing therapy team members for a particular team therapy session ranged from one to seven team members.

Dependent Variables

The dependent variables were the couples'/families' perceptions and attitudes of the therapy process and the therapy team members' perceptions and attitudes of the therapy process as well. As a second order cybernetics perspective suggests, the family-therapist-therapy team form an observing system with recursive interactions which indicates that the therapy process effects not only the family but the therapist and the therapy team as well. Therefore, perceptions of the therapy process from both the families and the therapy team members were gathered.

In measuring the couples'/families' perceptions of the therapy process quantitatively, a self-report instrument was used with subscales attempting to measure the overall positive or negative view of the treatment process, the couples'/families' perceptions of how the therapist views them, the couples'/families' perceptions of their ability to develop their own solutions for the presenting problem, the couples'/families' perceptions of hopefulness that the presenting problem will be reduced or resolved, the couples'/families' perceptions of being listened to and understood by the therapist, the couples'/families' perceptions that the therapist and family are a team working together to resolve the presenting problem, the

couples'/families' perceptions of liberation from their previous view of the problem, and the couples'/families' perceptions of being manipulated by the therapist.

Another measure of the dependent variable was the data collected from couples/families in the qualitative interviews. The qualitative interview questions attempted to complement the data that was obtained from the self-report instruments. Theoretically, the qualitative interview questions stem from the work of Andersen (1987, 1990) on the Reflecting Team Model and from Tomm's (1987a, 1987b, 1988) work on interventive interviewing.

The other quantitative dependent variable measure of the couples'/families' perceptions of the therapy process was the observational coding of two five minute segments of videotape of the marital/family therapy session done immediately prior to the collection of the posttest data.

Just as qualitative research measures are used to elicit the perceptions of the therapy process for couples/families, the therapy team members' perceptions of the therapy process were measured by qualitative interviews of current and past therapy team members who have participated in the team process during the time frame of the study. The qualitative interview asked team members of their experience using a Reflecting Team Model and asked them to compare the Reflecting Team Model with their experience using the Strategic Team Model. Besides the team

members' qualitative comparisons of the two team treatment models there was also a quantitative comparison of their level of comfort in using each of the team treatment models with a variety of commonly encountered clinical problems.

The overall purpose was to gain multiple perspectives on the therapy process by the various participants (i.e., the couples/families, the therapist, and the team members) in the treatment process and to see if these multiple perspectives complement each other (Gurman & Kniskern, 1978).

In the collection of the measures of the dependent variable, considerable effort had been made to gain sources of information/data from each couple/family on all three measures (i.e., the self-report instrument, observational coding system, and the qualitative interview). This was accomplished on some of the couples/families in the sample but did not occur with all couples/families in the study. For example, some subjects/participants, due to time constraints, took the posttest self-report questionnaire home to fill out and did not return it. Some subjects did not feel comfortable being videotaped for the observational coding and some subjects/participants agreed to the qualitative interview but did not have the time to stay after the therapy session to be interviewed. Again, given the exploratory nature of the study and the state of existing empirical research on the Reflecting Team Model, it

was decided that even partial data could be useful in understanding how the reflecting team process is being experienced by clients and professionals alike.

Research Hypotheses for the Clients Stated in the Null Form

1. There will be no difference in the perceptions of the therapy process between couples/families in the two treatment groups X1 and X2, where X1 is the Reflecting Team Model and X2 is the Strategic Team Model.
2. There will be no difference between the two treatment groups in the couples'/families' ability to find and use their own solutions to the presenting problem.
3. There will be no difference between the two treatment groups in the couples'/families' sense of hopefulness that the presenting problem will be resolved.
4. There will be no difference between the two treatment groups in the perceptions by the couples'/families' that they are united with and working together with the therapist in solving the presenting problem.
5. There will be no difference between the two treatment groups in the couples'/families' level of interest and cooperation in the therapy process.
6. There will be no difference between the two treatment groups in the couples'/families' ability to change their original view of the problem.
7. There will be no difference between the two treatment

groups in the couples'/families' perceptions of being manipulated by the therapist.

Research Hypotheses for the Therapy Team Members Stated in the Null Form

1. There will be no difference in preference for team members in terms of whether to use a Reflecting Team Model or a Strategic Team Model.
2. There will be no difference in team members' ability to focus on clients' strengths, exceptions to the problem, and on solutions to the problem when either a Reflecting Team Model or a Strategic Team Model is used.
3. There will be no difference in team members' awareness of and attention to the clients' problems, and problematic patterns when either a Reflecting Team Model or a Strategic Team Model is used.
4. There will be no difference in team members' experience of whether their ideas/interventions for the clients are listened to in the therapy process whether a Reflecting Team Model or a Strategic Team Model is used.
5. There will be no difference in team members' perceptions of the cooperativeness among the team members whether a Reflecting Team Model or a Strategic Team Model is used.
6. There will be no difference in team members' perceptions of their effort to attend to and focus on the family therapy interview whether a Reflecting Team Model or a Strategic Team Model is used.

7. There will be no difference in team members' perceptions of the pressure or anxiety that they feel to come with ideas/interventions for the clients whether a Reflecting Team Model or a Strategic Team Model is used.

8. There will be no difference in team members' experience of any hierarchical differences or professional distance between the therapy team and the clients whether a Reflecting Team Model or a Strategic Team Model is used.

9. There will be no difference in team members' experience of themselves as active participant observers in the therapy process whether a Reflecting Team Model or a Strategic Team Model is used.

10. There will be no difference in the therapists' perceptions of being supported and not judged by the therapy team whether a Reflecting Team Model or a Strategic Team Model is used.

11. There will be no difference in the therapists' perceptions of being connected to and aligned with the clients whether a Reflecting Team Model or a Strategic Team Model is used.

12. There will be no difference in the therapists' perceptions of the clients' ability to focus on their own ideas and solutions to their problems whether a Reflecting Team Model or a Strategic Team Model is used.

13. There will be no difference in the therapists' perceptions of the clients' comfort level and ease with the

therapy team process whether a Reflecting Team Model or a Strategic Team Model is used.

14. There will be no difference in the therapists' or the therapy team members' perceptions of the usefulness and effectiveness of the therapy team process whether a Reflecting Team Model or a Strategic Team Model is used.

Population and Sample

Given the already stated constraints in finding subjects for the study, it was proposed that each of the two treatment/comparison groups (X1 and X2) have a sample size of ten couples/families in each group (n=10). Issac and Michael (1983) indicated that small sample sizes with N's of 10 to 30 are easy to work with, allow for easier calculations, are adequate enough to test the study's hypotheses, and the N is small enough to prevent the appearance of less significant treatment effects that may be due to having a large sample for the study. The sample was drawn from a larger population of couples/families that are seeking marital/family therapy for some kind of marital/family problem. The population is generally low and middle income couples/families from an urban area in Oklahoma and the majority were Caucasian. The time constraints on the author made it difficult to develop a larger and more desirable sample size. As noted earlier, problems in solicitation of subjects combined with the time constraints for completion of this study led the author to

end the study prior to getting the desired sample size for the two treatment groups. This will be taken into account in the analysis of the data from the study.

Clearly, the study would be more rigorous (i.e., more statistical power and generalizability) with a larger sample but this was not practical for the completion of the study. Issac and Michael (1983) in discussing the selection of a large or small sample indicate that "between the economy and convenience of small samples and the reliability and representativeness of large samples lies a trade off point balancing practical considerations against statistical power and generalizability" (p. 190). These authors (Issac & Michael, 1983) suggested that small samples may be more useful than larger samples in studies involving various types of therapy/counseling or intensive interviewing. In a review of the literature on the Reflecting Team Model, the number of studies remains small and the sample sizes used in these studies are also small (Andersen, 1987, 1990; Griffith et al., 1992; Hoger et al., 1994; Sells et al., 1994; Smith et al., 1992, 1993, 1994).

As stated earlier in the chapter, the study sample was derived primarily from two sources. One was from couples/families who received either of the team treatment therapies for their first four therapy sessions at the study site. The other primary source was from the subgroup of couples/families who had received two to four sessions of

individual marital/family therapy and then received one of the team treatment therapies for their next two therapy sessions. In both of these sources for the two treatment groups, subjects were randomly assigned to the two treatment groups by the author.

The exceptions to the random assignment included the family that was referred to the family therapy team for their twelfth and last therapy session (in this case, the referring therapist requested a Reflecting Team Model) and one family that was referred due to child sexual abuse. The later family was also going through very stressful legal proceedings at the time of referral. For this family and the context it was in, the author made a clinical decision to use the Reflecting Team Model. This indicated the author's bias for the Reflecting Team Model over the Strategic Team Model. The author made the assumption that this family would have some difficulty with a team of observers, given the presenting problem, so the author assumed that the Reflecting Team Model would be less stressful for the family since the family gets to see and hear from the reflecting team directly in the therapy session. (With this particular case, Strategic therapists would argue that a Strategic Team Model can be quite sensitive to these issues as well.)

This last case, nonrandomly assigned to its treatment group, brings up the issue of the researcher's theoretical

preference for the use of a Reflecting Team Model in working with observing therapy teams in family therapy. However, the author is aware of this bias and made efforts to see that couples/families receiving the Strategic Team Model of treatment continued to receive therapy on a level comparable to the level achieved by the subjects in the Reflecting Team Model.

Instrumentation

The scales and subscales for the pretest and posttest measures are presented below. The reliability levels reported for each scale represents the level reported by the authors' of the scales in the original reliability and validity studies for each scale. The scales and subscales for the pretest measure included: The Family Issues Scale (FIS) (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1982) which is a 20 item self-report questionnaire that examines the stress in a family over the past year and has a reliability (alpha) of .85. The scale was used to measure the level of stress for families prior to beginning therapy. The Family Coping Style Scale (FCSS) (Olson et al., 1982) is a 10 item self-report scale that measures how a family is responding to stress; it has a reliability (alpha) of .83. The scale was used to measure the families perceived responses to stress in their lives at the pretest and posttest stages. The Family Communication Scale (FCS) (Olson et al., 1982) is a 10 item self-report questionnaire

that measures the quality of the communication within a family; it has a reliability (alpha) of .79. It was used to measure the perceived quality of couples/families communication at the prettest and posttest stages.

The Family Satisfaction Scale (FSS) (Olson et al., 1982) is a 10 item self-report questionnaire that measures the overall level of satisfaction within a family; it has a reliability (alpha) of .91. It was used to measure the overall satisfaction level for couples/families at the pretest and posttest stages. A revised version of The Problem Solving Confidence Subscale of the Problem-Solving Inventory (PSI) (Heppner & Peterson, 1982) is an 11 item self-report questionnaire that measures an individual's perceived confidence in solving their problems; it has a reliability (alpha) of .85. The subscale is one of three subscales that make up the 32 item Problem Solving Inventory (PSI). This subscale was revised by the addition of two items by the author and the items were rewritten to reflect a couple/family perspective rather than a self perspective. The subscale was used to assess the perceived level of problem solving confidence for couples/families at the pretest and posttest stages. Analysis of possible effects of the modification will be estimated in this study.

The General Functioning Subscale of the McMaster Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983) is 12-item questionnaire that measures the overall level of

family functioning; it has a reliability (alpha) of .92. This subscale was used to measure the level of functioning for couples/families at the pretest and posttest stages. The Hopelessness Scale (HS) (Beck, Weissman, Lester, & Trexler, 1974) is a 20 item true-false self-report questionnaire that measures the sense of hopelessness in individuals; it has a reliability (alpha) of .93. Sixteen items in the scale were rewritten to reflect a family perspective and were used to assess a continuum of hopelessness to hopefulness at the pretest and posttest stages. The items used had the scoring reversed for the study to better reflect the hypothesized relationships. The pretest self-report scale was comprised of 91 items. For a copy of the pretest questionnaire, see Appendix D.

The posttest measure included the following (sub)scales which have been described in the preceding paragraphs: The Family Coping Style Scale (FCSS) (Olson et al., 1982), The Family Communication Scale (FCS) (Olson et al., 1982), The Family Satisfaction Scale (FSS) (Olson et al., 1982), a revised version of the Problem Solving Confidence Subscale of the Problem-Solving Inventory (PSI) (Heppner & Peterson, 1982), The General Functioning Subscale of the McMaster Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983), and a revised version of the Hopelessness Scale (HS) (Beck et al., 1974).

The following scales were not used in the pretest

questionnaire but are part of the posttest instrument. The Mental Health Locus of Control (MHLC) Scale (Hill & Bale, 1980) is a 22 item self-report questionnaire that measures individuals' beliefs as to where the control for change in psychotherapy lies in terms of being the client's or the therapist's responsibility. The MHLC Scale has a reliability (alpha) of.84. Eighteen of the 22-items on the MHLC Scale were rewritten to reflect a family perspective and the revised 18 item scale was used in the study to measure couples'/families' beliefs as to whether change occurred due to their behavior or due to the behavior of the therapist.

The Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986) is a 29 item self-report questionnaire that measures the therapeutic alliance between the family and the therapist; it has a reliability (alpha) of .94. The FTAS Scale was used to measure the strength of the therapeutic alliance between the couples/families and the therapist. The last scale in the posttest instrument is the Session Evaluation Questionnaire (SEQ) (Stiles, 1980) which is a 22 item scale made up of 22 bipolar adjectives in a semantic differential format; it has a range of reliability (alpha) from .78 to .91. The SEQ Scale is designed to measure the perceptions and impact of a psychotherapy session that has just been finished. The SEQ scale was used in the study to measure the perceptions and feelings of couples/families

about their family therapy session just preceding the collection of the posttest data. This self-report posttest instrument has 141 items. For a copy of the posttest questionnaire, see Appendix E.

The qualitative research measure for clients includes eleven open-ended questions that the interviewer asked the couples'/families' about their perceptions of the treatment they received, their perceptions on how they believe the therapist and team view the client system, their current view of the presenting problem, possible new ideas or solutions in solving the problem, and a comparison with any previous or current therapies. For a copy of the clients' qualitative interview questions, see Appendix F.

The qualitative interview questions for the therapy team members were comprised of 28 open-ended questions that the interviewer asked the therapy team members. The first 9 questions were developed by Smith et al. (1992, 1993) in order to understand the clinical process of how the Reflecting Team Model works from the perspectives of the team members. Questions 10 through 28 were developed by the author in order to compare the contrasting and similar experiences and perceptions of the therapeutic process by therapy team members when the Reflecting Team and the Strategic Team Models were used. In the last part of the qualitative interview with the therapy team members, the author gave the team members a list of clinical problems and

asked them to rate on a 7-point Likert Scale how comfortable they were using each of the two therapy team models with each particular clinical problem. For a copy of the therapists'/team members' qualitative interview questions and a description of the therapists'/team members' ratings of the two treatment models, see Appendix G.

The last instrument to be used to assess the clients' experience of the therapy process is 16 item observational coding system measuring the therapy process from the outsider perspective. A review was made of the most widely used observational coding systems in the individual and the family therapy process research literature such as the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974), Family Therapist Coding System (FTCS) (Pinsof, 1980), The Client Resistance Code (CRC) (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1982) and the Marriage and Family Interaction Coding System (MFICS) (Olson & Ryder, 1978).

In a study noted earlier in the chapter by Griffith et al. (1992), the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974) was used by that research team to code the impact of the reflecting team process on families communication patterns. Griffith et al. (1992) reported that the SASB is one of the few observational coding systems that can adequately capture and code the richness and complexity of human interaction that occurs within family

systems. However, the author decided not to use the SASB, in this study, due to the significant amount of time needed to learn the coding system and to train raters in the coding system. The time to learn and train raters was one of the major obstacles to using any of these coding systems.

Therefore, given the time constraints, the author developed a preliminary coding system that included some of concepts found in study by Griffith et al. (1992) as well as some of the concepts hypothesized in this study. This observational coding system has not been validated in the literature and has no evidence of reliability at this time. However, given the exploratory and preliminary nature of this study, it is hoped that this rough coding system will provide the outsider perspective that Gurman and Kniskern (1978) recommend in family therapy research. Issues of interrater reliability were important in the analysis of the observational coding system and any conclusions from the findings will not be generalizable beyond this sample population.

Procedures

Couples/families were asked to complete the agency site's intake forms and the pretest questionnaire just prior to the initial therapy session at the agency where the data were collected. Couples/families agreeing to participate in the study were asked to give permission to videotape the therapy session immediately preceding the collection of

posttest data. After the videotaping of the clinical session, the couples/families were asked to participate in a face-to-face qualitative interview that was audiotaped. Upon completion of the qualitative interview, the couples/families were asked to complete the posttest questionnaire. Due to the length of the therapy session and the data collection process, some couples/families could not stay at the clinic site to fill out the posttest questionnaire. These couples/families were given the questionnaire to fill out at home and mail the completed questionnaire to the author.

Current and former therapy team members were asked to participate in qualitative interviews with the author; these interviews were also audiotaped. The author explained that the first part of the interview focused on the team members' experience using the Reflecting Team Model and the remainder of the interview focused on comparing the Reflecting Team Model with the Strategic Team Model. Team members were asked to use their own judgement in interpreting the interview questions and to feel free to be negative or critical of the therapy process.

For the observational coding system, the independent raters were given a summary of how to use the observational coding sheet and the author explained and went over the handout of the behavioral examples of the theoretical constructs that were used to help the raters to learn the

coding system. The author used videotapes of therapy sessions to review and practice the coding system with each independent rater prior to the raters use of the observational coding system with the clients in the study. The raters were asked to not review or code a videotaped segment if they recognized anyone person on the tape. To review the observational coding system and the coding sheet used by the raters, see Appendix H.

Data Collection

Pretest data were collected just prior to the initial interview for the couples/families. Posttest data were collected in one of two ways: first, subjects in the early part of the study were asked while they were filling out intake forms if they would be willing to participate in the study. This strategy was not successful in recruiting participation in the study. An adjustment to this involved asking subjects who began treatment using the therapy team process at the beginning of their fourth therapy session if they would be willing to participate in the study. If the couple/family agreed to participate, then the fourth session was videotaped and a qualitative interview and posttest questionnaire were administered immediately following the fourth session. Second, for couples/families that began treatment with an individual family therapist without the use of the therapy team, these couples/families were asked to participate in the study in their second to fourth

therapy session with their individual therapist. The next two therapy sessions for these clients involved using the therapy team. Data were collected for these couples and families during and after the second therapy session with the therapy team. With the shift to using the therapy team with these couples/families, their therapist remained constant.

The collection of data from the therapy team members using qualitative research techniques occurred during the month of April, 1993. The team members interviewed included current team members and former team members who had not participated in the team process for a period of five to eleven months.

In the observational coding, the first five minute segment of the interview to be coded was at the twenty minute mark in the session and the second five minute segment was immediately following the reflecting team intervention or right after the therapist-team consultation behind the one way mirror in the Strategic Team Model. With the Strategic Team Model, if the team phoned in an intervention prior to the twenty minute mark in the session, the five minutes of interaction just before the phone contact was used as the coded segment. The time line graphs in Appendix I may be useful as a visual aid in understanding the data collection process.

Data Processing and Analysis

Given the purposes of this study, to examine subject perceptions of the therapy process, the author did not use a statistical test that examines a cause-effect relationship between variables when the data from the study were analyzed. Finding a cause-effect relationship would be impossible with the confounding variables in the study as well. Since this study attempted to examine the perceptions of the therapy process, the author was looking at the strength of the relationship between the two methods of family therapy and the perceptions of the therapy process by both couples/families and the therapy team members.

However, t-tests were used to compare scores on the (sub)scales used in the pretest and posttest questionnaires. The t-tests were used to examine whether there were differences on each scale from the pretest to posttest periods for each treatment group. Comparisons at the posttest period examined differences in scores between treatment groups. To assess sample representativeness, pretest stage results were compared between the treatment groups and the larger group of clinic couples/families who chose not to participate in the study. The t-tests were also used to compare team members' quantitative responses to using the two treatment models given at the end of their qualitative interviews. The t-tests were also used to compare the clinical impressions of the independent raters

on each of the concepts used in the observational coding system.

The responses to the qualitative interview questions for both the subjects and the therapy team members were reviewed by the author to look for general patterns about the therapy process and for each particular treatment model. Smith et al. (1992) used a small research team to review their qualitative interview responses in order to elicit "representative and unique responses" from the qualitative data (Smith et al., 1992, p. 8). In this current study, the author looked for common themes and patterns as well as "unique responses" from the qualitative data but the author did not have the use of a research team to assist with the process.

Methodological Assumptions

Given the difficulty soliciting subjects for the study and concerns about mortality of subjects during the study period, it was assumed that subjects had enough treatment sessions after the fourth therapy session, (if their treatment was solely with the family therapy team), to respond to the dependent variable measures. It was also assumed that subjects, where their initial 2 to 4 therapy sessions were without the therapy team, were able to respond to the dependent variable measures after their second session with the therapy team. In both of these paths, the assumption was that the therapists were able to join with

the couples/families initially, that they were able to develop a clear understanding of the problem for both the therapist and the family, and that they discussed some possible solutions to the problem.

At times, there is little cross-over in use of self-report instruments that are used in the individual therapy and family therapy fields (Pinsof & Catherall, 1986). The self-report instruments used in individual therapy treatment models were designed from theories of individual personality development to be used with individual psychotherapy clients. The marital/family self-report instruments have generally been derived from systems theories and have been used to assess the larger family system rather than the individual subsystem within the larger family system. Some of the instruments used in this study were developed for individual therapy clients and have not previously been adapted for use with the larger family system. It is hoped that these scales which were revised to reflect the larger unit of treatment (i.e., couple or family) will contribute to a wider use of these instruments to encompass family systems as well. The reliability of the revised scores will be compared with the original reliability scores for these instruments.

Limitations

Since this study was drawn from a client population of mostly self-referred couples and families that were seeking

marital/family therapy, it was difficult to develop a large sample for the study. Other difficulties in developing a large sample size included the context of the study site, the time constraints, and the lack of staff and financial resources. The extensive amount of data collected also reduced the number of participants in the study.

The small sample size and the confounding variables (i.e., some subjects receiving individual marital/family therapy prior to using one of the therapy team models and the lack of random assignment to treatment groups in two of the cases) are threats to the internal and external validity of the study. These factors rule out the use of a true experimental design and require the use of an exploratory study design. Given the recent development of the Reflecting Team Model in the family therapy field and the lack of intensive empirical studies on this model, it is believed that many useful findings could emerge from exploratory/descriptive findings despite the numerous limitations in the current study.

Given the difficulty in collecting data experienced in the study and the extensive amount of data requested from subjects, not all subjects completed all of the quantitative and qualitative measures of the dependent variable. This complicated the statistical analysis of the data but should still provide useful information.

Another limitation is the aspect of the author's bias

as to his theoretical and treatment preference for the Reflecting Team Model over the Strategic Team Model. The author made efforts to distribute literature on both treatment theories and models of practice and to provide didactic discussions on both models. The author and the other team members made efforts to perform competently given our own limitations as clinicians. Subjects received the best therapy that we could provide regardless of the treatment model employed with any given family. However, a personal preference for the Reflecting Team Model was present and stated by the author and had some influence on the other team members experience of the therapy process.

Gurman and Kniskern (1978) pointed out how a study's research design is weakened when the therapist is not able to separate the roles of therapist and researcher. In this study, there was difficulty in separating the role of therapist and researcher due to staff and time limitations. As Gurman and Kniskern (1978) indicated, limited training and expertise of therapists in a treatment model or approach limits the effectiveness of the treatment provided and the potential conclusions that can be made from the data. (In general, caution must be exercised in any generalization of the results in any family therapy process or outcome study.) In the present study, the general theoretical and clinical inexperience of the therapy team members was another limitation in this study's design.

Since the research design in this study is weakened due to the above limitations, it calls into question the value of the findings in this study. However, given the recent development of the Reflecting Team Model, and the small number of studies on the model, it is argued that the findings do contribute to the existing knowledge on the Reflecting Team Model. Some researchers in the family therapy field (Moon et al., 1990, 1991; Sells, Smith & Sprenkle, 1995) have pointed out the need for qualitative methods to further theory generation with new theoretical models of practice. From this qualitative process, theoretical constructs can be brought forth for further empirical analysis using quantitative methods.

With a new model of practice like the Reflecting Team Model, the role of therapist as researcher may prove useful in the initial qualitative analysis of this new model. In such a new model, a researcher, without familiarity with the Reflecting Team Model, may not have enough information on the model to adequately do a qualitative analysis. As Moon et al. (1990, 1991) indicated the role of the researcher as a participant observer fits quite well with qualitative analysis. This fits with the scientist-practitioner model of the blending of the roles of practitioner and researcher as well. As the exploratory studies on the Reflecting Team Model are completed, the next stage in the research will be to have quantitative studies that have tighter controls on

extraneous and confounding variables where there is a clearer separation between the therapist and the researcher.

Operational Hypotheses for the Clients Stated in the Null Form

1. There will be no difference in the level of stress for couples/families in the two treatment groups at pretest stage as measured by the Family Issues Scale (FIS) (Olson et al., 1982).
2. There will be no difference in the responses to stress for couples/families in the two treatment groups at either the pretest or posttest stages as measured by the Family Coping Style Scale (FCSS) (Olson et al., 1982).
3. There will be no difference in the type of communication for couples/families in the two treatment groups at either the pretest or posttest stages as measured by the Family Communication Scale (FCS) (Olson et al., 1982).
4. There will be no difference in the level of satisfaction for couples/families in the two treatment groups at either the pretest or posttest stages as measured by the Family Satisfaction Scale (FSS) (Olson et al., 1982).
5. There will be no difference in the level of problem solving confidence for couples/families in the two treatment groups at either the pretest or posttest stages as measured by a revised version of the Problem Solving Confidence Subscale of the Problem-Solving Inventory (PSI) (Heppner & Peterson, 1982).

6. There will be no difference in level of functioning for couples/families in the two treatment groups at either the pretest or posttest stages as measured by the General Functioning Subscale of the McMaster Family Assessment Device (FAD) (Epstein et al., 1983).

7. There will be no difference in the level of hopefulness for couples/families in resolving their presenting problems in the two treatment groups at either the pretest or posttest stages as measured by a revised version of the Hopelessness Scale (HS) (Beck et al., 1974).

8. There will be no difference in the perceived responsibility and origin of therapeutic change for couples/families in the two treatment groups at the posttest stage as measured by a revised version of the Mental Health Locus of Control Scale (MHLC) (Hill & Bale, 1980).

9. There will be no difference in the perceived strength of the therapeutic alliance for couples/families in the two treatment groups at the posttest stage as measured by the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986).

10. There will be no difference for couples/families in the two treatment groups at the posttest stage in their perception of the therapist's ability to focus on therapeutic tasks that are meaningful to the clients and are directed at the couples/families stated problems as measured by the Family Therapy Alliance Task Subscale of the Family

Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986).

11. There will be no difference for couples/families in the two treatment groups at the posttest stage in their perception that they are in agreement with the therapist on the goals that need to be worked on in the therapy as measured by the Family Therapy Alliance Goal Subscale of the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986).

12. There will be no difference for couples/families in the two treatment groups at the posttest stage in their perception of the therapeutic bond between the therapist and the couple or family as measured by the Family Therapy Alliance Bond Subscale of the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986).

13. There will be no difference in the perceived impact of therapy session immediately preceding the collection of posttest data for couples/families in the two treatment groups as measured by the Session Evaluation Questionnaire (SEQ) (Stiles, 1980).

14. There will be no difference in the overall perceptions of the therapy process for couples/families in the two treatment groups as measured by qualitative interview data.

15. There will be no difference between the two treatment groups in the overall clinical impressions of the videotaped

segments of the couples'/families' therapy sessions immediately preceding the collection of posttest data by the independent raters.

CHAPTER IV

FINDINGS

This chapter presents the findings of this study and is divided into five different sections: one for each type of data collected in the study. The sections include: (1) the clients' responses to the quantitative self-report instruments; (2) the observational coding of clients' videotaped segments of their therapy sessions; (3) the therapists'/team members' responses to the quantitative measure of their comfort level in using the team treatment models with various clinical problems; (4) the clients' responses to qualitative interviews; and, (5) the therapists'/team members' responses to qualitative interviews. Each section presents the findings with a discussion of the data collected in that category. At the end of the chapter a discussion of the findings for the entire study is presented.

Demographic Data

The clients' demographic information is presented in Table 1. The demographic data presented includes data on all clients who initially enrolled in the study. However, due to subject mortality, not all clients represented in the table completed the study. Some clients participated in all

the data collection phases, some clients participated in part of the data collection process, and some of the clients withdrew from the study. For the study participants, the mean age was 30.9 years old, the mean level of education for the adults was 12.7 years, the mean income was $19,413, and the mean length of the presenting problem was 2.4 years. The subjects were more female (59%) than male (41%) and predominantly Caucasian (89%). The presenting problems were usually multiple in nature at the time of intake. The presenting problem listed in Table 1 is the primary problem as seen by the clients even though many of the clients presented with multiple concerns.

Table 1

Client Demographics

Category		Frequency	Percent	Mean
Sex:	male	19	41	
	female	27	59	
Age:	12-18 years	10	22	
	19-29 years	11	24	
	30-49 years	21	46	
	50-69 years	4	9	30.9
Education:	1-8 years	1	3	
	9-11 years	3	8	
	high school graduate	16	44	12.7
	13-15 years	14	39	for
	college graduate	2	6	adults
Race:	Caucasian	41	89	
	African American	4	9	
	Native American	1	2	

(Table 1--continued)

		Frequency	Percent	Mean
Family type:	first marriage intact	7	15	
	divorced/single parent	9	20	
	separated/single parent	6	13	
	blended	18	39	
	remarried/no children	2	4	
	divorced/no children	2	4	
	live-in relationship	2	4	
Stated problem:	parent-child	17	37	
	school problem	4	9	
	alcohol/drugs	0	0	
	child abuse	2	4	
	marital conflict	15	33	
	relationship	4	9	
	domestic violence	2	4	
	depression	0	0	
	suicide attempt	2	4	
Income:	0- 8,000	10	22	
	8,001-16,000	9	20	
	16,001-24,000	16	35	
	24,001-32,000	5	11	
	32,001-40,000	2	4	
	over-40,000	4	9	19,413
Past therapy:	Yes	23	50	
	No	23	50	
Current therapy:	Yes	5	11	
	No	41	89	
Length of problem:	0-6 months	16	35	
	7-12 months	9	20	
	13-23 months	0	0	
	2-5 years	19	41	
	6-10 years	2	4	2.4 years

Analysis of the Clients' Responses to the Quantitative Measures

Findings/Results of the Clients' Quantitative Measures

The self-report client questionnaires contained (sub)scales that had not previously been adapted for use with the larger family system. These (sub)scales were revised by the researcher to reflect the larger unit of treatment (i.e., couple or family). These revised (sub)scales were noted in the instrumentation section in Chapter III. Given the changes made in these (sub)scales and due to the limited number of client responses to the posttest questionnaires, reliability (alpha) estimates were obtained for the (sub)scales used in the study's pretest and posttest questionnaires. These reliability (alpha) scores were compared with the original reliability (alpha) scores for the instruments used in this study. The pretest instrument comparisons can be found in Table 2. The posttest instrument comparisons can be found in Table 3.

The alpha coefficients in this study were generally high enough to be considered acceptable and were generally comparable to the original reliabilities of the instruments; the range was from .66 to .93. However, alpha coefficients for the Family Coping Style Scale (FCSS) (Olson et al., 1982) at pretest (alpha .69) and posttest (alpha .66) fall within the low acceptable range, particularly when compared to the original alpha coefficient of .83. The (sub)scales that were revised by the researcher had alpha coefficients at pretest and posttest that were high enough to be

considered within an acceptable range. The revised Problem Solving Inventory Subscale (PSI) (Heppner & Peterson, 1982) had alpha coefficients at pretest and posttest of .80 and .88 respectively which compared favorably to the original alpha coefficient of .85. The revised Hopelessness Scale (HS) (Beck et al., 1974) had alpha coefficients at pretest and posttest of .88 and .92 respectively which compared favorably to the original alpha coefficients of .92/.83/.86. The revised Mental Health Locus of Control Scale (MHLC) (Hill & Bale, 1980) had an alpha coefficient at posttest of .72 which is in the acceptable range but lower than the original alpha coefficient of .84. The current reliabilities lend support for the adaptations/revisions and use of these (sub)scales for the purposes of the study but should not be generalized to any larger clinical population.

Table 2

Comparison of Pretest Instrument Alpha Scores with Original Alpha Scores

Scale	Total number of cases	Number of cases for alpha score	Number of items	Ranges of scores in theory
Family Issues Scale	99	61	20	20-100
Family Coping Style Scale	99	80	10	10-50
Family Communication Scale	99	93	10	10-50
Family Satisfaction Scale	99	90	10	10-60
Problem Solving Inventory Subscale*	99	68	13	13-78
Family Adaptability Subscale	99	81	12	12-48
Hopelessness Scale*	99	64	16	16-32

(Table 2--continued)

Scale	Mean	SD	Actual range	Sample alpha	Original alpha
Family Issues Scale	49.04	11.35	27-82	.74	.85
Family Coping Style Scale	29.99	5.87	14-47	.69	.83
Family Communication Scale	26.95	6.05	10-45	.79	.79
Family Satisfaction Scale	30.21	9.23	10-49	.89	.91
Problem Solving Inventory Subscale*	44.12	6.29	18-60	.79	.85
Family Adaptability Subscale	29.60	3.34	20-45	.87	.92
Hopelessness Scale*	23.77	1.87	18-28	.88	.92/.83 /.86

Key for Table:

* Indicates scales revised for this study

Table 3

Comparison of Posttest Instrument Alpha Scores with Original Alpha Scores

Scale	Total number of cases	Number of cases for alpha score	Number of items	Ranges of scores in theory
Family Coping Style Scale	17	11	10	10-50
Family Communication Scale	17	15	10	10-50
Family Satisfaction Scale	17	15	10	10-60
Problem Solving Inventory Subscale*	16	13	13	13-78
Family Adaptability Subscale	16	13	12	12-48
Hopelessness Scale*	17	12	13	16-32
Locus of Control Scale*	16	13	18	18-108
Family Therapy Alliance Scale	17	12	29	29-203
Session Evaluation Questionnaire Scale	17	12	22	22-154

(Table 3--continued)

Scale	Mean	SD	Actual range	Sample alpha	Original alpha
Family Coping Style Scale	29.12	5.51	21-37	.66	.83
Family Communication Scale	30.88	5.13	21-40	.87	.79
Family Satisfaction Scale	36.41	7.30	19-44	.86	.91
Problem Solving Inventory Subscale*	46.88	4.76	39-54	.88	.85
Family Adaptability Subscale	29.00	2.66	22-33	.92	.92
Hopelessness Scale*	24.94	1.56	22-27	.92	.92/ .83/.86
Locus of Control Scale*	65.31	6.34	57-75	.72	.84
Family Therapy Alliance Scale	112.17	6.00	101-125	.93	.94
Session Evaluation Questionnaire Scale	113.24	20.73	80-145	.93	.78 to .91

Key for Table:

* Indicates scales revised for this study

T-tests were preformed to compare scores on the (sub)scales used in the pretest instrument in order to examine whether there were any differences between the subjects in the two treatment groups, and between the subjects in each treatment group and the larger group of clients at the study site who did not participate in the study. Table 4 indicates the pretest t-test scores for the Reflecting Team treatment group as compared to the control group (i.e., study site clients not participating in the study). The results do not show any significant differences between these two groups on any of the pretest (sub)scales. This indicates that the Reflecting Team treatment group subjects are comparable to the larger clinical population at the study site as measured by the pretest instrument.

Table 4

Pretest t-Test Scores For Reflecting Team Treatment Group and Control Group

Scale	# of cases		RT mean	RT SD	CT mean	CT SD	t Value	DF	Prob
	RT	CT							
FIS	25	53	48.1	12.7	44.4	13.6	1.17	50.2	.247
FCSS	25	52	28.8	6.2	29.8	5.9	-.64	45.8	.524
FCS	25	52	25.6	4.9	27.8	6.5	-1.6	60.1	.121
FSS	24	53	30.0	9.2	30.1	10.2	-.04	48.7	.969
PSI	25	53	36.9	13.3	40.8	10.4	-1.3	38.2	.201
FAD	22	51	29.3	3.4	29.3	3.5	-.07	40.5	.946
HS	24	51	22.4	2.6	23.1	2.9	-1.1	52.3	.284

Key for Table:

RT = Reflecting Team Treatment Group
CT = Control Group
FIS = Family Issues Scale
FCSS = Family Coping Style Scale
FCS = Family Communication Scale
FSS = Family Satisfaction Scale
PSI = Problem Solving Inventory Subscale
FAD = Family Adaptability Subscale
HS = Hopelessness Scale

Table 5 indicates the pretest t-test scores for the Strategic Team treatment group as compared to the control group. The results do not show any significant differences between these two groups and indicates that the Strategic

Team treatment group subjects are similar to the larger clinical population at the study site as measured by the pretest instrument.

Table 5

Pretest t-Test Scores For Strategic Team Treatment Group and Control Group

Scale	# of cases		ST mean	ST SD	CT mean	CT SD	t Value	DF	Prob
	ST	CT							
FIS	20	53	43.8	9.2	44.4	13.6	-.22	50.8	.83
FCSS	20	52	29.2	5.6	29.8	5.9	-.37	36.2	.72
FCS	19	52	26.3	5.9	27.8	6.5	-.88	34.8	.38
FSS	19	53	29.5	6.7	30.1	10.2	-.32	48.6	.75
PSI	19	53	39.0	15.2	40.8	10.4	-.48	24.3	.64
FAD	17	51	28.2	4.8	29.3	3.5	-.91	21.9	.37
HS	18	51	21.2	7.5	23.1	2.9	-1.03	18.9	.32

Key for Table:

ST = Strategic Team Treatment Group
CT = Control Group
FIS = Family Issues Scale
FCSS = Family Coping Style Scale
FCS = Family Communication Scale
FSS = Family Satisfaction Scale
PSI = Problem Solving Inventory Subscale
FAD = Family Adaptability Subscale
HS = Hopelessness Scale

Table 6 indicates the pretest t-test scores for the Reflecting Team treatment group compared to the Strategic

Team treatment group. The results do not show any significant differences between the two treatment group subjects and indicates that the subjects in each treatment group are similar at the pretest stage as measured by the pretest instrument.

Table 6

Pretest t-Test Scores For Reflecting Team and Strategic Team Treatment Groups

Scale	# of cases		RT mean	RT SD	ST mean	ST SD	t Value	DF	Prob
	RT	ST							
FIS	25	20	48.1	12.7	43.8	9.2	1.32	42.6	.196
FCSS	25	20	28.8	6.2	29.2	5.6	-.23	42.2	.821
FCS	25	19	25.6	4.9	26.3	5.9	-.40	35.0	.691
FSS	24	19	30.0	9.2	29.5	6.7	.23	40.7	.816
PSI	25	19	36.9	13.3	39.0	15.1	-.49	36.0	.632
FAD	22	17	29.3	3.4	28.2	4.8	.79	27.8	.434
HS	24	18	22.4	2.6	21.2	7.5	.63	19.9	.538

Key for Table:

RT = Reflecting Team Treatment Group
ST = Strategic Team Treatment Group
FIS = Family Issues Scale
FCSS = Family Coping Style Scale
FCS = Family Communication Scale
FSS = Family Satisfaction Scale
PSI = Problem Solving Inventory Subscale
FAD = Family Adaptability Subscale
HS = Hopelessness Scale

A comparison of the pretest t-test scores with the posttest t-test scores for the combined study sample which included the subjects from both the Reflecting Team treatment group and the Strategic Team treatment group shows significant changes from the pretest time period to the posttest time period on three of the six (sub)scales used in the comparison. This includes the Family Communication Scale (FCS) (Olson et al., 1982) where $t= -3.44$, $df=15$, $p < .05$; The Family Satisfaction Scale (FSS) (Olson et al., 1982) where $t= -2.43$, $df=15$, $p < .05$; and the Hopelessness Scale (HS) (Beck et al., 1974) where $t= -2.09$, $df=15$, $p= .05$. A trend is indicated on the Problem Solving Inventory Subscale (PSI) (Heppner & Peterson, 1982) where $t= -2.04$, $df=13$, $p= .059$ (significant at .05 level using a 1-tail probability).

Table 7 illustrates the pretest-posttest comparison for the combined sample. These scores reflect or infer that there was a positive treatment effect for the two types of therapy treatment models used in this study at least for the subjects who responded to the posttest questionnaire.

Table 7

Pretest and Posttest Comparison of t-Test Scores For Combined Sample (Reflecting Team and Strategic Team Groups)

Scale	# of cases	Pre-mean	Pre SD	Post mean	Post SD	t Value	DF	Prob
FCSS	16	28.86	5.51	28.69	5.19	.09	15	.929
FCS	16	27.31	5.15	30.44	4.95	-3.44	15	.004*
FSS	16	30.88	8.55	36.25	7.51	-2.43	15	.028*
PSI	16	40.19	13.07	46.63	4.80	-2.04	15	.059+
FAD	14	28.57	3.35	29.14	2.80	-.63	13	.539
HS	16	23.13	3.01	24.25	2.21	-2.09	15	.054*

Key for Table:

* significant at .05 level using 2-tail and 1-tail probability
+ significant at .05 level using a 1-tail probability

FCSS = Family Coping Style Scale
FCS = Family Communicatin Scale
FSS = Family Satisfaction Scale
PSI = Problem Solving Inventory Subscale
FAD = Family Adaptability Subscale
HS = Hopelessness Scale

Table 8 illustrates the comparison of the posttest t-test scores for the Reflecting Team treatment group with the Strategic Team treatment group. The results indicated that there were no significant differences between the two treatment groups on any of the (sub)scales at the posttest time period using a 2-tail t-test with separate variance

estimate. In examining the results, the researcher did not find statistical significance but the data does indicate a trend of consistently higher mean scores for the Reflecting Team treatment group on nine of the twelve (sub)scales analyzed at the posttest time period. Of the remaining three (sub)scales, the means of the Reflecting Team treatment group and the Strategic Team treatment group were equal on the Family Adaptability Subscale (FAD) (Epstein et al., 1983) and on the Family Coping Style Scale (FCSS) (Olson et al., 1982). The mean of the Strategic Team was higher than the Reflecting Team mean for the Hopelessness Scale (HS) (Beck et al., 1974) (24.90 vs. 24.00). Further examination of this posttest data indicated that the Family Therapy Alliance Bond Subscale was significant at .05 for the reflecting team when a 1-tail t-test was used with a pooled variance estimate. An item by item analysis of the session evaluation questionnaire using a 1-tail t-test with a separate variance estimate shows that item #3 (difficult to easy) and item #18 (powerless to powerful) were significant at the .05 level for the Reflecting Team treatment group.

Table 8

Posttest t-Test Scores For Reflecting Team and Strategic Team Treatment Groups

Scale	# of Cases		RT Mean	RT SD	ST Mean	ST SD	T Value	DF	Prob
	RT	ST							
FCSS	10	7	28.4	5.54	28.3	5.12	.04	13.7	.966
FCS	10	7	31.7	4.24	29.7	6.37	.72	9.7	.488
FSS	10	7	37.8	7.17	34.6	7.64	.85	12.5	.410
PSI	10	6	47.2	4.83	45.7	5.05	.80	10.3	.563
FAD	10	6	29.0	3.16	29.0	1.80	.00	13.9	1.00
HS	10	7	24.0	2.58	24.9	1.46	-.87	14.6	.399
MHLCS	10	7	65.0	5.56	58.6	18.8	.88	6.7	.410
FTAS	10	7	111.8	6.00	103.1	18.9	1.17	6.9	.281
FTAS Task	10	7	49.0	2.50	47.3	6.24	.69	7.4	.512
FTAS Goal	10	7	23.2	3.12	21.4	6.10	.71	8.2	.498
FTAS Bond	10	7	39.6	1.78	34.4	8.50	1.59	6.4	.16*
SEQ	10	7	116.3	23.4	108.9	16.9	.76	14.9	.46+

Key to Table:

* Family Therapy Alliance Bond Subscale is significant at .05 level when a 1-tail t-test is used with a pooled variance estimate. The above scores are derived from a 2-tail t-test using a separate variance estimate.

(Key for Table 8--continued)

+ In item by item analysis of the Session Evaluation Questionnaire using 1-tail t-tests with a separate variance estimate, item 3 (difficult to easy) and item 18 (powerless to powerful) were significant at the .05 level.

RT = Reflecting Team Treatment Group
ST = Strategic Team Treatment Group
FCSS = Family Coping Style Scale
FCS = Family Communication Scale
FSS = Family Satisfaction Scale
PSI = Problem Solving Inventory Subscale
FAD = Family Adaptability Subscale
HS = Hopelessnes Scale
MHLCS = Mental Health Locus of Control Scale
FTAS = Family Therapy Alliance Scale
FTAS Task = Family Therapy Alliance Task Subscale
FTAS Goal = Family Therapy Alliance Goal Subscale
FTAS Bond = Family Therapy Alliance Bond Subscale
SEQ = Session Evaluation Questionnaire Scale

Discussion of the Clients' Self-Report Quantitative Data

In analyzing this portion of the study data, (the clients' self-report quantitative measures), it is apparent that there is a positive treatment effect or impact on the couples/families in the study as evidenced by the differences in the posttest scores of the combined treatment groups in comparison to their pretest scores. However, at posttest, there was no significant differences between the Reflecting Team treatment group and the Strategic Team treatment group. There were trends (i.e., higher mean scores) at posttest for the Reflecting Team treatment group in nine of the twelve (sub)scales but the difference in scores was not great enough to be statistically significant. Whether this was due to there being actually no significant difference between the two treatment groups or whether the

small and uneven sample group sizes at posttest contributed to the loss of statistical power, the researcher is uncertain. In summary, based on the data available from this portion of the study, the clients' who responded to the quantitative measures indicated that either type of couple/family therapy treatment (Reflecting Team Model or the Strategic Team Model) had a positive treatment effect on them. However, neither treatment model was significantly better than the other model according to the clients' quantitative measures.

Analysis of Observational Coding of Clients Therapy Sessions

This portion of the study involved the observational coding of two five minute segments of the couples/families therapy session at the time the posttest study data were collected. Again, due the study's problems in recruitment and mortality of subjects, an opportunistic sampling strategy (Sells, et al., 1994) was employed. There were a total of 14 couples/families involved in the observational coding of the therapy session at the posttest time; this included 9 couples/families from the Reflecting Team treatment group and 5 couples/families from the Strategic Team treatment group. Two independent raters were recruited by the researcher from an out of state marriage and family therapy doctoral program. The two doctoral students were given an overview of the coding system and participated with

the researcher in practice codings of non-sample therapy sessions. The training was done separately for each rater. Due to academic and professional constraints on the raters, the amount of time that they were available for prior training in the coding system was quite limited. The amount of training by the researcher for each of the raters was 3 to 4 hours in training time. During the coding of the study videotapes, the researcher was available to respond to any questions that the raters had about the coding system. In the course of the coding of the clients' therapy sessions, the raters were to let the researcher know if they recognized any of the couples/families involved. Client confidentiality never became a concern with the raters living out of state and a significant distance from the study city.

Findings/Results of the Observational Coding by Raters

Interrater reliability was computed by the percentage agreement of the two raters for the 16 constructs in the observational coding system. For the pretest videotape segments, the percent agreement between the raters was 53%. The percent agreement was for the raters responses to the clinical impression section of the coding system where a Likert-type scale was used by the researcher to quantify the raters' clinical impressions where 1-none, 2-very low, 3-low to medium, 4-medium to high, 5-very high. When clinical impression responses 2 (very low) and 3 (low to medium) were

grouped together as similar (i.e., presence of construct in videotape segment is low) and when responses 4 (medium to high) and 5 (very high) were also grouped together as similar (i.e., presence of construct is high), the percent agreement between the raters for the pretest segments rose to 87%. For the posttest videotape segments, the percent agreement between the raters was 56%. When similar responses were grouped together, as in the pretest segments, the percent agreement rose to 81%.

The t-tests were performed on each of the sixteen constructs in the observational coding system. The constructs included family's use of own solution/ideas, change in view of problem, curiosity, creativity, being reflective, hopefulness, trust, humor, connection and affiliation, being manipulated, blaming, control/domination, being comforted, interest in session, cooperativeness with therapist and team, and the perception/reaction to team intervention. The t-tests were done on each construct to determine pre and post differences for each treatment model, for posttest differences between the two treatment models on each construct, and pre and post differences for the total sample of the treatment groups combined together.

The construct of family's use of own solutions/ideas showed a significant difference ($t=2.294$, $df=8$, $p=.05$) for the Reflecting Team treatment group from pretest to posttest. The construct of change in view of problem showed

a significant difference (t=5.715, df=4, p< .01) for the Strategic Team treatment group from pretest to posttest. The construct of controls/dominates conversation showed a significant difference (t=6.325, df=4, p< .01) and a decrease in the construct for the Strategic Team treatment group from pretest to posttest. And, in a comparison of the combined treatment sample from pretest to posttest, there was a significant difference (t=4.270, df=14, p< .01). The significant findings from the observational coding are presented in Table 9.

Table 9

Significant Results of the Observational Coding of Clients' Videotapes (Pre-Test to Post-Test)

Constructs	Treatment model	a T-Value	DF	Probability
Use of own solutions	Reflecting team	2.29	8	.05*
Change in view of problem	Strategic team	5.72	4	.01**
Controls & dominates	Strategic team	6.33	4	.01**
All constructs combined	Reflecting & strategic team subjects combined	4.27	14	.01**

Key for Table:

a Scores are for differences in constructs pretest to posttest
* Significant at .05 level
** Significant at .01 level

Discussion of the Observational Coding

Overall, the results of the observational coding show very little significant differences between the Reflecting Team treatment group and the Strategic Team treatment group in how the independent raters viewed the treatment interviews from their outsider perspective. Only three of the sixteen constructs (family's use of own solutions/ideas, change in view of problem, and controls/dominates conversation) showed any significant differences using t-tests comparisons.

Using a small opportunistic sample for the observational coding calls into question any statistical conclusions that can be drawn from the data. Since the observational coding system has been recently developed by the researcher for the purposes of this study, it has no empirical reliability or validity as of yet, which also limits any conclusions drawn from the data. Some of the videotaped segments chosen for the postsession show the influence of an extraneous variable, namely the requirements of the agency study site.

In order to be fair to both the Reflecting Team and the Strategic Team Treatment Models, the researcher decided to code as the postsession videotape segment, the five minutes

of the clinical interview immediately following the therapy team intervention for both treatment models. For the Reflecting Team Model that was after the therapy team's reflective conversation and for the Strategic Team Model that was immediately after the therapist went back into the treatment room after consulting with the therapy team behind the one-way mirror. Generally, in the Strategic Team Model, the therapist consultation with the therapy team occurred at the end of the session. As a therapy team, when using the Strategic Team Model, we tried to facilitate some discussion and questioning of the therapy team's intervention when the therapist returned to meet with the couple/family.

This is consistent with the research done by Green and Herget (1991) suggesting more discussion of the therapy team interventions with clients when using a Strategic/Systemic Treatment Model. However, in some of these postsession segments, the therapists had to do an agency treatment plan that may have interfered with the natural direction of the therapy conversation at that time. It also invited the therapist to do most of the talking at the end of some of the segments due to the delivery of the team intervention and the need, in some cases, to do an agency treatment plan. This may account for the significant difference in the decrease in the controls/dominates conversation construct from pretest to posttest for the Strategic Team treatment group. On the coding sheets, the raters noted at times,

during these postsession segments, that the therapist dominated the therapy conversation.

Again, with no significant differences between the two treatment groups on most of the constructs, there was a significant difference from pretest to posttest for the combined treatment groups which suggests that the raters found the interventions of both team treatment groups to have a positive impact on the therapy session. The combining of the treatment groups also increased the sample size, as compared to the sample size of each treatment group separately, which may have helped in this part of the statistical analysis.

After the coding, the researcher interviewed the raters about their impressions of the observational coding system and their experience with the coding process. The raters were somewhat surprised that the coding sheet was fairly easy to use, particularly given the number of constructs represented on the coding sheet. With only limited practice, they were able to pick up constructs being operationalized in the clinical interviews. However, there did appear to be too many constructs for measurement, and that a number of times, there were blurring of boundaries between some of the constructs which made it difficult for the raters to distinguish between them. Some of the constructs also appeared hard to operationalize as well. For instance, operationalizing and distinguishing between

curiosity and creativity may have been difficult. The same problem arises in distinguishing between a sense of trust and a sense of connection/affiliation in the coding system. One rater recommended a place on the coding sheet to notice and code clients' non verbal behavior because the verbal behavior of the client may not suggest the presence of a desired construct but the construct may be there nonverbally. One of the raters commented on the clinic site as an extraneous variable by wondering if the agency requirements (i.e., doing a treatment plan in the fourth session) invited the therapist to rush the interaction at the end of the fourth session.

One rater wondered if the five minute time frame for the videotape segments presented an accurate view/picture of the therapy session that usually lasted from 70 to 90 minutes in length. This was mentioned in spite of the fact that the raters commented on many of the coding sheets that the segments viewed seemed to be fairly representative of the larger session as far as they could tell with their limited view of the session. One positive note from one of the raters was that the coding of these constructs for this study opened space for him to look for these constructs in his own clinical work and in the work of others at the university based marriage and family therapy clinic in his doctoral program.

Analysis of the Therapists'/Team Members' Ratings of the Two Team Treatment Models for Various Clinical Problems

Therapists/team members were asked to use a 7-point Likert type scale to rate the use of the two team treatment models with various clinical problems commonly encountered in clinical practice at the study site. (Response choices were: 1-strongly disagree, 2-disagree, 3-disagree more than agree, 4-neutral, 5-agree more than disagree, 6-agree, 7-strongly agree). At the end of the qualitative interview with the therapist/team member, the researcher explained and showed the Likert-type scale to the respondent and then, the respondent was shown a written list of 12 clinical problems. The respondent was then asked how comfortable he/she felt using each team treatment model with each clinical problem. The respondent's numerical response to using each treatment model with each clinical problem was then recorded by the researcher. A total of twelve past and current team members responded to this rating of clinical problems by type of team treatment.

Findings/Results of the Therapists'/Team Members' Ratings

Therapists'/team members' ratings of their preference for using the Reflecting Team Treatment Model and the Strategic Team Treatment Model with each clinical problem is illustrated in table 10. T-tests were performed on each clinical problem to compare the responses for the team treatment models and on the therapists'/team members' total ratings of the combined clinical problems.

Table 10

Therapists' Preference For Use of Team Treatment Therapy Models by Clinical Problem

Clinical problem	Number of therapists	RT mean	RT SD	ST mean	ST SD
Sexual abuse	12	3.7	1.3	3.6	2.0
Alcohol	12	6.0	1.2	4.9	1.7
Parent-child	12	7.0	0.3	5.5	1.2
Marital	12	7.0	0.3	5.3	1.1
Child physical abuse	12	5.2	1.5	4.6	1.9
Marital violence	12	5.7	1.3	5.2	1.8
Depression	12	5.4	1.7	4.0	1.3
Suicide attempt	12	4.4	2.0	3.2	2.0
Adolescent & parent	12	6.3	0.8	4.9	1.8
Medical-somatic	12	5.2	1.8	4.1	1.6
Anxiety/phobia	10	4.5	2.0	4.6	1.7
Major mental illness	8	3.5	1.1	3.8	1.4
Total		5.3	1.1	4.5	0.7

Key to Table:

RT = Reflecting Team Treatment Model
ST = Strategic Team Treatment Model

For the following clinical problems: child sexual abuse, child physical abuse, marital violence, suicide attempt, anxiety/phobias, and major mental illness there were no significant differences in the therapists'/team members' preferences on whether to use a Reflecting Team Model or a Strategic Team Treatment Model. For six of the twelve clinical problems, the therapists'/team members' preferred to use the Reflecting Team Model. These preferences were statistically significant for alcohol problems ($t=2.469$, $df=11$, $p< .05$), parent-child problems ($t=3.957$, $df=11$, $p< .01$), marital problems ($t= 5.380$, $df=11$, $p< .01$), depression problems ($t=3.254$, $df=11$, $p< .01$), adolescent problems ($t=2.966$, $df=11$, $p< .01$), and medical/somatic problems ($t=3.026$, $df=11$, $p< .01$). The preference scores for the combined list of clinical problems, indicated a significant difference in terms of a preference for the Reflecting Team Treatment Model over the Strategic Team Model ($t=4.412$, $df=11$, $p< .01$).

Discussion of the Therapists'/Team Members' Ratings of Clinical Problems

It is interesting to note that the therapists'/team members' ratings of child sex abuse problems and child physical abuse problems showed no significant difference in choice of team treatment models between the reflecting team and the strategic team but did prefer the Reflecting Team Model for parent-child problems in general. For the problem

of marital violence, there was no significant difference in choice of the team treatment models but for marital problems in general, there was a significant preference for the Reflecting Team Model. For the problem of suicide attempts, there was no difference in preference but for the problem of depression, there was a significant preference for the Reflecting Team Model. These findings can be understood from the therapists'/team members' verbal responses to the researcher while doing the problem ratings.

Some of the therapists/team members wondered how comfortable clients would be having a team of observers with such sensitive problems as sexual abuse, domestic violence, and attempted suicide. From the therapists'/team members' verbal comments, some would prefer to use therapy without an observing therapy team, at least initially, for some of these sensitive problems that are difficult to have a discourse on in the community and sometimes in the therapy room as well. These comments fit with the clients' responses in the domain analysis study of the reflecting team process (Sells et al., 1994) where some clients felt the reflecting team was ineffective in the beginning of therapy when the therapeutic alliance is just being formed. (This may fit with the large number of clients who initially chose not to participate in this study.) The team members also had concerns about the use of a team treatment model, with clients who had a major mental illness or had

significant paranoid ideation, wondering how comfortable these clients would be having observers watching the therapy session.

It is evident that these are legitimate clinical concerns that the therapists/team members raised. However, it is noted that both team treatment models worked with clients that had difficult and sensitive clinical problems during the study period. Two of the sample reflecting team families had sexual abuse and attempted suicide as presenting problems, respectively. One of the sample strategic team families had domestic violence as the presenting problem. The responses of these clients indicated that they had a positive experience of this therapy process which included observing therapy teams in the therapeutic process. However, our family therapy team experience over the past few years, has shown the researcher that certain clients, clients dealing with issues of violence, have difficulty with a team of observers being involved in their therapy experience, particularly during the initial therapy session. This phenomenon was a factor in subject mortality for this study as well. The concerns raised in the therapists'/team members' ratings and in their verbal comments during the ratings, match some of the concerns the therapists/team members raised during the qualitative interview portion of this study. It also speaks to similar concerns raised by the clients in the reflecting

team qualitative study by Sells et al. (1994).

Analysis of the Clients' Responses to the Qualitative Interviews

The qualitative interviews with clients were audiotaped by the interviewers (i.e., author and other team members) and then transcribed by an independent transcriptionist. The verbatim transcripts were then analyzed by the author. The transcribed interviews were first read a number of times by the author, then each couple's/family's responses to the eleven qualitative interview questions were edited and placed in a database. For a copy of the database for the Reflecting Team treatment group clients' qualitative interviews, see Appendix J, and for a copy of the Strategic Team treatment group clients' qualitative interviews, see Appendix K.

Once in the database, each subjects' responses to each interview question could be viewed and compared to the other subjects in each treatment group and between the two treatment groups by rows and columns. For example, row 1 of the database listed the first interview question and each of the subjects' summarized responses to question #1. During the initial readings of the transcripts, through the editing of the responses, and the comparison of the subjects' responses in the database, the researcher looked for common themes and patterns that were surfacing from the couples'/families' responses as well as looking for specific

or unique responses that differed from the overall common themes and patterns. This process was done within each treatment group and between the two treatment groups. This process was similar yet different from a previous qualitative study of client perceptions of the Reflecting Team Model (Smith et al., 1993). In this previous study, common themes and patterns as well as exceptions to the patterns were analyzed using an iterative method. In this process, each analysis of the clients' responses led to the development of new qualitative interview questions. These new questions were then responded to again by the clients which led a series of three qualitative interviews for the clients. In that study (Smith et al., 1993), the final set of interview questions were not predetermined but evolved based on the clients' responses in each of the three qualitative interviews.

In the current study, the qualitative interview questions were predetermined so that this study's hypotheses could be tested by using both qualitative and quantitative measures. The composition of the qualitative interview questions were based on theoretical concepts from the Reflecting Team Model (Andersen, 1987, 1990) and the interventive interviewing literature (Tomm, 1987a, 1987b, 1988a). These questions were intended to help with the measurement of the operationalized hypotheses in this study.

For the clients' qualitative interviews, there were six

subjects from the Reflecting Team treatment group and five subjects from the Strategic Team treatment group with a total of eleven subjects participating in this portion of the study. These eleven subjects were comprised of seventeen adults and nine children.

Categories of the Qualitative Interview Questions

The eleven qualitative interview questions for clients can be divided into two different categories based on the themes that the questions were trying to elicit from the couples/families in the study. The first category explores the clients' perceptions and experience of the therapy process both generally and specifically and includes the following qualitative interview questions:

Category 1a-Clients' view of current therapy and comparison to any previous therapy:

Q1) "What are your thoughts about the type of marital/family therapy you are receiving?" (general question)

Q2) "If, you had previous marital/family therapy, how does this current therapy compare to it?" (general question)

Q4) "What is positive and negative about this therapy experience?" (general question)

Category 1b-Clients' perceptions of the therapist(s) and the clients' perceptions of how they are viewed by the therapist(s):

Q5) "What are your perceptions of the therapist?" (specific question)

Q6) "How do you think the therapist views or sees you in your efforts to solve or cope with the problems that brought you to seek therapy?" (specific question)

Category 1c-Clients' perceptions of having an observing therapy team and the clients' perceptions of how they are viewed by the observing therapy team:

Q7) "If, the therapy involves the use of a team what are your thoughts about having a team as part of your therapy?" (specific question)

Q8) "How do you think the team sees you in your efforts to solve or cope with the problem that led to your seeking therapy at this time?" (specific question)

The second category of qualitative questions examines the clients' perceptions of the presenting problem(s) and possible new ideas or solutions for the presenting problem(s) and includes the following qualitative interview questions:

Category 2a-Clients' change in their view or understanding of the presenting problem:

Q9) "Has your view or understanding of the problem changed during this therapy?"

Category 2b-Clients' perceptions of hopefulness that the presenting problem(s) will be reduced or resolved:

Q3) "How optimistic are you now that the problem will be reduced or resolved?"

Category 2c-Clients' perceptions of the development of new ideas/solutions for the presenting problem(s) and their understanding of the origin of these new ideas/solutions:

Q10) "Have any new ideas or solutions developed as a result of the therapy?"

Q11) "If, you now have some new ideas concerning the resolution of the problem, where did the ideas come from?"

Findings/Results of the Clients' Qualitative Interviews

Clients' responses to each category of the qualitative interview questions are presented for both the Reflective Team treatment group and the Strategic Team treatment group.

Due to the similarity in the clients' responses to the questions in each treatment group, certain individual responses are documented here as being representative of the treatment group as a whole. Also documented are client responses that are seen as having a different perception/view than the other subjects in that particular treatment group. As noted previously, the Reflecting Team treatment group clients' qualitative responses have been reviewed, edited, and placed in a database in Appendix J. The Strategic Team treatment group clients' qualitative responses have been reviewed, edited, and placed in a database in Appendix K.

Category 1-Clients' Perceptions of the Therapy Process

For category 1a-clients' view of current therapy and comparison to any previous therapy, question #1 asks "What are your thoughts about the type of marital/family therapy you are receiving?", The respondents indicated the following:

". . .Like having other people observe and then getting feedback from them, because it gives you more points of view-different people perceive different things, pick up on different things. (Mother). . . .You put all the different views together (son)" (Reflecting Team couple/family #1).

". . .Expected one-on-one [counseling] just because I figured it would take time just to talk all of our problems out and then therapy would start. While you guys are also talking, it kind of helps; it is different. You know, I'm not used to it yet" (Reflecting Team couple/family #5).

". . .After having all the conflict that we have had for 5 or 6 years. . .I really think that there's hope. . .its the one-way mirror, not having everyone sit in here, that the people are behind the mirror, the therapist can be more

subjective. . .have more insight than if everyone was sitting here (wife)" (Strategic Team couple/family #4).

In category 1a, question #2 asks "If, you had previous marital/family therapy, how does this current therapy compare to it?", The respondents indicated the following:

". . .Before it was one-on-one, you wondered if you're getting anywhere. . .like group more than one-on-one" (Reflecting Team couple/family #3).

". . .Seen different ways of doing counseling,. . .every type. . .I've received has been a little different in some way so its not similar" (Reflecting Team couple/family #5).

". . .This is. . .superior (husband). . . .Having one of each [opposite sex co-therapists] is really great because you can't get around thinking like a woman or thinking like a man. . .I think that with part of each [male and female co-therapists], I think it is much better (wife)" (Strategic Team couple/family #4).

In category 1a, question #4 asks "What is positive and negative about this therapy experience?", The respondents indicated the following:

"Well, the positive thing. . .is that the feedback that we get from the people involved is not always negative. . .a lot of positive things that are said...that's very important. . .when you are in the middle of a crisis, it is real hard for you to see the positive kinds of things...the only negative thing. . .is that we just don't have the whole family here, so we're not getting a whole picture. . . (mother)" (Reflecting Team couple/family #1).

"Positive about the comments, and most of them are good, and every once in awhile, one might not be so good, but in its way it is still positive because you can still find out more about yourself. So I don't really see any negatives (mother)" (Reflecting Team couple/family #3).

"On a positive note. . .I consider her feelings more. . .on the other hand, I'm quite a private person and don't like the experience itself. But, overall, it's beneficial (male partner). . . .It promotes me to think and it makes me examine myself. . .[I] like it when [the] counselor gives us things to do. . .think about [the tasks] outside of office (female partner)" (Strategic Team couple/family #1).

In category 1b-clients' perceptions of the therapist(s) and the clients' perceptions of how they are viewed by the therapist(s), question #5 asks "What are your perceptions of the therapist?", The respondents indicated that:

"He tries to be helpful. He takes time out, and he listens to all of us. . .(mother)" (Reflecting Team couple/family #6).

". . .Like him [counselor]. I thought I would come in here and just sit here and not say a darn thing. . .he brings things that are upsetting but they don't get out of hand (male partner)" (Strategic Team couple/family #1).

In category 1b, question #6 asks "How do you think the therapist views or sees you in your efforts to solve or cope with the problems that brought you to seek therapy?", The respondents indicated that:

"I think he thinks we are going in the right direction and working on the problems (wife)" (Reflecting Team couple/family #4).

"Just confused. . .I don't think there is anything very major wrong. It is just that we have to learn a few things. You know, he is just trying to straighten us out by: if you open up to me, what do you expect me to do for you. You know, just those types of things. Just seeing us as confused (husband)" (Reflecting Team couple/family #5).

"As trying to cope, to keep my head above water...he can see that I am really trying. . .he tells the boys that he sees that they are really trying too. . .they are doing a little better than what they were (mother)" (Strategic Team couple/family #5).

". . .Sees us as boring. I'm sure there are people with lots worse problems. . .I almost feel like I am wasting his time (male partner). . .Sees me as a person that he is trying to help in whatever way he can (female partner)" (Strategic Team couple/family #1).

In category 1c-clients' view of having a therapy team and their perception of how the therapy team views them,

question #7 asks "If, the therapy involves the use of a team what are your thoughts about having a team as part of your therapy?", The respondents indicated that:

". . .Like it. . .I think there is a lot to just. . .sitting back and completely listening and then coming in and talking to him [counselor]. . .I learn as much from you two [team] talking as I do from him [counselor] talking to us (mother)" (Reflecting Team couple/family #6).

". . .Like it. . .might be difficult for some of the team . . .like the gentleman who was here tonight. . .first time, so he is jumping in in the middle. . .doesn't know a lot about what is going on which kind of makes it difficult for him to interpret maybe some of the things that are going on that are being said (mother). . . .Like the way it's handled. . . letting [us] hear views from the people [team] and getting different aspects of it (son)" (Reflecting Team couple/family #1).

"I'm kind of nervous about it, particularly when they are watching us-I'm not used to being watched. . .but. . .its a good process. . .much more feedback (male partner). . . . Like having the different opinions. . .they all pretty much stay in line. . .all agree but yet they bring out...different options (female partner)" (Strategic Team couple/family #1).

". . .Its fine. . .the more people that have insight the better advice I'm going to get (husband). . . .At first, felt a little strange about people sitting back there listening to me and being able to see me without me seeing them but. . .I need all the help I can get, so if their input helps, fine (wife)" (Strategic Team couple/family #3).

In category 1c, question #8 asks "How do you think the team sees you in your efforts to solve or cope with the problem that led to your seeking therapy at this time?", The respondents indicated that:

". . .See us as strong people. . .you guys see us as better than we see ourselves. . .you know, we see the problem, and you guys see the strength (husband). . . .You know, its like you guys saw something in us differently than what we're seeing in us right now, because we feel like we're at this low point. . .and we're not able to see our high points right now (wife)" (Reflecting Team couple/family #5).

". . .If I were standing back there, you know, I would feel and hopefully they would feel this way, that we are trying, you know, because we are communicating, be it in a negative or a positive way, we are trying-we come back, both of us in one piece, every week, and that has got to say something (wife)" (Strategic Team couple/family #4).

Category 2-Clients' Perceptions of the Presenting Problem(s) and Possible New Ideas or Solutions for the Presenting Problem(s)

For category 2a-clients' change in their view or understanding of the presenting problem(s), question #9 asks "Has your view or understanding of the problem changed during this therapy?", The respondents indicated the following:

". . .See that it is not just one person's problem-its all of our problems, and we all need to work towards them. (mother)" (Reflecting Team couple/family #2).

"Somewhat. . .some days I have doubts wondering if it is going to work or not. I know, I believe in the long run, it will. . .I have thought about giving up, you know; but I still have hope that, you know, I don't think it is all for nothing (mother)" (Reflecting Team couple/family #6).

". . .Have a stronger belief that I have to put this behind me before we can go on with our life (husband). . . .Have gained a little more insight to my feelings. . .that allows me to have a different perspective on my problem-that I do have options (wife)" (Strategic Team couple/family #3).

". . .See things a little differently, different light (husband). . . .There might be a light, no matter how dim, at the end of the tunnel (wife)" (Strategic Team couple/family #4).

For category 2b-clients' perceptions of hopefulness that the presenting problem(s) will be reduced or resolved, question #3 asks "How optimistic are you now that the problem will be

reduced or resolved?", The respondents indicated the following:

". . .Know we're getting along better (husband). . . .Don't think we're getting along better because of counseling. . . better because we are trying a little bit more. . .feel optimistic just with my own mind and my own feelings (wife)" (Reflecting Team couple/family #5).

"Think it will be reduced a lot. I mean, it helps coming here and talking about everything (mother)" (Strategic Team couple/family #5).

For category 2c-clients' perceptions of the development of new ideas or solutions for the presenting problem(s) and their understanding of the origin of these new ideas or solutions, question #10 asks "Have any new ideas or solutions developed as a result of the therapy?", The respondents indicated the following:

"I have different ideas about my mother, because I never knew some things that we have talked about, and this is a good way to find out things, you know, that you haven't known before (daughter)" (Reflecting Team couple/family # 3).

". . .They are on the verge of happening, really (male partner). . . .Still putting them into practice. . .not natural yet. . .at home trying to solve it [a problem] . . . have to learn to think back to-what's going on in counseling, and I have to learn to calm myself down. . .am changing. . .in communicating with him (female partner)" (Strategic Team couple/family #1).

For category 2c, question #11 asks "If, you now have some new ideas concerning the resolution of the presenting problem, where did the ideas come from?", The respondents indicated the following:

"Well, I think from all of us talking it out as a whole. It is not just me; I think it is all of us, all together, discussing (mother)" (Reflecting Team couple/family #6).

"Counselor (daughter). . . .The group comments and maybe some of the counselor, but the group helps a lot (mother)" (Reflecting Team couple/family #3).

"Here (female partner). . . .Not so much that we were given the ideas but given the opportunities to gain the ideas themselves (male partner). . . .The thinking was promoted-I mean our ideas (female partner)" (Strategic Team couple/family #1).

"Some of them [ideas] came from the counselor and the team, and a lot of them came from Jesus Christ. I pray all the time. (Mother)" (Strategic Team couple/family #5).

Discussion and Comparison of the Clients' Responses to the Qualitative Interviews

For the clients' who participated in the qualitative interview portion of this study, at the posttest time period, the overall perceptions and views of their experience of the therapy process in the Reflecting Team treatment group and the Strategic Team treatment group did not differ significantly. An analysis of the clients' qualitative data, reveals that the therapy experience for these respondents, in both treatment groups, were generally positive in terms of their perceptions of therapy, their perceptions of using a therapy team, their alliance with the therapist(s) and the therapy team, and in their hopefulness in the reduction or resolution of the problem. Clients, in both treatment groups, tended to have these positive perceptions of the therapy process. However, some subtle distinctions between the treatment groups emerged as the qualitative data were analyzed.

An analysis of the Reflecting Team treatment group and

the Strategic Team treatment group responses to each qualitative questions follows. The clients' responses in this study will also be compared to clients' responses in the qualitative study of the Reflecting Team Model done by Smith et al. (1993).

Clients' perceptions of the therapy process. The clients' perceptions of the therapy process in general (qualitative question #1) indicates that the clients, in both treatment groups, liked using the team treatment models. One Reflecting Team client (RT #1) liked getting the multiple points of view that the team experience offers. Another Reflecting Team client (RT #1-son) responded that one team member interprets the problem one way and someone else on the therapy team will interpret it differently and the client puts all the different views together.

Two Reflecting Team clients' (RT #1, #5) reported that the team process was different than individual therapy and that it took some getting used to. A Strategic Team treatment group client (ST #4) indicated that the team allowed the therapist to be more subjective which the researcher assumes that the client felt the observing team's vantage point behind the mirror allowed for more objectivity. This interpretation matched the perception of client #1 in the Smith study who stated in response to the question of how the reflecting team works felt that "they were just debating amongst themselves, um like objective

outsiders looking in..." (Smith et al., 1993, P. 36). The researcher found that the responses of one Strategic Team treatment group couple/family (ST #1) fit well with the responses of the Reflecting Team couple/family (RT #3). The Strategic Team client's response (edited) was that the counseling "brings up issues that wouldn't be brought up; learning things about myself and about my behavior with him (partner)". The Reflecting Team client's response (edited) was that she "get(s) insight on things you said you might not have realized; gives me more understanding about myself".

All of the Strategic Team treatment group clients' responded that they liked the therapy experience. In comparison, all of the Reflecting Team treatment group clients' liked the experience as well but some (two clients) in this group mentioned some of their uncertainty as well. One Reflecting Team client (RT #1) brought out the positive aspects of having the experience of multiple views/perspectives. This response by the Reflecting Team client is similar to the clients' responses in the Smith study where client #6 in that study felt the reflecting team was useful due to ". . .different points of view. Not everyone can think of everything. Different people,. . .different experiences. . .when you get a team, you get a broader spectrum. . ." (Smith et al., 1993, P. 35-36). In the Smith study, client #1 in response to the question of

what it meant when team members disagreed responded that ". . .means that there are different points of view, there is no one answer. . ." (Smith et al., 1993, P. 36).

Clients' comparison of the team therapy process to previous therapy. The clients' comparison of the team treatment process to previous counseling (qualitative question #2) indicated that the Strategic Team treatment group felt their current experience in the team treatment approach to therapy was positive when compared to their past therapy experiences. The Reflecting Team treatment group responded in the same manner to this question. Some clients' in both treatment groups indicated both positive and negative prior therapy experiences. One client in the Smith et al. (1993) study indicated a preference to have individual therapy in order to work with just the individual therapist with a possible occasional session with the therapy team; that client felt sometimes the reflecting team was not hearing him/her correctly but that the team did offer different perspectives. This client's comments fit with some of the positive and negative comparisons raised by some of the clients in the current study where a few clients had difficulty with the treatment context (i.e., an observing team) but still felt the team's interventions were useful to have in both the Reflecting Team Model and the Strategic Team Model.

Positive and negative aspects of the team therapy process. In response to what is both positive and negative about the Reflecting Team and the Strategic Team Models (qualitative question #4), clients in both treatment groups perceived the therapy experience as positive with very few negative comments offered. Reflecting Team client #1 experienced the team therapy process in a manner that the proponents of the constructivist position, the social constructionist position (Efran et al., 1988; Gergen, 1991; Keeney, 1983), and the Reflecting Team Model (Andersen, 1987, 1990; Lax, 1989; Miller & Lax, 1988) have suggested in the literature. This client (RT #1) indicated that the different perspective and position of the therapy team allows for a different view and perspective that the family has hard a time seeing when they are in a crisis period. The team's different views opened space for this client to change her own perspective on her family's issue.

At least, one client from each treatment group (ST #1 & RT #5) felt that the team's comments/ideas were sometimes difficult to hear but that they could learn from being able to listen to the team's comments in both the Reflecting Team and the Strategic Team Models. These perspectives match some of the clients' comments in the Smith et al. (1993) study where the reflecting team's ideas were not always easy to hear but provided an opportunity to learn or reflect on one's situation in a different manner. Reflecting Team

client #6 indicated that her twin teenage daughters have not changed their behavior as of yet, but that she still had hope that positive change will occur. It seems that the therapy experience helped to invite a change in attitude for this mother, with change first occurring in her belief system, rather than in actual behavioral change in the daughters. This may be an example of the beginning of the process of change described by Anderson and Goolishian (1988). Anderson and Goolishian (1988) believed that changes in clients' perceptions lead to a different type of conversation for the family with problematic patterns, which then allows for a positive change in the family's way of viewing the problem or for the resolution of the problem.

Clients' view of the therapist(s). In response to the clients' view of the therapist(s) (qualitative question #5), the clients' in both treatment groups made comments that indicated a positive alliance with the therapist(s) and that the therapists' efforts to bring out issues to be discussed, during the therapy session, were helpful for clients in both treatment groups.

Clients' perceptions of how their therapist(s) view them. When the clients were asked how the therapist views them in their efforts to solve their problem(s) (qualitative question #6), the clients are asked to take a meta-position and comment on another part of the therapy system. Clients in both treatment groups commented that the therapist(s)

sees them as positive and trying or making honest efforts to resolve their problems/issues. One Reflecting Team treatment group client (RT #5) thought the therapist saw him as "confused"; a Strategic Team treatment group client (ST #1) thought he was viewed as "boring". It is interesting that these responses came from male partners presenting with marital/couple issues and they were both males who had never been in therapy before. Overall responses to this question indicated that most were positive (i.e., therapist viewed them and their actions as positive) but the Strategic Team treatment group clients' had more mixed responses (e.g. I'm boring) than the Reflecting Team treatment group clients. Two Strategic Team treatment group clients had mixed responses and one Reflecting Team treatment group client had a mixed response.

Clients' view of the observing therapy team. The clients' in responding to how they view the observing therapy team (qualitative question #7) had some interesting observations. Overall, clients' in both treatment groups liked using the therapy team as part of their therapy experience but some clients' from both treatment groups expressed some uneasiness with having a team of observers. Client #1 in the Smith study expressed a similar response when responding to the limitations of the reflecting team stating that ". . .I like it and I don't like it, it's intimidating, but. . .I take advantage. . ." (Smith et al.,

1993, P. 39). One Reflecting Team treatment group client (RT #6) commented that she listened better behind the mirror; another Reflecting Team treatment group client (RT #3) indicated that she learned in a different manner from the therapist than she did from the team and seemed to indicate that she gained more from the team's comments.

In the Smith study, in response to a question of the value of the reflecting team to the client, a client (#1) had a similar experience of the reflecting team process as the above client (#3) in this study. The client, in the Smith et al. (1993) study, indicated that the reflecting team is "quite important, because (index therapist) was just talking with me but they (RT) gave me feedback which (index therapist) didn't give me, um which was enjoyable" (Smith et al., 1993, P. 38).

One Reflecting Team treatment group client (RT #1) expressed some concerns with the inconsistency in team membership at times which was expressed by a client in the Smith et al. (1993) study as well but another client in that study felt that having new team members may help when "bogged down" in a session (Smith et al., 1993, P. 38). Some Strategic Team treatment group clients' (ST #1 & #3) commented that it was difficult not seeing the team behind the mirror but that their input helps. Another Strategic Team treatment group client (female partner of ST #1) felt that the strategic team allowed for different opinions and

options (different from the therapist's views and their own views) and also experienced the team's ideas as unified and not varying, which fits with the Strategic Team Model and contrasts with the use of the team in the Reflecting Team Model.

Clients' perceptions of how the observing therapy team views them. The clients were invited again to take a meta-position, when asked how the therapy team viewed them in their efforts to resolve their problem(s) (qualitative question #8), some of the Strategic Team treatment group clients' indicated that they believed that they were viewed in a positive manner by the strategic team (e.g. making an effort) and one Strategic Team treatment group client (ST #2) was uncertain how the team viewed them but hoped that they were viewed in a positive light by the team. The Reflecting Team treatment group clients as a whole felt the team viewed them in a positive manner; their comments appeared to be more hopeful, in terms of how they thought they were viewed. In essence, more able to picture how the team views them than the Strategic Team treatment group clients'. One Reflecting Team treatment group client (RT #5) commented that the team is able to see more of their strengths as a couple than they were able to see when he felt they were at a low point. A Strategic Team treatment group client (ST #1) believed that he was viewed as boring but was able to overcome that perception of himself and take

useful ideas from the Strategic Therapy Team.

Change in view of the presenting problem during therapy process. When clients' were asked if their view of the problem had changed during the therapy process (qualitative question #9), the Strategic Team treatment group clients' commented that their view of the problem had changed and that they were more hopeful about resolving their issues. These responses by the Strategic Team treatment group clients' seemed to indicate more of a change in attitude or in their perceptions of the problem instead of stating that there were actual changes in behaviors. This seemed more in line with the Reflecting Team Model and constructivist beliefs about change than it does with the Strategic Team Model where the goal is more of a change in behavior. However, Strategic therapists would be quite satisfied if a client's attitude or beliefs changed. In a Strategic Therapy Model, the reframing of the presenting problem implies a change in the client's beliefs about the problem (Haley, 1976, 1987).

For the Reflecting Team treatment group clients', the problem view had changed; generally a change in view or beliefs prior to a behavioral change as well. One Reflecting Team treatment group client (RT #2) commented on the shift from seeing the identified patient (a 13 year old school phobic girl) as the problem to seeing this as a shared problem among the four family members where the whole

system needed to change not just the identified patient. Reflecting Team treatment group clients (RT #5 & #6) were hopeful (change in belief/attitude) but still expressed some realistic doubts about their situations, that the change process would take time. (Possibly more realistic than some of us using a Brief Therapy Model in the family therapy field.) One Strategic Team treatment group couple (ST #1) seemed to express two different levels of change. In this one couple system, the male partner indicated more of a cognitive change with a change in belief/attitude whereas the female partner experienced a change in her feelings, so an affective change. So, change may be different for different members of the same system and may be expressed in typical gender differences such as this couple did.

Clients' hopefulness about problem resolution. In terms of the clients' hopefulness that the problem will be reduced/resolved (qualitative question #3), the responses of both treatment groups were similar. The Strategic Team treatment group clients' were all optimistic or hopeful in changing their presenting problem. All of the Reflecting Team treatment group clients' were also hopeful/optimistic. In general, clients perceived it would take some time to change, so hang in there; there is hope. A theme that ran through the Reflecting Team treatment group client responses was that change may be more in their control and they were not looking for the therapist(s) to make the changes for

them. The Strategic Team treatment group clients' talked about a forum to talk about their problems as being helpful.

Perceptions of new ideas/solutions from the therapy process. In response to whether any new ideas/solutions have developed from the therapy process (qualitative question #10), three of the five Strategic Team treatment group couples/families indicated that they had new ideas and all of the Strategic Team treatment group clients' were hopeful. With the Reflecting Team treatment group clients', all of them were also hopeful. Responses differed in that all the Reflecting Team treatment group clients gave examples of new ideas or changes going on as compared to Strategic Team treatment group clients. One Reflecting Team treatment group client (RT #3) felt that, in essence, space had been opened to have previously unspoken conversations which led to new information for this daughter (age 12) and a change in perception about her mother. A Strategic Team treatment group client (ST #1) indicated when back out in everyday life, she found it helpful to think about how she handled the situation in the therapy session which helped her to not be so reactive with her partner.

Origin of new ideas/solutions for the presenting problem. In terms of looking at the origin of any new ideas or solutions (qualitative question # 11), the Strategic Team treatment group clients' view of where the ideas/solutions came from varied; from such sources as the therapy

conversation, the clients own awareness of the impact of the problematic patterns on the family, the therapist and an extraneous but important variable such as their spiritual belief system (i.e., God). So, the Strategic Team treatment group clients' ideas about change came from multiple sources/origins. For the Reflecting Team treatment group clients', the origin of change included: the therapy conversation, other client experiences (i.e., one client's individual therapist), and the therapist and therapy team.

For the Reflecting Team treatment group clients, there was more acknowledgement of the importance of the therapy team whereas, in the Strategic Team treatment group clients, the importance of the therapist was commented on more so than the importance of the therapy team in the Strategic Team model. One Reflecting Team treatment group client (RT #6) felt that the origin of new ideas was the therapy conversation, in essence, it was generated not from one person but from the interplay in the social domain (Andersen, 1987; Bateson, 1972, 1979; Maturana, 1975). Another Reflecting Team treatment group client (RT #3) felt the origin of new ideas came from the therapist but that the therapy team's conversation/reflection may have been a more important source for her. A Strategic Team treatment group client (ST #4) seemed to agree with a Reflecting Team treatment group client (RT #6) that the origin came from the therapy context, meaning the therapy conversation. Again,

one Strategic Team treatment group client (ST #5) stressed the importance of God in the origin of her ideas, as well as the input from the therapist and the team.

Analysis of the Therapists'/Team Members' Responses to the Qualitative Interviews

The qualitative interviews with past and current family therapy team members occurred at the end of the data collection period for this study in April, 1993 and were conducted by the researcher. The potential for bias and the blurring of roles (i.e., as therapist, as team supervisor, and as researcher) were communicated to each team member prior to every qualitative interview by the researcher. There were a total of twelve past and current team members interviewed; by gender the composition was nine women and three men. Each therapist/team member was asked to respond to twenty-eight qualitative interview questions which included both open-ended (descriptive) and close-ended (structured) questions (Sells et al., 1994). The composition of the qualitative interview questions for therapists/team members were based on theoretical concepts from the Reflecting Team Model literature (Andersen, 1987, 1990), the interventive interviewing literature (Tomm, 1987a, 1987b, 1988a), and the quantitative and qualitative studies of the reflecting team process (Griffith, et al., 1992; Smith et al., 1992, 1993). The first nine qualitative interview questions were taken directly from the

Smith et al. (1992, 1993) qualitative studies of clients' and therapists' perceptions of the reflecting team process with the author's permission in an attempt to see if this current study replicates the findings in the Smith et al. (1992, 1993) studies. The therapists' qualitative responses were reviewed, edited and placed in a database in Appendix L.

At the end of the qualitative interview, the therapists/team members were asked to respond on a Likert-type scale to a list of various clinical problems in terms of how comfortable they would be using a Reflecting Team Model and a Strategic Team Model with each of the clinical problems listed. For further information on the clinical problems and the therapists'/team members' responses, see Appendix G. The responses were analyzed in the same manner as the clients' responses to the qualitative interviews.

Categories of the Qualitative Interview Questions for the Therapists/Team Members

The twenty-eight qualitative questions were divided by the researcher into eight different categories based on the themes that the questions were trying to elicit from therapists/team members in the study. The first four categories were derived initially from the work done by Smith et al. (1992). However, this researcher chose to not use all of the categories developed in the former study (Smith et al., 1992) and chose to place some qualitative

questions from that study (Smith et al., 1992) in different categories in the current study. However, the composition or content of the first nine questions in this study were taken verbatim from the study done by Smith et al. (1992). Questions 10-28 were developed by the researcher to understand the therapists'/team members' experiences with the therapy team process and to examine any perceived differences in the therapy team experience depending on whether the Reflecting Team Model or the Strategic Team Model were used.

The twenty-eight qualitative questions can be viewed as fitting into the overall guiding themes that are seen in the following eight categories. The categories are presented below with the questions that are classified in each of the categories. The questions are represented by their number only due to large number of therapists'/team members' qualitative questions. For the wording of each question, see Appendix G. The categories are as follows:

Category 1-Therapists'/team members' understanding of the reflecting team (Smith et al., 1992) (Questions 1, 2, 6-8).

Category 2-Value of reflecting team for therapists/team members (Smith et al., 1992) (Question 4).

Category 3-Suggestions for changes in the reflecting team (Smith et al., 1992) (Question 5).

Category 4-Perceived limitations of the reflecting team (Smith et al., 1992) (Questions 3, 9).

Category 5-Therapists'/team members' perceptions/experiences participating in a therapy team (Question 10).

Category 6-Therapists'/team members' comparisons of their experiences participating on a reflecting team and a strategic team (Questions 11, 14-22, 25, 28).

Category 7-Therapists'/team members' perceptions/experiences as a therapist using a therapy team in general and a comparison of their experiences when a Reflecting Team Model and a Strategic Team Model is used (Questions 12, 24-25).

Category 8-Therapists'/team members' perceptions of the clients experiences participating in a Reflecting Team Model in comparison to their participation in a Strategic Team Model (Questions 13, 26-27).

Findings/Results of the Therapists'/Team Members' Qualitative Interviews

Therapists'/team members' responses to each category of the qualitative interview questions are presented. Due to the similarity in the therapists'/team members' responses to the questions, certain individual responses are documented here as being representative of the therapy team as a whole. Also, documented were the therapists'/team members' responses that were seen as having a different perception/view than the other therapists/team members on the therapy team. Due to the large number of interview questions (twenty-eight), responses to each question will not be placed in this section but can be found in the therapists'/team members' database in Appendix L.

Category 1-Therapists'/Team Members' Understanding of the Reflecting Team

This category includes questions 1-2, 6-8. Question #1 asks "Are reflecting teams useful?", and the therapists'/team members' responses included the following:

". . .Families appreciate all the feedback;. . .useful as a training tool. . .I get a chance to practice skills of asking those tentative questions;. . . cotherapists. . . watching the team reflect. . .are listening to comments that they might not have thought of on their own. . ." (team member #1).

". . .Useful. . .get a variety of ideas and perspectives; . . .not only that. . .the sum of all those different opinions is greater than individual input because you get some synergy going there-one person will build on another person's ideas. . ." (team member #7).

". . .Very useful;. . .most useful with families that have less pathology in them [than] with more pathology. . .best to be more directive" (team member #12).

In category 1, question #6 asks "What relationship do you expect will exist between you and your team?", and the therapists'/team members' responded with the following:

". . .It creates a bond. I think at first it was difficult because, as a therapist, I sort of felt like I was on stage somewhat and that was anxiety provoking for me;. . .once I learned to really respect other people's opinions and learn from their styles. . .it really created a bond" (team member #7).

"Well, it was interesting to watch myself and the relationship with the team members grow, just based on what you saw them say in the reflecting team. . .sometimes it opened up possibilities for a relationship that you might not have suspected otherwise" (team member #10).

In category 1, question #7 asks "Does it matter whether your team is predominately male or female?", and the therapists/team members indicated the following:

"I don't think it matters to the team members particularly. It might matter to some clients. . .only if you had a client [where] that was a specific issue. . .possibly some sex abuse issues or harassment. . .some issue in their childhood, maybe some transference issues with gender" (team member #6).

"I think it does. Sometimes the issue that is presented would make a difference;. . .still real hard for therapists to know and overcome their own gender biases. . .best of all

worlds would have a balance of genders as well as cultures" (team member #11).

In category 1, question #8 asks "What does it mean to you when team members disagree?", and the therapists'/team members' responses indicated the following:

"It means that we are perhaps looking through a different lens, a different framework;. . .don't think there is one right way of seeing things;. . .believe in multiple realities and I don't see that as being bad when people disagree. . .probably things to be learned from that disagreement" (team member #7).

"That's fine;. . .you are going to have that. . .if they disagree in a reflective process, the family can see that; and that kind of gives the family a sense of 'Well, they are having problems, too' or that this can be seen to go several different ways and give the family different directions to go from" (team member #9).

Category 2-Value of the Reflecting Team For the Therapist/Team Members

This category includes question 4, which asks "What kind of things do you learn from the team?", and the therapists'/team members' responses included the following:

"Well, I learn what other people's perspectives are;. . . something that they may say or bring out in the reflection I'd kind of think, 'Yeah, that's really good or I haven't thought of that' and it changes my whole view and perspective. . ." (team member #3).

"You learn how the family is interpreting what you say. For instance, if you say something and you didn't mean it that way, you learn that you really need to express yourself in clearer terms. . ." (team member #5).

". . .I think [what] I learned was the degree to which groupthink. . .occurs;. . .if people behind the mirror communicate with one another, a consensus is. . .rapidly arrived at;. . .if you hold off with that, as you do in reflecting model. . .you really get divergent points of view. . .that was very interesting and very helpful. . ." (team member #12).

Category 3-Suggestions For Changes in the Reflecting Team

This category includes question 5, which asks "What would you change about how the team works?", and the therapists/team members responded with the following:

". . .More consistency in membership [on team]" (team member #2).

". . .Streamlining switching the rooms;. . .I guess one thing I would really try to do is keep a strong awareness of . . .the possibility of information overload on clients; . . .the model invites us to be real energetic and creative and enthusiastic. . .that might be overwhelming although it might be change promoting. . ." (team member #7).

"Contracting with the families to show up. It is kind of frustrating when you are ready to do it, and the family doesn't show" (team member #8).

Category 4-Perceived Limitations of the Reflecting Team

This category includes questions 3 & 9. Question #3 asks "When doesn't the team work?", and the therapists'/team members' responses included the following:

"Yes, I think it has always worked, from my viewpoint. We have seen clients refuse it because of too many therapists; and I think it was just overwhelming to them-the first session when they declined that" (team member #1).

". . .People who are somewhat paranoid-I feel it wouldn't work in that situation either or just with an issue that they feel is really sensitive, they may not feel comfortable having the reflecting team back there" (team member #8).

". . .Team worked less well when the participants were less familiar with reflective techniques. . ." (Team member #12).

"It doesn't work, I would imagine, if you had somebody on the team who was monopolizing more than other people" (team member #9).

"Well, there were a few times when I was the team, and then that's not really a team approach;. . .there's an alliance with the therapist who is with the client and the single team representative;. . .so in that sense, it's kind of a

team approach in that. . .both working. . .for client; but I did have kind of a feeling of being sort of out there and kind of isolated" (team member #2).

In category 4, question 9 asks "How can the team be disruptive?", and the therapists/team members indicated the following:

". . .If they are not taking it seriously. If, the team gets too friendly or in a playful mood or doesn't want to be there then it can be disruptive because it is not. . .a good therapeutic atmosphere for the family" (team member #5).

"If they try to be too directive or controlling or if they did take things personally and get into arguments" (team member #6).

Category 5-Perceptions/Experiences Participating in a Therapy Team

This category includes question 10, which asks "What is your experience participating as a member of a team observing a marital/family therapy session/conversation?", and the therapists/team members responded with the following:

". . .Positive, uplifting kind of experience to really be a part of a process and to feel that you have input and that something that you hear or your perspective could make a real difference in what the client hears when you reflect, that one of your insights might be a real clue...to successful intervention" (team member #3).

". . .Good way to learn how to do therapy;. . .helpful to watch a therapist's style;. . .exciting to come up with some ideas and see pieces of them implemented and/or see them misunderstood and maybe think of different ways that it could have been implemented. . .real learning experience . . . very reactive, energetic" (team member #7).

Category 6-Therapists'/Team Members' Comparison of their Experiences with the Reflecting Team and the Strategic Team Models

This category includes questions 11, 14-23, 28. Given the large number of questions in this category, the researcher will document, in this section, only the qualitative questions that are open-ended (descriptive) in nature. The responses to the more structured qualitative questions will be discussed later in the chapter when the therapists'/team members' hypotheses are analyzed. In this category, question #11 asks "Is there any difference in your experience of and participation in an observing team when a reflecting team is used vs. when a strategic team is used? If, your experience is different, how is it different? How is your experience the same whether a reflecting team or a strategic team is used?", and the therapists/team members responded with the following:

". . .Like the strategic [team] but. . .like reflecting [team] more. Sometimes the strategic, to me, seems to force instead of moving at a pace. It is intrusive, at times or harsh. I'm not sure that if I were on the other side [client], I would be comfortable about strategic" (team member #3).

". . .Preferred the reflecting team. . .thought it was more effective;. . .strategic team gives the therapist more control. . .reflective team is going to give the client a tremendous amount of information and ways to think about his problem, and he is free to pick and choose which one he wants to follow through with" (team member #4).

". . .In Reflecting [Team] Model. . .kept our ideas to ourselves behind the mirror;. . .different than when we called in an intervention and there was discourse between us [Strategic Team Model];. . .sometimes enjoyed the strategic

. . .putting our heads together. . .better than sitting silently behind the mirror [Reflecting Team Model];...but...as the therapist, I liked the reflecting format better" (team member #7).

". . .On the reflecting team I felt less pressure to come up with. . .some kind of an idea. . .it was more important to just share my thoughts. . .so it felt like a gentler or more peaceful process;. . .during the strategic team...felt more pressure to come up. . .[with] some idea;. . .in both [models], I felt there was a bond, a working relationship" (team member #12).

". . .On the strategic team, you know that you are not going to be put on the spot;. . .when you know that you are coming in [reflecting team], then you know that you are going to have some thoughts and you had all better be able to kind of bring them harmoniously together;. . .on strategic team have opportunity to visit with other therapists. . .kind of plan . . .more teamwork" (team member #1).

In category 6, question #17 asks "Do you have a preference

to use a Reflecting or a Strategic Team Model?", and the

therapists/team members responded with the following:

". . .Prefer the reflecting...more uses to the therapist; . . .thought back to some of the groups [families] with small children. . .the strategic model might be preferable because that [reflecting conversation] might be over the heads of the small children" (team member #6).

". . .Rather be involved in a reflecting team;. . .have several different comments that the family can choose as to what fits for them and what doesn't fit. . .the strategic [team] is kind of along those line but. . .it [reflecting team] is more nonthreatening. . .team members become more a part of the family. . ." (Team member #9).

". . .Prefer the reflecting team. I think a lot of spontaneous what you may think are incidental comments, like someone may have made an observation that they would have not highlighted,. . .and it sparks and sometimes it can just grow from what might have been an incidental comment whereas in strategic [team], you kind of have to funnel [ideas] into the presentation [by the therapist to the clients]" (team member #10).

In category 6-question #28 asks "Is there any difference in

your perception of the usefulness and effectiveness of the

team process when a strategic team is used vs. when a reflecting team is used?", and the therapists/team members indicated the following:

". . .The reflecting team is [more useful] because I have heard the family members comment 'Oh, I take all of this home with me, and I kind of think about it later' and they have heard so much, so many different voices speaking out. And maybe they can't comment on all of it right there, but they . . .take it home and think about it...I don't hear those comments coming from families in strategic therapy" (team member #1).

"At first I really thought the reflecting team was much stronger, but I did begin to see at times when the strategic team was very effective. . ." (Team member #6).

"Each have their own positive and negative points. The strategic [team] is more immediate, and it is also more interruptive. In the reflecting team, you get possibly more detail, but you don't get it immediately" (team member #8).

Category 7-Perceptions/Experiences as a Therapist with a Therapy Team and a Comparison of the Experience of Being a Therapist with the Reflecting Team Model and the Strategic Team model.

This category includes questions 12, 24-25. Question #12 asks "What is your experience as a therapist when you work with an observing team? Is your experience as a therapist different when a strategic team is used as compared to when a reflecting team is used?", and the therapists/team members indicated the following responses:

". . .Just seeing it [therapy session] from a different viewpoint;. . .sometimes I get so into what's being said that I miss some cues;. . .drawback with the strategic [team] is that sometimes it is hard to time the call [from team to therapist] where it isn't disruptive" (team member #7).

". . .Was kind of good to have a backup. . .could

concentrate more on what was going on right there. . .didn't have to be as aware of everything. . .nervous. . .the first time;. . .the strategic [team] has positive benefits of being immediate but negative of being interruptive. . .the reflective [team] has positive of your getting to decide when you are going to switch and the negative of not getting immediate feedback. . ." (team member #8).

". . .It seemed like a more comfortable atmosphere with the reflecting team in that I wasn't necessarily required to do something with the information the team provided. . .could observe with the family. . .they were privy to the same information that I got in exactly the same way. . .learned a lot by watching how they received those things. . .strategic team, the therapist felt more pressure to use the information provided [by team]" (team member #12).

In category 7, question #24 asks "When you have been the therapist has there been any difference in the support you felt from the therapy team or whether you felt judged by the team when a strategic team is used vs. when a reflecting team is used?", and the therapists/team members indicated the following:

"I think I did feel a tug between whether the strategic team was the expert or I [the therapist] was the expert. I don't feel that so much with the reflecting team, and it may be again back to having five options generated with the reflecting team and having the strategic team come up with only one option" (team member #11).

". . .Felt more supported and more judged during the strategic type of intervention just because the intervention was more direct;. . .I did feel very supported in that way. But also I felt some judgement coming out about the direction to be used" (team member #12).

In this category, question #25 asks "Is there any difference in the connection with or your alliance with the clients when a reflecting team is used vs. when a strategic team is used?", and the therapists/team members indicated the following:

". . .More of an alliance with the reflecting team because there again it was taking the mystery out of it. . .putting it where these are just people. . .seemed to reenforce that 'I'm a human and I'm trying and I have the way I see things and here is another one that is different'" (team member #7).

". . .Where you are the therapist, I don't think there is an alliance difference;. . .I think, depending on what the strategic message. . .or intervention [is] [and it] doesn't happen to go along with your line of thinking, I think there may be some [alliance] but not as strong a degree of alliance with that family" (team member #9).

Category 8-Therapists'/Team Members' Perceptions of the Clients' Experiences Using the Reflecting Team Model and the Strategic Team Model

This category includes questions 13, 26-27. Question #13 asks "Do you think families that you work with perceive or experience any difference when a reflecting team is used compared to when a strategic team is used?", and the therapists/team members indicated the following responses:

". . .If, I were a family member, I would like knowing who the team members were [reflecting team];. . .it seems like it almost adds an air of magic to it to have that team back there that you never see, that just calls in occasionally [strategic team]" (team member #6).

"My subjective opinion of it is that the families enjoyed the reflecting team better. I think it was to move from feeling like I am in a lit room and people are watching me to move from that atmosphere into a darkened room in which I am the one who is watching and hearing what people say. I think it is kind of an intriguing thing for the family" (team member #12).

In this category, question #26 asks "Is there any difference in your perception of the family's ability to focus on their own ideas and solutions to their problems when a strategic team is used vs. when a reflecting team is

used?", and the therapists/team members indicated the following responses:

". . .They [clients] felt more comfortable disagreeing with the reflecting team. . .with the strategic [team] suggestions that I recall were more or less. . .[taken] more as a command;. . .more likely to happen with the reflecting team [families using own ideas]" (team member #11).

In this category, question #27 asks "Is there any difference in your perception of the clients' comfort level and sense of ease with the team process when a reflecting team is used vs. when a strategic team is used?", and the therapists/team members indicated the following responses:

". . .Could go both ways. . . with strategic [team]. . . times when they forget we are back there until the phone rings;. . .but. . .being able to see people. . .I think that increases the comfort level of being able to see these people [team members]" (team member #7).

". . .When they got used to either, there wasn't any difference in their comfort level. I think it was just a matter of getting used to the process" (team member #9).

"I think that families think they are going to be less comfortable with a reflecting team but I think what evolves is that they are more comfortable with it and they almost form a relationship with the team. . .they create a relationship with the team and that can't happen with the strategic [team]. . ." (team member #10).

Discussion of the Therapists'/Team Members' Responses to the Qualitative Interview

Therapists'/team members' understanding of the Reflecting Team Model. In response to category 1 (qualitative questions 1-2, 6-8) which asked about the therapists'/team members' understanding of the reflecting team (Smith, et al., 1992), the therapists/team members found the Reflecting Team Model to be very useful (question

#1). Some of the comments included that the reflecting team was useful for practice/training, and that team members notice what's going on in the session differently, which in turn triggers a variety of ideas. Team members believed that the reflecting team gives information to the clients that the therapist may not give either due to not picking up on a certain idea or because the therapist didn't feel comfortable bringing up the idea. Basically, the unique observing position of the team may allow them to bring forth ideas that the therapist may be hesitant to bring up out of concern for the clients' response and the impact on the therapeutic alliance.

In Sells' et al. (1994) qualitative study of the reflecting team process that analyzed clients' and team members' responses using a domain analysis, the reflecting team was seen as a buffer that allowed clients to have time to hear and reflect on alternative views of their problems, and the process allowed sensitive or difficult subjects to be breached by team members that would have been difficult for clients to bring up themselves. In that study (Sells et al., 1994), this process of listening differently was considered to be in the domain of "spatial separateness" which allows clients to hear differently and to have time to reflect before responding (Andersen, 1990). Another comment was that the reflecting process allowed the team to become real people to the clients. And, the reflecting team

process let the family comment or respond back to the team's reflecting conversation, so in a sense, dialogue develops between these two different parts of the therapy treatment system.

Therapists'/team members' perceptions of how the Reflecting Team Model works. Category 1, question #2 asks about how the reflecting team works and one therapist/team member (#7) summed up the process by stating "it's recruiting an audience for clients where they can hear about improvement, strength, and resources from different perspectives". This is a good description of the process but there is danger for team members if they solely focus on the positives that they see in the clients in that the reflecting team process needs to also challenge clients to change as well. As Andersen (1987) draws upon Bateson's (1972, 1979) work, the reflecting team process needs to be not too similar or too different from the family but just different enough in the ideas it offers the family so that the family will consider these alternative pictures of their situation.

Therapists'/team members' relationship with the reflecting team. In category 1, question #6 asks about the therapists'/team members' relationship with the reflecting team. One team member (#5) felt there was a camaraderie that develops by the team listening to the therapist-family conversation and that listening process helped trust to

develop between team members in doing the reflection. Another team member (#7) indicated there was a supportive bond but it was difficult at first, feeling on-stage as a therapist with the team. Team member #4 felt the team should be supportive of one another and if they disagreed, members should expand on the idea rather than disagreeing openly. Team member (#10) commented that the relationship between team members grew during the reflections and opened space for new relationships with team members. This response seems to be somewhat different but also complements the process described by team member (#5) who saw the act of listening together prior to the reflection as helpful in the building of relationships for team members on the therapy team.

Gender differences in reflecting team composition. In category 1, question #7 asks about gender differences in the team's composition. Most of the team members felt a mix in gender was more helpful and that a racial and ethnic mix of team members would also be useful. Some of the team members felt a gender diverse team would be particularly useful when clients present with such problems as sex abuse and domestic violence.

Disagreement among reflecting team members. In category 1, question #8 asks about disagreement among team members. Team member #5 responded that it was enlightening that multiple viewpoints make the team work. Another (team

member #5) saw disagreement on the team as a way to role model communication with families which fits some of the ideas in the study by Griffith et al. (1992). Another team member (#9) felt that team disagreement gave clients a sense that there are multiple options or alternatives in solving their problems. This fits with the researcher's experience with the reflecting team but we also found that some clients want one answer. These clients had difficulty with not getting a firm unified direction from the therapist and the therapy team and they may be more likely to benefit from models that are more purposive in nature, such as the Strategic Team Model.

What team members learn from the reflecting team process. Category 2 discusses the value of the reflecting team and question #4 asks what team members learn from the team. Responses included that team members could observe different styles and skills among team members (team member #1). Team members (#2) and (#5) talked about learning by observing and noticing which ideas from the team are picked up by the family. This fits with Maturana's (1975) theory of structure determinism that one can perturb a living system but only the system knows whether and how it will respond to that perturbation (i.e., intervention in the context of therapy). Team member (#3) commented that the reflecting process not only allowed for a shift for the family but also saw changes in his/her own view or

perspective as well. The reflecting process allows, at times, for a different way of seeing and understanding for all members of the therapeutic treatment system. These responses fit with the Smith et al. (1993) study where therapists/team members indicated that they improved their own therapy skills by observing fellow team members in the role of therapist in front of the mirror.

Changes in the reflecting team process. Category 3 (question #5) asks about suggestions for changes in the reflecting team process. Team members responded that a larger therapy room would be useful so that the therapy team would be in the room with the therapist and family and could avoid having to change rooms with the therapist and family for the reflection. (This corresponds with the experience of Kassis and Matthews (1987) in their use of team therapy models.) Two team members comments indicated a desire to combine the Reflecting Team Model with the Strategic Team Model by suggesting that the team phone in interventions as well as doing a reflection and that, at times, it might be useful to discuss their ideas prior to having the reflection. This is similar to the use of a team therapy model by Shilts et al. (1993) where the process involved a Solution-Oriented therapy interview with a reflection by the observing therapy team.

One reason that some team members may want a "pre-conferencing" among the team prior to the reflection is

that, at times, team members found it difficult to come up with ideas that noted the strengths and positive resources of certain clients. This was particularly true in client systems where it was easy to see problematic patterns and difficult to see the clients' strengths and abilities. The researcher believes that one reason for this is the relative theoretical and clinical inexperience of many of the team members in this study. As one team member noted an experienced therapy team may work better. There was a concern also to not overwhelm clients' with too much information which matches some of the concern in the Smith et al. (1992) study. Another team member felt that more consistency in team membership would be helpful as well.

Limitations in the Reflecting Team Model. Category 4 (questions #3 & #9) asks about the perceived limitations of the reflecting team (Smith et al., 1992). Question #3 asks about when the team doesn't work. Team members felt that it didn't work well with inconsistent membership on the team or, at times, with certain client populations such as abuse victims or paranoid clients. Another team member (#3) commented that when a family is really stuck they may not be able to hear the therapy team's ideas. This is in contrast to some of the therapists' responses in the domain analysis of the reflecting team (Sells et al., 1994) where the team members believed the reflecting team was ineffective when the clients weren't in any real crisis or no major problems

existed in the family system. In that same study (Sells et al., 1994), the clients perceived the reflecting team as ineffective during the beginning stages of the therapy process where the therapeutic alliance had not been formed as of yet between the clients and the therapist.

How the reflecting team process is disruptive. In category 4, question #9 asks about how the team is disruptive. Some team members felt that the reflecting team process may feel disruptive to some clients presenting with problems that are difficult to talk about such as abuse and suicide. The reflecting team could also be disruptive if the reflecting team didn't focus behind the mirror or became too playful behind the mirror.

There were also some concerns about one team member monopolizing the team conversation or about a negative team conflict emerging during the reflection. Some members commented on time pressures being disruptive, suggesting that stopping the therapy conversation just to have a reflection for the sake of having one, may disrupt the flow of the therapy session for the therapist and the clients.

Experience being a member of an observing therapy team. Category 5 of the therapists'/team members' qualitative interview questions (question #10) explored their general experience participating as a member of an observing therapy team. Many team members felt that being a part of the team allowed for a different way of observing the therapy

process. For instance, team member (#12) indicated it was freeing to be the observer and not the therapist. Team member (#1) perceived that the clients enjoyed the process and looked forward to the input from the team.

This process seemed to be going on, in a simultaneous manner, both for the family and also for the therapy team as well. Team members have commented that they looked forward to the reflecting conversation and have sometimes altered their views as a result of the conversation. In a different manner, this occurs in the Strategic Team Model when the team brainstorms to come up with some interventions for the family. This discussion may invite some team members to change their view on how they were seeing the clients.

Another team member (#4) felt that the observing position of the reflecting team allowed the team to make comments that the therapist might be hesitant to suggest to the family. In a sense, team member (#10) gave a good description of the process stating that "You never knew what would be spawned by the interaction-it moved everyone to observe".

Perceptions of difference between the two team treatment models. Category 6 involves the therapists'/team members' comparisons between the Reflecting Team Treatment Model and the Strategic Team Treatment Model. These questions (#11, #14-23, #28) are both open-ended and close-ended in nature. When asked about any differences in their

experiences using the two treatment models (question #11), nine out of the twelve team members indicated a preference to use the Reflecting Team Model. In contrast to the predominant view, one team member (#1) felt more pressure to come with ideas with the reflecting team and preferred the discourse between the team members behind the one-way mirror rather than sitting silently and listening behind the one-way mirror as the Reflecting Team Model suggests. Another team member (#7), who responded in a similar fashion to team member (#1), indicated that he/she enjoyed the discourse behind the mirror in the Strategic Team Model but, in the therapist role, this team member preferred to use the Reflecting Team Model.

Therapists'/team members' preferences in using the two team treatment models. Question #17 asks team members directly if they have a preference between the two treatment models. All twelve of the team members indicated a preference for the Reflecting Team Model. Team member #7's response seemed to fit the general view of the team in stating "pros and cons to both models; but prefer reflecting team, it seems more human and [has] more. . . contact with different people".

Differences in the effectiveness of the two team treatment models. Question #28 asked team members if they found any difference in the effectiveness or usefulness between the two treatment models. Their responses indicated

that seven out of twelve believed the Reflective Team Model was more effective or useful, three team members felt that both models were effective, and two team members were uncertain of any difference in effectiveness. Within these responses, two team members felt that the effectiveness would depend on the type of problem that the family was dealing with. Team member (#8) commented on some of the distinctions in the process between the two models stating "each has positive and negative; strategic team is more immediate and more interruptive; reflecting team possibly get more detail but not immediately" (edited).

Differences in how team members' ideas were listened to in the two team treatment models. The remaining questions in category 6 (#14-16, #18-23) are more close-ended (directive) questions that asked team members to make specific comparisons between the two team treatment models. When asked about differences in how your ideas were listened to on the two therapy team models, eight out of twelve team members felt their ideas/observations were listened to more in the Reflecting Team Model while four team members felt there was no difference between the two models. Team member (#1) expressed the general perception stating that there is "more opportunity to be heard on a reflecting team; all contribute in strategic team but it gets reduced-in reflecting team your ideas go outright to families" (edited).

Experience of cooperativeness vs. competitiveness in the two team treatment models. In this category, the therapists/team members where asked if there were any differences in the cooperativeness vs. the competitiveness that they felt to have their ideas heard and implemented on the therapy team (question #15). Six team members felt there was less competitiveness among team members in the Reflecting Team Model, one team member felt there was less competitiveness in the Strategic Team Model and five team members expressed no difference between the models. In general, team members saw some subtle differences (i.e., Reflecting Team Model slightly less competitive) but saw team members as being cooperative in both models. Team member (#5) described some of the opinions stating that "in reflecting team, people are really paying attention so they can go in and reflect; in strategic team don't think it is competitive-members want to work together" (edited).

Perceptions of differences for team members in what is focused on in the observation of the therapy session. In response to any perceived differences for the team members in what they focus on as observers in the two treatment models (question #16), two out of twelve team members responded that they focused more on positives and clients' strengths in the Reflecting Team Model. While ten of the team members either experienced no differences or slight differences in what they focused on. Since the therapeutic

process is different for the two treatment models, at least in how the therapy team intervenes, the team members' comments indicated that they organize their observations differently depending on which model they were using. For instance, one team member (#3) stated that the "questions I'd ask are different-in strategic team more looking at what happened that moment; in reflecting team more going back over-more curiosity" (edited). Another team member (#5) stated "in strategic team listen for things to get an intervention-so different cues than in reflecting team; in reflecting team listen to everything due to having to reflect-look differently" (edited).

Another team member's (#7) comments seemed to express the process that occurs in the Strategic Team Model for the observing therapy team in stating that ". . .because we were more free to converse while observing in the strategic team-what others noticed influenced what I focused on" (edited). This process behind the one-way mirror probably helped the team to come up with common or unified interventions that are given to the clients.

This description is in contrast to Andersen's (1987, 1990) belief that the observers should remain quiet while observing the session so that team members won't influence one another behind the mirror and can offer the clients a number of different ideas. (In contrast, the Strategic Team Model would argue that giving clients too many ideas may be

confusing to clients, whereas a planned and purposive intervention may be more useful for clients in trying out new solution behaviors, at least, according to the Strategic Team Model.) However, as some of the team members have commented, the reflecting conversation may influence or stimulate the team members to think about the family in a different way than they had prior to the reflection, as they hear unrehearsed thoughts/ideas from other team members. So, one distinction that could be drawn from these few comments, is that the team discourse behind the one-way mirror (Strategic Team Model) may influence what the team members' observe during the session, while the team discourse in front of the one-way mirror during the reflection (Reflecting Team Model) may influence the team members' way of thinking or their ideas about the clients.

Ability to focus on clients' strengths and solutions in the two team treatment models. In question #18, team members were asked about differences in their ability to focus on clients' strengths and solutions between the two therapy team models. Nine out of twelve team members believed they were more able to focus on client strengths and solutions in the Reflecting Team Model, one team member focused more on these in the Strategic Team Model, and two team members experienced no distinction between the two models in these areas. One team member (#1) had an interesting dichotomy indicating she was more able to see

client strengths and exceptions to the problem in the Reflecting Team Model but was more able to focus on solutions in the Strategic Team Model.

Differences in the cooperativeness between team members in the two team treatment models. When asked about any differences in the amount of cooperativeness between team members in the two models (question #19), two out of twelve responded that there was more cooperativeness with the Reflecting Team Model, three team members felt the Strategic Team Model was more cooperative and seven team members believed there were no distinctions. There was a theme that the act of coming up with an intervention is both cooperative and competitive as evidenced by one team member's (#11) comments who stated that "the strategic team [has]. . .more competitiveness and more cooperation in that competitiveness was cooperating".

Ability to attend and focus on therapy session in the two team treatment models. Question #20 asked about team members' ability to attend to and focus on the therapy session in the two models (i.e., ability to concentrate) and is contrasted with question #16 which asked about distinctions in what the team members focused on as part of an observing system. Responses indicated that five out of twelve team members believed they focused better in the Reflecting Team Model, two team members felt they focused better in the Strategic Team Model and five team members

experienced no distinctions. An interesting distinction was noted in the team members' comments where one team member (#4) felt less focus as a therapist due to wondering when the team was going to phone in an intervention (Strategic Team Model) and another team member (#1) had an easier time focusing as a team member with the Strategic Team Model since she didn't have the pressure of having to participate in a team reflection.

Experience of pressure for team members to develop ideas/interventions in the two team treatment models. In response to question #21 which asked about differences in pressure to come up with ideas for the clients, seven of the twelve team members felt less pressure in the Reflecting Team Model, four team members felt less pressure in the Strategic Team Model, and one saw no difference between the two models. In general, some team members felt more pressure to come up with a "single intervention" in the Strategic Team Model while other team members felt more pressure in having to share their ideas with the clients watching and listening to the team's reflection in the Reflecting Team Model.

Perceptions of hierarchical distance between clients and the therapy team in the two team treatment models. In terms of the team members' perception of hierarchical distance between the clients and the therapy team (question #22), seven out of the twelve team members believed the

Reflecting Team Model had less hierarchical distance, one team member felt the Strategic Team Model had less hierarchical distance, and four team members saw no distinction between the two models. For those who felt the Reflecting Team Model was less distant, the responses centered around the clients not being able to see and hear the therapy team in the Strategic Team Model.

Team members' activity level during observation of the therapy session. When asked for differences in how active the team members were as observers (question #23), six of the twelve team members perceived themselves as more active observers in the Reflecting Team Model, two team members were more active in the Strategic Team Model and four team members perceived no differences. Team member (#12) expressed some of the distinctions in observation as "more interchange [discussing therapy session with team members] in strategic team-worked harder to watch carefully in strategic team but more effective an observer in reflecting team due to less interchange [during observation]" (edited).

Therapists' experience of the two team treatment models. Category 7 involved the team members' perceptions and experiences as a therapist using a therapy team in general and their comparisons being a therapist with the two treatment team models. Question #12 asked about the team members' general experience as a therapist using a team and any differences being a therapist with the two treatment

models. Responses indicated that six out of twelve team members preferred being a therapist with the Reflecting Team Model and four team members experienced no differences between the two models.

Many of the team members expressed some initial anxiety as a therapist being observed by the team, particularly given the clinical inexperience of the team. This was expressed by team member (#4) who stated that "being new I wondered, like the clients, what the team thought of the job I was doing-didn't follow-up on some things with clients due to team being there" (edited). However, team member (#10) indicated that after being anxious initially, as the therapist, she realized that the therapy team could see and hear things that she couldn't see/hear due to their different observing position in the therapy treatment system. As other comments, by team members, to previous questions indicated, the relationship among team members grew in trust over time.

Therapists' perception of support vs. judgement from the therapy team. When asked about the support vs. judgement the team members experienced as the therapist (question #24), six of ten team members felt more support from the Reflecting Team Model, one team member felt more support from the Strategic Team Model, and three team members experienced no differences (two team members were not asked this question due to either lack of experience as

a therapist with a therapy team or only experience as a therapist with one of the treatment models).

Therapists' alliance with clients in the two team treatment models. When asked about any difference in the connection the team members felt with the clients when they were the therapist (question #25), six of eleven team members felt more of a connection with their clients in the Reflecting Team Model, five team members didn't experience any differences (one team member was not asked this question due to not having the experience of being the therapist during the study period). Team member (#5) expressed the distinctions in the two models in the following manner "more alliance in reflecting team as therapist since you sit with the family during the reflection; in strategic team you're more linked to the authority of the team" (edited).

Therapists'/team members' perceptions of the team therapy process for clients. In category 8, therapists/team members were asked to take a meta-position by thinking about the therapy experience for their clients in using the two therapy team models. Question #13 asked if the team members felt that clients experienced any difference in general with the therapy process with a Reflecting Team Model and a Strategic Team Model. In response, ten of the twelve team members felt that the experience was more positive for their clients with the Reflecting Team Model, two team members did not experience any differences. One team member's (#7)

comments seemed to fit for most of the team members in stating that "clients reacted pretty positively to some ideas in both models; but see the validation clients get hearing [their] point of view understood in the reflection [Reflecting Team Model]" (edited).

Therapists'/team members' perceptions of the clients ability to focus on their own ideas and solutions. When asked about differences in clients' ability to focus on their own ideas and solutions (question #26), nine of the ten team members believed that clients were more able to focus on their own strengths and solutions in the Reflecting Team Model, and one team member saw no difference (two team members either felt they didn't have enough information to respond to this question or weren't asked this question by the researcher).

Therapists'/team members' perceptions of the clients comfort level with the two team treatment models. In response to their perception of the clients' comfort level with the therapy process using the two team models (question #27), eight of the eleven team members believed that clients were more comfortable with the Reflecting Team Model and three team members saw no differences in the clients' comfort level (one team member was not asked this question by the researcher). A good description of the distinction was expressed by team member (#1) who indicated that she "believe(s) families are much more comfortable with

reflecting team; haven't heard them complain about strategic team but see difference in gestures" (edited).

Results of the Operational Hypotheses Testing for the Clients

1. Operational hypothesis #1 stated that there will be no difference in the level of stress for couples/families in the two treatment groups at the pretest stage as measured by the Family Issues Scale (FIS) (Olson et al., 1982). Scale scores on the FIS do not indicate any significant differences between the two treatment groups in their level of stress. Based on lack of difference in these scores, the null hypothesis is found to be confirmed.

2. Operational hypothesis #2 stated that there will be no difference in the responses to stress for couples/families in the two treatment groups at either the pretest or posttest stages as measured by the Family Coping Style Scale (FCSS) (Olson et al., 1982). Scale scores for the FCSS, at pretest, do not reveal any significant difference between the two treatment groups. Scale scores, at posttest, for the FCSS do not indicate any significant difference between the two treatment groups in their response to stress. Based on the FCSS scale scores, at pretest and posttest, the null hypothesis is confirmed.

3. Operational hypothesis #3 stated that there will be no difference in the type of communication for couples/families in the two treatment groups, at either pretest or posttest

stages, as measured by the Family Communication Scale (FCS) (Olson et al., 1982). Scale scores for the FCS, at both pretest and posttest stages, do not indicate any significant differences between the two treatment groups. Based on the FCS scale scores, the null hypothesis is confirmed.

4. Operational hypothesis #4 stated that there will be no difference in the level of satisfaction for couples/families in the two treatment groups, at either the pretest or posttest stages, as measured by the Family Satisfaction Scale (FSS) (Olson et al., 1992). Scale scores on the FSS do not indicate any significant differences between the two treatment groups at either pretest or posttest stages. Based on the FSS scale scores, the null hypothesis is confirmed.

5. Operational hypothesis #5 stated that there will be no difference in the level of problem solving confidence for couples/families in the two treatment groups, at either the pretest or posttest stages, as measured quantitatively by a revised version of the Problem Solving Confidence Subscale of the Problem-Solving Inventory (PSI) (Heppner & Peterson, 1982) and as measured qualitatively by questions #3 and #9 in the clients' qualitative interview. Subscale scores on the Problem Solving Confidence Subscale of the (PSI), at pretest and posttest, and the clients' responses to qualitative interview questions #3 and #9, at posttest, do not indicate any significant differences between the two

treatment groups. Therefore, the null hypothesis is confirmed.

6. Operational hypothesis #6 stated that there will be no difference in the level of functioning for couples/families in the two treatment groups, at either the pretest or posttest stages, as measured by the general functioning subscale of the McMaster Family Assessment Device (FAD) (Epstein et al., 1983). Subscale scores on the FAD General Functioning Subscale do not indicate any significant differences between the two treatment groups at either pretest or posttest stages. Based on these scores, the null hypothesis is confirmed.

7. Operational hypothesis #7 stated that there will be no difference in the level of hopefulness for couples/families in resolving their presenting problems in the two treatment groups, at either the pretest or posttest stages, as measured quantitatively by a revised version of the Hopelessness Scale (HS) (Beck et al., 1974), and as measured qualitatively by question #3 of the clients' qualitative interview. Scale scores on the HS and clients' responses to question #3 in the clients' qualitative interview do not indicate any significant differences between the two treatment groups. Therefore, the null hypothesis is confirmed.

8. Operational hypothesis #8 stated that there will be no difference in the perceived responsibility and origin of

therapeutic change for couples/families in the two treatment groups, at the posttest stage, as measured quantitatively by a revised version of the Mental Health Locus of Control Scale (MHLC) (Hill & Bale, 1980) and as measured qualitatively by question #11 in the clients' qualitative interview. Scale scores on the MHLC scale and clients' responses to question #11 in the clients' qualitative interview do not indicate any significant differences between the two treatment groups at the posttest stage. Therefore, the null hypothesis is confirmed.

9. Operational hypothesis #9 stated that there will be no difference in the perceived strength of the therapeutic alliance for couples/families in the two treatment groups, at the posttest stage, as measured quantitatively by the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986) and as measured qualitatively by questions #5 and #6 in the clients' qualitative interview. Scale scores on the FTAS and clients' responses to questions #5 and #6 in the clients' qualitative interview do not indicate any significant differences between the two groups at posttest. Therefore, the null hypothesis is confirmed.

10. Operational hypothesis #10 stated that there will be no difference for couples/families in the two treatment groups, at the posttest stage, in their perception of the therapist's ability to focus on therapeutic tasks that are meaningful to the clients and are directed at the

couples/families stated problems as measured by the task subscale of the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986). Subscale scores from the FTAS Task Subscale, at posttest, do not indicate any significant differences between the two treatment groups. Based on these scores, the null hypothesis is confirmed.

11. Operational hypothesis #11 states that there will be no difference for couples/families in the two treatment groups, at posttest, in their perception that they are in agreement with the therapist on the goals that need to be worked on in the therapy as measured by the Goal Subscale of the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986). Subscale scores on the FTAS Goal Subscale do not indicate any significant differences, at posttest, between the two treatment groups. Based on these scores, the null hypothesis is confirmed.

12. Operational hypothesis #12 stated that there will be no difference for couples/families in the two treatment groups, at the posttest stage, in their perception of the therapeutic bond between the therapist and the couples/families as measured quantitatively by the Bond Subscale of the Family Therapy Alliance Scale (FTAS) (Pinsof & Catherall, 1986), by constructs #14 and #15 in the observational coding of clients' videotaped sessions, and as measured qualitatively by questions #5 and #6 in the clients' qualitative interview. The subscale scores, the

observational coding by independent raters, and the clients' responses in the qualitative interview do not reveal any significant differences, at posttest, between the two treatment groups. Therefore, the null hypothesis is confirmed.

13. Operational hypothesis #13 stated that there will be no difference in the perceived impact of the therapy session immediately preceding the collection of posttest data for couples/families in the two treatment groups as measured by the Session Evaluation Questionnaire (SEQ) (Stiles, 1980). Scores on the SEQ, at posttest, do not indicate any significant differences between the two treatment groups. Based on the scale scores, the null hypothesis is confirmed.

14. Operational hypothesis #14 stated that there will be no difference in the overall perceptions of the therapy process for couples/families in the two treatment groups as measured by qualitative interview data. Based on the analysis of the qualitative interview data gathered, at the posttest stage, there were no significant differences between the two treatment groups. Therefore, the null hypothesis is confirmed.

15. Operational hypothesis #15 stated that there will be no difference between the two treatment groups, in the overall clinical impressions of the independent raters, for the videotaped segments of the couples'/families' therapy sessions that immediately preceded the collection of

posttest data. Observational coding scores, by the raters, did not indicate significant differences between the two treatment groups. Therefore, the null hypothesis is confirmed.

Results of Hypotheses Testing for the Therapists/Team Members

1. Operational hypothesis #1 stated that there will be no difference in preference for team members in terms of whether to use a Reflecting Team Model or a Strategic Team Model as measured qualitatively by questions #17 and #28 in the team members' qualitative interviews and as measured quantitatively by the overall preference of team members in response to the team members' level of comfort in the clinical problem scale. Qualitative and quantitative responses by team members indicated a significant preference for the Reflecting Team Model. Therefore, the null hypothesis is rejected.

2. Operational hypothesis #2 stated that there will be no difference in team members' ability to focus on clients' strengths, exceptions to the problem, and on solutions to the problem when either a Reflecting Team Model or a Strategic Team Model is used as measured by question #18 in the team members' qualitative interviews. Team members' responses indicated that there were significant differences in their ability to focus on clients' strengths, exceptions to the problem, and solutions to the problem in favor of the

Reflecting Team Model. Therefore, the null hypothesis is rejected.

3. Operational hypothesis #3 stated that there will be no difference in the team members' awareness of and attention to the clients' problems and problematic patterns when either a Reflecting Team Model or a Strategic Team Model is used as measured by questions #16 and #18 in the team members' qualitative interviews. Based on the team members' qualitative responses no significant differences were found. Therefore, the null hypothesis is confirmed.

4. Operational hypothesis #4 stated that there will be no difference in team members' experience of whether their ideas/interventions for the clients are listened to, in the therapy process, whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #14 and #21 in the team members' qualitative interviews. Qualitative responses by team members indicated that there were significant differences in their experience of how their ideas/interventions are listened to with a preference for the Reflecting Team Model. Based on these qualitative responses, the null hypothesis is rejected.

5. Operational hypothesis #5 stated that there will be no difference in team members' perceptions of the cooperativeness among team members whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #15, #19, and #24 in the team members' qualitative

interviews. Based on the qualitative responses, there were no significant differences between the two treatment groups. Therefore, the null hypothesis is confirmed.

6. Operational hypothesis #6 stated that there will be no difference in team members' perceptions of their effort to attend to and focus on the family therapy interview whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #16, #20, and #23 in the team members qualitative interviews. Based on the qualitative responses, there were no significant differences between the two treatment models. Therefore, the null hypothesis is confirmed.

7. Operational hypothesis #7 stated that there will be no difference in team members' experience of pressure or anxiety to come with ideas/interventions for clients whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #14 and #21 in the team members' qualitative interviews. Qualitative responses indicated that there were significant differences in the amount of pressure/anxiety that team members experienced to come up with ideas/interventions for clients. Team members experienced less pressure/anxiety with the Reflecting Team Model. Therefore, the null hypothesis is rejected.

8. Operational hypothesis #8 stated that there will be no difference in the team members' experience of any hierarchical differences or professional distance between

the therapy team and the clients whether a Reflecting Team Model or a Strategic Team Model is used as measured by question #22 in the team members' qualitative interviews. Qualitative responses indicated less hierarchical difference for the team members when the Reflecting Team Model was used and the differences between the two treatment models were significant. Therefore, the null hypothesis was rejected.

9. Operational hypothesis #9 stated that there will be no difference in the team members' experience of themselves as active participant observers in the therapy process whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #20 and #23 in the team members' qualitative interviews. Qualitative responses indicated no significant differences between the two team treatment models. Therefore, the null hypothesis is confirmed.

10. Operational hypothesis #10 stated that there will be no difference in the therapists' perceptions of being supported and not judged by the therapy team whether a Reflecting Team Model or a Strategic Team Model is used as measured by question #24 in the team members' qualitative interviews. Qualitative responses indicated that there were significant differences in the amount of support team members experienced when they were in the therapist role. As therapists, they experienced more support with the Reflecting Team Model. Therefore, the null hypothesis is rejected.

11. Operational hypothesis #11 stated that there will be no difference in the therapists' perceptions of being connected to and aligned with clients whether a Reflecting Team Model or a Strategic Team Model is used as measured by question #25 in the team members' qualitative interviews. Qualitative responses indicated no significant differences between the two treatment models. Therefore, the null hypothesis is confirmed.

12. Operational hypothesis #12 stated that there will be no difference in the therapists' perceptions of the clients' ability to focus on their own ideas and solutions to their problems whether a Reflecting Team Model or a Strategic Team Model is used as measured by question #26 in the team members' qualitative interviews. Qualitative responses indicated significant differences in the team members' perceptions of the clients' ability to focus on their own ideas and solutions to their problems in favor of the Reflecting Team Model. Therefore, the null hypothesis is rejected.

13. Operational hypothesis #13 stated that there will be no difference in the team members' perceptions of the clients' comfort level and ease with the therapy team process whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #13 and #27 in the team members' qualitative interview. Qualitative responses indicated that there were significant differences in the therapists'

perceptions of their clients' comfort level. The therapists' perceptions were that the clients felt more comfortable with the Reflecting Team Model. Therefore, the null hypothesis is rejected.

14. Operational hypothesis #14 stated that there will be no difference in the team members' perceptions of the usefulness and effectiveness of the therapy team process whether a Reflecting Team Model or a Strategic Team Model is used as measured by questions #17 and #28 in the team members' qualitative interviews. Qualitative responses indicated significant differences for the Reflecting Team Model, in terms of, it being viewed as more effective and useful by the team members. Therefore, the null hypothesis is rejected.

Summary of Findings

This chapter presented the results and data analysis of this quantitative and qualitative process study comparing the Reflecting Team Treatment Model and the Strategic Team Treatment Model. The study sought and analyzed data that were both quantitative and qualitative and attempted to access data from both an insider and an outsider perspective as Gurman and Kniskern (1978) have recommended for family therapy research. The insider perspective was gained from all subsystems (i.e., clients, therapist, and therapy team) of the treatment system. The outsider perspective was gained by the observational coding of client videotapes by

independent raters. This chapter was divided into five sections indicating the five different areas of data collection for this study. These areas included: the clients' qualitative interviews, the therapists'/team members' qualitative interviews, the clients' quantitative self-report instruments, the therapists'/team members' quantitative model-preference scale, and the observational coding of videotaped segments of client interviews.

Due to difficulty with client recruitment, client mortality, and the large amount of data requested of clients, an opportunistic sampling procedure was implemented by the researcher. This probably had an impact on the data received from clients' in the study and makes generalization beyond the sample population limited to clients with similar demographics in similar settings as the study site. A revision of some of the quantitative self-report instruments and the use of a new observational coding system that is just being validated also would not allow for generalization to a more general clinical population. However, the results of this study adds to the small number of exploratory and pilot studies, in the literature, on the Reflecting Team Model and may help stimulate more rigorous and controlled empirical studies comparing the Reflecting Team Model with the Strategic Team Model.

From the clients' perspective, data were sought using both the insider and outsider vantage points. The clients'

qualitative interviews did not show any significant differences between the two treatment models. However, distinctions did emerge from the data, indicating some differing perceptions of the therapy process by the clients. Overall, clients in both treatment groups believed that the therapy process was positive. However, clients in the Reflecting Team Model were slightly more hopeful about how they thought they were viewed by the therapy team, and seemed to be more able to take a meta-position to comment on how another part of the therapeutic system views them when compared to the Strategic Team Model clients in this study. The Reflecting Team Model clients seemed to have more of a sense of their own control, in resolving their presenting problem, than the Strategic Team Model clients. But, this response was countered when clients were directly asked about the origin of any new ideas and a number of clients in both treatment groups indicated frequently that their new ideas came from the therapist and/or the therapy team. The Reflecting Team Model clients were also more able to give examples of new ideas than the Strategic Team Model clients. The Reflecting Team Model clients had more of an acknowledgement of the importance of the therapy team while the Strategic Team Model clients seemed to place more importance on the role of the therapist.

In reviewing the clients' qualitative data, this study suggests that there is possibly more opportunity for clients

to learn from the therapy team in the Reflecting Team Model than in the Strategic Team Model due to the clients witnessing what Andersen (1987) called the act of creation (i.e., clients listening to the therapy team's unrehearsed reflection where multiple ideas on the problem situation are discussed). In contrast, in the Strategic Team Model, the clients do not get to witness the actual process but get to hear only the outcome or finished product (i.e., the team intervention) which fits with the premises of the Strategic Team Model.

The Reflecting Team Model clients were more likely to bring up the positive experience of hearing multiple views/perspectives on their problems than the Strategic Team Model clients. This experience of clients being able to hear multiple and diverse views of their problem situation fits with the clients' experience of the reflecting team process in the qualitative study on clients' perspectives done by Smith et al. (1993). However, in this current study, client mortality most likely indicated that some clients who did not participate in the data collection had more of a negative view of the therapy experience when the therapy team was employed.

From the clients' quantitative self-report data, no significant differences in treatment effects were noted when the two treatment models were compared at pretest and posttest stages. However, when the two treatment models

were combined, there were significant differences for the clients, from the pretest stage to the posttest stage, in three of the six self-report scales that were given in both the pretest and posttest stages. This indicates that both treatment models had a positive impact on clients although a statistical analysis of the two treatment groups at posttest did not reveal any significant differences between clients in the two treatment groups. This positive overall treatment effect (but the lack of difference between the two treatment groups at posttest) may indicate that there were not enough distinctions or variations between the two team therapy models. Gurman and Kniskern (1978) did warn that this can occur in marital and family therapy research. The lack of difference may also be due to the small sample size for this section of the study.

Trends (i.e., higher mean scores) in favor of the Reflecting Team Model were noted in nine out of the twelve (sub)scales used to measure clients' responses. Overall, the researcher noted a subtle trend for the Reflecting Team Model in comparison to the Strategic Team Model in both the qualitative and quantitative client measures. However, this trend was not statistically significant in the clients' quantitative data and was more subtle than significant in the client qualitative data. The acceptance of the clients' null hypotheses indicates the lack of any statistically significant differences between the two treatment groups

from the clients' insider perspective employing both quantitative and qualitative measures. Further research is needed with tighter design controls to see if there are any significant differences from clients' perspectives between the two therapy team treatment models.

The other insider quantitative and qualitative data came from the therapists'/team members' perspective. The therapists'/team members' responses to the qualitative interviews on the Reflecting Team Model indicated that there is the development of a dialogue between the therapy team and the clients due to the clients' responses to the therapy team's reflecting comments. This is described, in a similar manner, in the therapists' perceptions of the reflecting team process in the Smith et al. (1992) study where clients seemed to have a relationship with the therapy team. In that study, the relationship with the team members developed and grew for the clients as they participated in the reflecting team process over time. It should also be noted, in this present study, that the building of the team members' relationship with the clients over time occurred in the Strategic Team Model as well. It is hard to distinguish the connection and bond among the team members, by treatment model, since team members participated in both treatment models. However, in the qualitative interviews, team members did indicate that a relationship among team members developed in both treatment models. The process was

different in each therapy team treatment model due to the differences in the team interactions for the two models.

In the Reflecting Team Model, the perception is that one sees differently behind the one-way mirror which helps allow for the ascent of multiple ideas (Andersen, 1987, 1990). It was thought by the team members that a bond develops by listening behind the one-way mirror and by participating in the team reflections. However, some team members, when asked later in their qualitative interviews, seemed to prefer the discussion among team members behind the one-way mirror in the Strategic Team Model over listening silently behind the one-way mirror in the Reflecting Team Model. This discourse that occurs behind the one-way mirror in the Strategic Team Model helped to facilitate the connection or bond among team members in that treatment model.

Some team members expressed concern about the use of the Reflecting Team Model with sensitive clinical problems which is in contrast to the views of some of the experts on the Reflecting Team Model that these sensitive problems do not rule out the use of the reflecting team process (Jenkins, 1992). Some team members' comments seemed to suggest that the reflecting conversation, in the Reflecting Team Model, may invite a shift or change not only in the clients' view of the problem situation, but also in the team members' view of the problem situation. This occurs as the

team members hear each others' unrehearsed comments during the reflecting conversation.

This value of hearing diverse or multiple ideas were also important for the clients in the Smith et al. (1993) study. However, the hearing of multiple ideas were also useful for the therapists/team members in the present study. In the present study, the hearing of different ideas, during the reflecting conversation, allowed for varied and less fixed ideas about the problem situation not only for the clients but for the team members as well. Team members believed that new or alternative ideas developed as a result of the reflecting conversation. Some team members found themselves noticing which ideas were picked up and seemed to be useful for the clients which, in turn, invited these team members to be more aware of how they used language to express their ideas during the reflecting conversation.

Overall, the team members had a preference for the Reflecting Team Model over the Strategic Team Model and believed that the clients also preferred the Reflecting Team Model. However, even with a preference for the Reflecting Team Model, the team members also viewed the Strategic Team Model in a positive manner. The team members' belief that the clients preferred the Reflecting Team Model was not validated by the clients' own perspectives of the therapy process.

Due to the differing ways of intervening into the

therapist-family system, in the two team treatment models, some team members tended to organize their observations differently depending on which team model was being used. Team members believed that there is pressure in both team models, with pressure in the Strategic Team Model to come up with unified interventions. In the Reflecting Team Model, there is pressure to participate in the reflecting conversation with the clients watching and listening.

In the fourteen hypotheses for therapists/team members, nine of the null hypotheses were rejected with a positive difference for the Reflecting Team Model in the following categories: the overall model preference, the focus on clients' strengths/solutions, the team members having their ideas listened to, the pressure/anxiety to come with interventions/ideas, the hierarchical distance, the amount of therapist support experienced from the therapy team, the therapists' perceptions of the clients' ability to focus on solutions, the therapists' perceptions of the clients' level of comfort with the team therapy process, and the usefulness/effectiveness of the therapy team models. No significant differences were found in the therapists'/team members' responses in five of the fourteen hypotheses which confirmed the null hypotheses in these categories. The categories included: the team members' focus on problems and problematic patterns, the cooperativeness among team members, the team members' ability to attend/focus on

therapy session, the active observation of therapy session by team members, and the connection/alliance for team members with the clients.

In the therapists'/team members' ratings of their level of comfort in using the two team treatment models with various clinical problems, there were concerns about using either team treatment model with sensitive clinical problems such as abuse and violence. There were significant preferences for using the Reflecting Team Model in six of the twelve problem areas. These problem areas included alcohol problems, parent-child problems, marital problems, depression, adolescent problems, and medical/somatic problems. When the twelve problem areas were combined, there was an overall significant preference by team members to use the Reflecting Team Model. This preference for use of the Reflecting Team Model is consistent with the team members' qualitative interview responses. This may indicate not only the team members' personal preference but may also indicate the influence of the confounding variable of the researcher's bias in favor of the Reflecting Team Model. However, team members were able to perceive positive and negative aspects of both team treatment models and came to see therapeutic value in both the Reflecting Team Model and the Strategic Team Model.

In the observational coding of videotapes of clients' therapy sessions, immediately prior to the collection of

posttest data, there were no significant differences between the two treatment groups on any of the 16 constructs in the observational coding system. As with the clients' self-report quantitative data, the observational coding showed a significant total treatment effect from pretest to posttest when the two treatment groups were combined. The combining of the two treatment groups may have provided for a large enough sample size to have an adequate statistical analysis. Limitations of the observational coding system included the following: the use of an opportunistic sample in the data collection, the use of a new coding system, and the time segment used for the posttest data collection for the Strategic Team Model.

In summary, the quantitative and qualitative data gained from the clients' insider perspective and the quantitative data gained from the independent raters outsider perspective did not indicate any significant differences in preference for the clients in either the Reflecting Team Model or the Strategic Team Model. This was indicated, by the fact, that no significant differences were found in the clients' operational hypotheses. Therefore, the null hypotheses were confirmed for all of the clients' operational hypotheses. Since there were no significant differences in the clients' operational hypotheses, the research hypotheses were also found to have no significant differences for clients in the Reflecting Team treatment

group and the Strategic Team treatment group. The research hypotheses were that there would be no significant differences for clients in the two treatment groups in the clients' perceptions of the therapy process, in the clients' use of their own solutions, in the clients' sense of hopefulness in the resolution of the presenting problem, in the clients' perception of being united and working together with the therapist, in the clients' interest and cooperation in the therapy process, in the clients' change in view/perception of the presenting problem, and in the clients' perception of manipulation by the therapist in the therapy process. In this study's research hypotheses, the clients' null hypotheses were confirmed. However, subtle trends for use of the Reflecting Team Model were indicated in the clients' quantitative and qualitative data from the insider perspective. The quantitative and qualitative data gained from the therapists'/team members' insider perspective indicated a significant preference for the use of the Reflecting Team Model over the Strategic Team Model.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to gain further information regarding the practice of the Reflecting Team Model of family therapy as it is perceived and experienced by participants in the therapeutic process, namely the clients, therapists, and therapy team members. Their experiences of the Reflecting Team Model were compared to the experiences and perceptions of clients, therapists, and therapy team members using a Strategic Team Model. A qualitative descriptive and exploratory pilot study was undertaken at a clinic site where the two team treatment models were compared and contrasted using both quantitative and qualitative data from insider and outsider perspectives.

Summary

Chapter I discussed the significance of the research problem and stated the purpose, objectives, assumptions, and limitations of this study. In spite of a growing demand for family therapy services of all modalities, only a limited number of outcome studies on team treatment models in the family therapy field have been published at this time. Some of this research had focused on the Milan Systemic Team Treatment Model (Boscolo et al., 1987). These studies

(Coleman, 1987; Green & Herget, 1989; Mashal, et al., 1989) suggested that the Milan Systemic Family Therapy Team Model did not develop a strong therapeutic alliance for clients with therapists and therapy team members. Green and Herget (1991) responded to the perceived distance in the therapeutic alliance with research suggesting therapist/team guidelines to improve the clients' alliance with the treatment system. These guidelines were used to operationalize the Strategic Team Model as the comparison group for the Reflecting Team treatment group in this study. In the past three years, a small number of research studies (Griffith et al., 1992; Hoger et al., 1994; Sells et al., 1994; Smith et al., 1992, 1993, 1994) have analyzed both clients' and therapists' experiences using the Reflecting Team Model.

The null hypotheses proposed in Chapter I stated that there would be no difference between the Reflecting Team Treatment Model and the Strategic Team Treatment Model, at the posttest stage, for clients in: (1) their perception of the therapy process; (2) their ability to focus on their own solutions; (3) their awareness of their own strengths and abilities to generate exceptions to the problem; (4) their sense of hopefulness that the problem will be reduced or resolved; (5) their perception of being united and working with their therapist; (6) their interest and cooperation in the therapy process; (7) their perception of a change of

view regarding the presenting problem; and, (8) their perception of being manipulated by the therapy process.

Difficulties were encountered in data collection due to problems in the recruitment of subjects and in subject dropout since data were collected over time. In response to these study design problems, data were collected immediately after the fourth therapy session to reduce the effect of client/subject mortality due to typical patterns of therapy dropout.

As noted by Smith et al. (1993), research on the reflecting team process is still in the early stages with only two quantitative studies (Griffith et al., 1992; Hoger et al., 1994) and four small qualitative studies currently in print (Sells et al. 1994; Smith et al., 1992, 1993, 1994). Given the paucity of research, exploratory studies were still needed to supplement research completed so far on the reflecting team process. This study builds on previous work by including a new qualitative interview questionnaire for clients and the therapy team and replicates the basic design of the qualitative study done by Smith et al. (1992). This study expanded beyond these other studies by: (1) the use of existing and revised quantitative self-report instruments; (2) the inclusion of a new but unvalidated observational coding system; (3) the comparison of the Reflecting Team Model with the Strategic Team Model; and, (4) the inclusion of responses from children, which was not

available in other studies, as part of the collection of data.

Chapter II provided a detailed literature review and included summaries of the guiding conceptual frameworks for Systemic Family Therapy such as general systems theory (Bertalanffy, 1968), cybernetics (Bateson, 1972, 1979), and constructivism (Efran et al., 1988). An understanding of first order and second order cybernetics (Keeney, 1983; Sluzki, 1983) and structure determinism (Maturana & Varela, 1987) were also reviewed. A brief review focused on the Systemic Family Therapy literature from the Milan Systemic Family Therapy Model (Selvini Palazzoli et al., 1978) to more recent clinical developments derived from the Milan Systemic Family Therapy Model. These included interventive interviewing (Tomm 1987a, 1987b, 1988a), the Collaborative Language Systems Model (Goolishian & Anderson, 1988), and narrative therapy (Dickerson & Zimmerman, 1992; White & Epstein, 1989; Zimmerman & Dickerson, 1993).

In addition to deductive approaches using the above conceptual frameworks, the Reflecting Team Model also included strategies from inductive theory development. Initially, the Reflecting Team Model began with descriptions in the literature of its value for clients from a purely theoretical perspective. These studies suggested that the reflective process was consistent with the principles of systems theory in terms of non-directiveness, respect for

clients, the offering of multiple ideas, and the attempt to decrease the boundaries between the therapist, the therapy team, and the clients. Validation for this reflective process came from anecdotal claims by adherents and from the use of a small number of retrospective case studies. During the past three years, the enthusiasm for the reflecting team process has spurred the beginning of a small number of studies examining both the clients' and the therapists'/team members' perceptions of the process (Sells et al., 1994; Smith et al., 1992, 1993, 1994).

Chapter III presented the methodology for the study including the primary independent variable comparing two team treatment models. The dependent variables included the clients' perceptions of the therapy process as measured by quantitative and qualitative data from both the insider and outsider perspective. Perceptions of the therapists/team members were also measured to contrast with the clients' perceptions of the process. Similarities and differences from all parts of the treatment system were hypothesized to increase understanding of the therapeutic process from all parts of the treatment system. The role of the therapy team and its experience level was discussed as well as the need to blend the role of researcher and therapist for the author. The researcher noted personal experience and theoretical preference for the Reflecting Team Model over the Strategic Team Model. Other limitations to the study

design were also noted. Instruments used as part of the dependent measures were discussed and the modification of individual oriented instruments to reflect the family system were noted. The research hypotheses were put forth in operational language.

The findings in chapter IV indicated that the clients' qualitative interviews did not show any significant preference for either the Reflecting Team Treatment Model or the Strategic Team Treatment Model in terms of the clients' perceptions/experience of the therapy process. However, distinctions did emerge from the clients' qualitative data that suggested some subtle differences in the therapy process for the clients. Since the clients' indicated an overall positive experience of the team therapy process in both treatment groups, the distinctions that emerged could prove to be helpful in future studies that contrast the two team treatment models. Due to the limitations of this study, the distinctions should not be viewed or interpreted as being a significant distinction or difference between the two treatment groups. Some interesting differences from the clients' qualitative responses were found. Clients in the Reflecting Team Model were slightly more hopeful about how they thought they were viewed by the therapy team and seemed to be more able to take a meta-position to comment on how other parts of the therapy system viewed them. The Reflecting Team treatment group clients seemed to have a

greater sense of their own control in resolving their presenting problem than the Strategic Team treatment group clients. However, when asked directly about the source of the new ideas/solutions, a number of clients in both treatment groups believed that new ideas came from the therapist or the therapy team. Although, some clients, in both treatment groups, indicated other sources for the development of new ideas as well.

Reflecting Team treatment group clients seemed more able to give examples of new ideas and they expressed more acknowledgement of the significance of the therapy team. Clients treated with the Strategic Team Model put more emphasis on the role of the therapist instead of the therapy team in their experience of the therapy process. The Reflecting Team treatment group clients were more likely to bring up the positive experience of hearing multiple views/ideas on their problems. In general, the qualitative methodology helped these subtle distinctions to come forth in the data analysis but distinctions for clients in the two treatment groups are to be expected since the two team therapy models operate in different ways. These subtle distinctions should not be viewed as showing a preference for one of the treatment models over the other. Unfortunately, the need to use an opportunistic sample due to client mortality led to a small qualitative sample size and probably indicates that clients' with more negative

perceptions of team therapy models were not represented in the qualitative interviews.

Client quantitative self-report data revealed no significant difference in treatment effect when the two models were compared at the pretest and posttest stages. When the two treatment models were combined, there were significant differences from the pretest to posttest stage in three of the six self-report scales given at both stages. This indicates that both treatment models had some positive impacts on the clients even though no significant differences could be found in the posttest scores between the two treatment models. The positive treatment effect for both treatment groups may be due to the measures selected, the small sample size, or the lack of differences between the models. Trends (i.e., higher mean scores) were noted for the Reflecting Team Model in nine out of the twelve (sub)scales used to measure the clients' responses. Overall, a trend was indicated for the Reflecting Team Model in both qualitative and quantitative client measures but since the distinction was not significant, more rigorous study designs will be needed to replicate these findings.

Additional insider quantitative and qualitative data were collected from the therapists/team members. The therapists'/team members' responses to the qualitative interviews examined the dialogue between the therapy team members and clients when clients respond to the reflecting

team's conversation. The therapists/team members perceived that a view from behind the one-way mirror, while observing the therapy session in the Reflecting Team Model, helps to bring forth a number of different ideas for the clients. A bond between the team members takes place during the process of observing and reflecting. Some team members noted that they preferred the discourse behind the one-way mirror in the Strategic Team Model. Other team members expressed concern about how clients might react to the use of an observing therapy team when sensitive problems such as violence and abuse were present.

Team members noted that the reflecting conversation invited a shift or change in their thinking about the family and the problem situation similar to the way clients are hypothesized to be able to shift their view. Some team members began to focus on which ideas seemed more useful for the clients and adjusted their language with clients to see if their ideas were received by the clients in a different manner. The team members noted a slight preference for the Reflecting Team Model over the Strategic Team Model and believed that clients also had a preference for the Reflecting Team Model. Even so, team members discussed the strength of the Strategic Team Model as well. The team members' belief in the clients' preference for the Reflecting Team Model was not corroborated in the clients' perceptions of the therapy process.

Team members seemed to organize their method of observation differently depending on which treatment model was being used. Team members reported experiencing pressure to come up with ideas/interventions but the pressure was different in each model. In the Reflecting Team Model, the team members reported pressure to go into the therapy room and have to share their ideas with the clients watching and listening behind the one-way mirror. In the Strategic Team Model, the team members reported pressure to have to come up with a single intervention to give to the clients being seen in the therapy session; it was difficult to narrow down all of their ideas into one unified intervention. Nine of the fourteen null hypotheses were rejected in favor of the Reflecting Team Model and no significant differences were found in the therapists'/team members' responses in five of the fourteen null hypotheses.

When therapists'/team members' rated their level of comfort using each team treatment model, with various clinical problems, there was a significant preference to use the Reflecting Team Model in six of the twelve clinical problems. A combination of all problem areas produced a significant preference by team members for the use of the Reflecting Team Model. This quantitative preference for using the Reflecting Team Model matches statements of the therapists'/team members' in their qualitative responses. However, due to the author's preference to use a Reflecting

Team Model, these findings should only be regarded as exploratory due to the author's bias which may have influenced the therapists'/team members' responses towards the author's preference.

In the observational coding of clients' videotapes, results did not indicate any significant differences between the two treatment groups on any of the sixteen constructs in the coding system. As with the clients' self-report quantitative data, the coding system showed a significant total treatment effect from pretest to posttest when the two treatment groups are combined.

In summary, the quantitative and qualitative data gained from the clients' insider perspective and the quantitative data obtained from the raters outsider perspective in the observational coding do not indicate any significant differences in preference for clients, in the study, for either the Reflecting Team Model or the Strategic Team Model. However, trends for use of the Reflecting Team Model were indicated in the clients' data. The quantitative and qualitative data obtained from the therapists'/team members' insider perspective indicated a significant preference for the use of the Reflecting Team Model over the Strategic Team Model.

Conclusions

This study attempted to further the understanding of the Reflecting Team Model as perceived by all members of the

therapeutic system and began a comparison of the Reflecting Team Model with the Strategic Team Model. This study used an opportunistic sampling procedure similar to other qualitative studies on the Reflecting Team Model (Sells et al., 1994; Smith et al., 1992, 1993, 1994). Results from this study can not be generalized to a larger clinical population due to the opportunistic sample and the small sample size. However, the data and conclusions continue the process of understanding the Reflecting Team Model and also provide some information on how observing therapy teams in general are perceived by both clients and therapists/team members.

The data, in the study, indicated that both clients and therapists/team members believed that there were positive and negative aspects to both team treatment models. The conclusions concurred with the clients' and therapists' perceptions of the reflecting team process that were found in the qualitative studies done at Florida State University (Smith et al., 1992, 1993). The positive perception of the therapy process for the clients in the Strategic Team Model suggests that the recommendations and guidelines for Strategic/Systemic Team Treatment Models found in the study by Green and Herget (1991) are valid for a Strategic Team treatment approach in this study as well.

The results of this study indicate that a positive therapeutic alliance can develop with both team treatment

models. The proponents of the reflecting team process (Andersen, 1987 & 1990; Lax, 1989; Miller & Lax, 1988; Roberts et al., 1989) are accurate in their claims that this is a helpful and innovative process for clients and therapists. An advocacy for this approach that views an observing therapy team using a Strategic Team Model in a negative manner does not seem warranted. In essence, the way of using an observing therapy team in the Strategic Team Model has advantages and criticism may not be warranted. In short, this study demonstrated a positive therapeutic alliance can be developed with both team treatment models when the effort is made to be respectful and open with clients no matter how the observing therapy team is used in the therapeutic process.

There were similar and unique perceptions of the therapy process for clients in both treatment models as well as for the therapists/team members. It is evident that the clients in both treatment groups, who dropped out of the study, may have had a different or more negative view of the therapy process than the clients who remained in the study. It was the author's observation that clients who dropped out of the study, tended to fall into two groups. One group of clients may have felt uncomfortable being part of the study due to the data collection methods (i.e., the videotaping, the qualitative interviews, and the filling out self-report instruments). Another group of clients may have found the

observing therapy team approach with either treatment model as being too different from their expectations of therapy. Therefore, it is likely that these clients could have had a more negative view of the therapy process than the clients who were willing to share their perceptions of the process at the posttest stage. This issue of client mortality also limits any generalizations to other clinical populations.

In reviewing the therapists'/team members' perceptions of their clients' experience of the therapy process, team members were not accurate in their perceptions that clients would prefer the Reflecting Team Model over the Strategic Team Model. The team members may have shared the author's bias in favor of the Reflecting Team Model. Since clients in both treatment models had overall positive perceptions of the therapy process, the only way to accurately assess the clients' preference between the two models would have been to have each couple/family experience both team treatment models by alternating the use of both models with each couple/family.

The overall positive treatment effect for both team treatment models from the pretest to posttest stages was evident in both the qualitative and quantitative data and from both the insider and outsider perspectives. However, the inability to make distinctions between the two treatment models may be due to a number of factors including the small sample size, the lack of differentiation between how the

models were operationalized, or due to the lack of real treatment effect differences between the two team treatment models. The lack of significant posttest differences between the two treatment models is clear but it is also evident that there were trends (i.e., higher mean scores) for the Reflecting Team Model over the Strategic Team Model in the clients' quantitative data. There were also some small subtle distinctions between the Reflecting Team Model and the Strategic Team Model in the clients' qualitative data. The use of both quantitative and qualitative measures of clients' perceptions yielded helpful data. The clients' qualitative responses allowed for more subtle and finer distinctions that would have been missed if only quantitative data were used in this study. This fits with the complementarity between quantitative and qualitative measures that Moon et al. (1990) suggested for family therapy research. This study also found that self-report instruments designed for individual psychotherapy can be adapted for use with larger systems (i.e., couples and families) as well.

The qualitative data gained from the therapists/team members indicated that the two treatment models invite team members to observe the therapy process differently because the two models intervene into the therapeutic system in different ways. Since the two team treatment models intervene differently, the bond or connection between the

team members also developed differently, for some team members, depending on which model was being used. The team members' conversation behind the one-way mirror in the Strategic Team Model helped members strengthen their bond or connection as a group. In the Reflecting Team Model, the process of listening quietly behind the one-way mirror followed by the reflecting conversation in front of the clients helped to strengthen their bond as team members. The therapists/team members were able to see value in the use of both team treatment models even though there was a slight preference for the Reflecting Team Model.

Recommendations

The results of this study indicated that clients do have positive perceptions of the therapy process when both the Reflecting Team Model and the Strategic Team Model are used. It also found that the therapists/team members in the study identified positive uses for both team treatment models even when they may have had an initial preference. From both the insider and outsider perspectives, the clients' data did not reveal significant differences in the treatment effect for either treatment model. Results did indicate a significant treatment effect for both models at the posttest stage as measured by clients' self-report data, clients' qualitative data and observational coding by independent raters.

This study showed that even with a small client and

therapist sample that both team treatment models had a positive therapeutic effect on the clients and both models were perceived as useful by the therapists. Despite the common positive aspects of both team models, distinctions did emerge in the two team treatment models in the clients' and therapists'/team members' qualitative responses. However, the small opportunistic sample and compromises to the original study design limit any generalization of the results of this study. Therefore, it is recommended that a next step in the analysis of the reflecting team process include studies that allow for larger sample sizes and stricter adherence to the study design. As this study indicated quantitative and qualitative measures can complement each other to more fully understand the reflecting team process and future studies should include both types of measurements.

In using the qualitative interview as the qualitative methodology for this study, the author was able to access finer and subtle distinctions that the quantitative data could not access. The interview process revealed that some of the qualitative interview questions were repetitive or unclear to some of the clients and the therapists/team members. An iterative method of question development, as used by Smith et al. (1992, 1993), would help with the development of future qualitative questions for participants in any team treatment study in the future.

Client mortality, in this study, may be partially related to the large number of measures for the dependent variable. The author believes that future studies would have less client mortality and a tighter study design if fewer measures of the dependent variable are used. For example, one quantitative instrument and a qualitative interview may lessen clients' anxiety and concerns about participation in a research study. It should be noted that the previous studies (Griffith, 1992; Sells et al., 1994; Smith et al., 1992, 1993, 1994) on the reflecting team process did not attempt to use as many dependent measures and these studies still had small sample sizes.

As recommended in the most recent studies on the reflecting team process (Sells et al., 1994; Smith et al., 1994), future studies on the reflecting team process that use qualitative methodologies should consider using a domain analysis (Spradley, 1979) and a content analysis (Weber, 1990). This would assist in organizing and recording recurrent themes in the data and help to quantify the predominance of certain themes that repeat throughout the qualitative data.

This study is the first to compare the Reflecting Team Treatment Model with the Strategic Team Treatment Model. In order to solicit more informed opinions and perceptions from clients in the comparison of these team treatment models, it would be useful in future studies to alternate the team

treatment models with each couple/family so that a true comparison could be experienced by the subjects in the study.

Just as the finding of differences between team treatment models is important, the finding of and acknowledgement of similarities in the team treatment models will be important in future research. Future studies should continue to examine the therapeutic process from the outsider perspective as the Griffith et al. (1992) study did when they used the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974) to code observationally the clients' conversations before and after the reflecting team intervention. It is recommended that future studies use a validated observational coding system like the SASB when gathering data from the outsider perspective. Use of a validated coding system in comparison studies of team treatment models will help elicit both differences and commonalities in team treatment models. The present study used a new coding system that is in the process of being validated, so generalization is not possible at this time.

To reduce mortality, the posttest data collection for such a study should be earlier than it was in the current study. Another recommendation is based on the therapists'/team members' responses questioning the effectiveness of the Reflecting Team Model with families with small children and families where a member has a major

mental illness. Future studies may look to examine the effectiveness of the reflecting team process with these clinical populations. Since client mortality is a problem in this type of research, qualitative interviews with clients who drop out of the study should be included in future study designs if possible.

In closing, the following is a summary of what was learned from this study, what future research on the Reflecting Team Model might include based on the findings in this study, and what the therapy team members learned as participants in both the therapy and the research processes from the author's perspective.

From the author's perspective, what was learned from this study included the following:

(a) The collection of too many measures of the dependent variable made this process study of family therapy practice difficult to complete.

(b) Client reluctance to participate in the study may raise a question about the desirability of using family therapy treatment models that involve the use of an observing therapy team.

(c) Subject attrition, during the study time period, made this process study difficult to complete and complicated the analysis of the data.

(d) Given subject attrition during the study, it may be more useful in a process study to collect posttest data sooner

such as in the first or second therapy sessions.

(e) Given the difficulty with subject recruitment and attrition, it may be more useful to limit or decrease the number of measures for the dependent variable.

(f) Both the Reflecting Team Model and the Strategic Team Model have positive and negative aspects. Both team treatment models can be effective, and can be perceived by clients to be useful in helping them resolve the issues that they bring to family therapy. It is not an either/or choice between the two team treatment models.

(g) Clients will listen to observers (i.e., the therapy team) if what they have to say is relevant and fits their experience regardless of which process is used, the Reflecting Team Model or the Strategic Team Model.

(h) Having observers (i.e., the therapy team) is at times difficult for clients when they bring their personal issues to therapy but this hesitancy can be overcome if the observers are respectful of the clients, and if their comments fit for the clients in their situation or context.

(i) The process of being an observer (i.e., therapy team member) is difficult if you want to do it in a responsible manner. There is pressure as an observer in both the Reflecting Team Model and the Strategic Team Model but the pressure seems to be experienced differently by team members in each treatment model. In the Strategic Team Model, there is pressure to come with only one or two interventions. It

is difficult to narrow down the multiple ideas that team members have into a single uniform intervention. In the Reflecting Team Model, there is pressure to talk in front of the clients and exposure your ideas and thoughts to the clients and the therapist. This may help team members to understand more clearly how difficult it can be for clients to share their story in the therapy process.

(j) It is important to be grounded in theory; sometimes it was difficult for the team members to see the strengths, positive behaviors, and exceptions to the problem with clients that were struggling with difficult problematic patterns. Obviously, the team members with more experience had less difficulty with this process than the team members with relatively little therapy experience.

(k) There is a value in hearing multiple ideas not only for clients but for the therapy team members as well. This allowed both clients and team members to be open to alternative points of view. For team members, there is a tendency to think that your personal ideas about the clients' situation are important. The hearing of other ideas about the same client situation, during the therapy team's reflection, can open space for a change in thinking about the situation for team members. This can lead to the conclusion that there is no one right direction to go in, but many possible directions to go in as clients work to resolve their problems.

(l) For clients in this study, change may occur initially in one's ideas or beliefs about the problem situation rather than change first taking place at the behavioral level.
(m) The clients in the study were realistic that change takes time, and they may be more realistic about change than some of proponents of brief therapy in the family therapy field.
(n) On a personal note, the dual role of clinician and researcher sometimes made it difficult for the author to complete this study. The service needs of the clients and the training needs of the team members naturally had to take a priority over the recruitment of subjects and the collection of data for this study.

From the author's perspective, future research on the Reflecting Team Model could include the following:
(a) A qualitative study on the way team members observe the therapy process, focusing on the similarities and differences in the process of observation when a Reflecting Team and a Strategic Team Model are used.
(b) A qualitative study exploring how the bond, connection, and trust between therapy team members develops when the Reflecting Team and the Strategic Team Models are used.
(c) Developing a direct comparative study of clients' experience of the Reflecting Team and the Strategic Team Models that includes quantitative and qualitative methods. The treatment model would be alternated by session for the

subjects in the study (i.e., the Reflecting Team Model would be the treatment modality in sessions one and three, and the Strategic Team Model would be the treatment modality in sessions two and four). This would allow the subjects in the study to have experiences with both team treatment models and provide the opportunity for a more direct comparison of the two team treatment models.

(d) Provide a follow-up study on clients that dropped out of the comparative study of the team treatment models.

(e) Use the iterative method process to further refine and develop qualitative interview themes and questions for both clients and therapy team members that participate in the reflecting team process. Clients and team members would participate in the co-research process by receiving information on the initial themes that were developed from the qualitative analysis of the data, and then give feedback to the researcher which would allow for further refinement of themes and questions in a recursive manner.

(f) Use of a co-researcher to verify themes that are developed in the qualitative interview process.

(g) Use of a Domain Analysis and a Content Analysis on the qualitative responses in further comparative studies.

(h) A qualitative study examining how clients listen during the therapy session in their conversation with the therapist in comparison to how they listen to the reflecting team from behind the one-way mirror.

(i) Doing a comparative study of the Reflecting Team and the Strategic Team Models using quantitative methods where the posttest data would be collected after the first therapy session. More rigorous control of the study design would include controlling for the clients' presenting problem and complete random assignment to treatment groups.

(j) A comparative study of the regular Reflecting Team Model as it was used in this study with a more recent version of the Reflecting Team Model where the team members interview each other during the reflection about the origin and reasons for their comments.

(k) A comparative study of the Reflecting Team Model with regular family therapy without the use of a therapy team for families dealing with sensitive issues such as domestic violence and abuse issues.

(l) Exploration and study of how the reflecting team process can be adapted to physician education in family medicine to help physicians to be reflective in their patient encounters, and to open space to see that there are multiple views of the psychosocial problems that medical patients present with.

Based on the team members' qualitative interviews and the author's observation of the therapy team process during the study period, it is believed that team members learned the following:

(a) The way team members learned about the therapy process

by observing behind the one-way mirror was different than the way they learned about the therapy process as a therapist or co-therapist.

(b) Team members bonded and connected with each other during the therapy process. The bond developed in both the Strategic Team Model and in the Reflecting Team Model. The process of the bonding and the building of trust was different in each model.

(c) Team members learned about two different types of family therapy.

(d) Team members learned from watching and listening to all members of the treatment system (i.e., from the clients, the therapist, and from the other team members).

(e) In their experience interviewing clients, in the qualitative interviews, team members learned about the clients' experience of the therapy process.

(f) Team members learned to take a meta-position (i.e., an observing position of the therapy process). The team members participation in the qualitative interviews gave them the opportunity to be reflective of the therapy process.

(g) Team members preferred the Reflecting Team Model but liked and saw value in the Strategic Team Model.

(h) The therapy team process invited team members to examine the words and phrases they use with clients in the therapy process.

(i) By using two different therapy team models, team members became aware that they observe differently depending on which therapy team model was being used at a particular time. The observation process is somewhat different in the two therapy team models.

REFERENCES

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. Family Process, 26, 405-414.

Andersen, T. (Ed.). (1990). The reflecting team: Dialogues and dialogues about the dialogues. Broadstairs, Kent: Borgmann Publishing.

Anderson, H., Goolishian, H., & Winderman, L. (1986). Problem determined systems: Towards transformation in family therapy. Journal of Strategic and Systemic Therapies, 5, 1-13.

Anderson, H. & Goolishian, H. (1988). Human systems as linguistic systems: Evolving ideas about the implications for theory and practice. Family Process, 27, 371-393.

Atkinson, B. J., & Heath, A. W. (1987). Beyond objectivism and relativism: Implications for family therapy research. Journal of Strategic and Systemic Therapies, 6, 8-17.

Atkinson, B., Heath, A., & Chenail, R. (1991). Qualitative research and the legitimization of knowledge. Journal of Marital and Family Therapy, 17, 161-166.

Bateson, G. (1972). Steps to an ecology of mind. New York: Ballantine.

Bateson, G. (1979). Mind and nature. New York: Dutton.

Beck, A. T., Weissman, A., Lester, D. & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. Journal of Consulting and Clinical Psychology, 42, 861- 865.

Becvar, R. J., & Becvar, D. S. (1982). Systems theory and family therapy: A primer. Washington, DC: University Press of America.

Benjamin, L. (1974). Structural analysis of social behavior. Psychological Review, 81, 392-425.

Bertalanffy, L. (1968). General systems theory: Foundation, developments, applications. New York: George Braziller.

Best, J. W., & Kahn, J. V. (1989). Research in education (6th ed.). Engelwood Cliffs, NJ.: Prentice-Hall.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research and Practice, 16, 252-260.

Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). Milan systemic family therapy. New York: Basic Books.

Bourdieu, P. (1988). Homo academicus. Stanford, CA: Stanford University Press.

Bruner, J. (1986). Actual minds, possible worlds. Cambridge, Ma: Harvard University Press.

Bruner, J. (1990). Acts of meaning. Cambridge, MA: Harvard University Press.

Burbatti, G. L., & Formenti, L. (1988). The Milan approach to family therapy. Northvale, NJ.: Jason Aronson.

Bussell, D. A. (1994). Ethical issues in observational family research. Family Process, 33, 361-376.

Caesar, P. L. & Roberts, M. F. (1991). A conversational journey with clients and helpers: Therapist as tourist not tour guide. Journal of Strategic and Systemic Therapies, 10(3 & 4), Fall and Winter, 38-51.

Carter, B. & McGoldrick, M. (1989). Overview the changing family life cycle: A framework for family therapy. In B. Carter & M. McGoldrick (Eds.). The changing family life cycle: A framework for family therapy. (2nd ed.). Boston, Mass: Allyn and Bacon.

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. Family Process, 26, 415-428.

Cavell, T. A. & Snyder, D. K. (1991). Iconoclasm versus innovation: Building a science of family therapy-Comments on Moon, Dillon, and Sprenkle. Journal of Marital and Family Therapy, 17, 167-171.

Chamberlain, P., Patterson, G., Reid, J., Kavanagh, K., & Forgatch, M. (1984). Observation of client resistance. Behavior Therapy, 15(2), 144-155.

Coale, H. W. (1992). The constructivist emphasis on language: A critical conversation. Journal of Strategic and Systemic Therapies, 11(4), Spring, 12-26.

Coleman, S. (1987). Milan in Bucks County. The Family Therapy Networker, 11, 42-47.

Conran, T., & Love, J. (1993). Client voices: Unspeakable theories and unknowable experiences. Journal of Systemic Therapies, 12(2), Summer, 1-19.

Davidson, J., Lax, W., Lussardi, D., Miller, D., & Ratheau, M. (1988). The reflecting team. The Family Therapy Networker, 12, 44-46, 76-77.

Dell, P. F. (1985). Understanding Bateson and Maturana: Toward a biological foundation for the social sciences. Journal of Marital and Family Therapy, 11, 1-20.

DeShazer, S. (1985). Keys to the solution in brief therapy. New York: W. W. Norton.

DeShazer, S. (1988). Clues: Investigating solutions in brief therapy. New York: W. W. Norton.

DeShazer, S. (1991). Putting difference to work. New York: W. W. Norton.

DeShazer, S., & Berg, I. K. (1992). Doing therapy: A post-structural revision. Journal of Marital and Family Therapy, 18, 71-81.

Dickerson, V. C. & Zimmerman, J. (1992). Families with adolescents: Escaping problem lifestyles. Family Process, 31, 341-354.

Efran, J., & Lukens, M. (1985). The world according to Humberto Maturana. The Family Therapy Networker, 9, 23-28, 72-75.

Efran, J. S., Lukens, M. D. & Lukens, R. J. (1990). Language, structure and change: Frameworks of meaning in psychotherapy. New York: W. W. Norton.

Efran, J. S., Lukens, R. J., & Lukens, M. D. (1988). Constructivism: What's in it for you? The Family Therapy Networker, 12, 26-35.

Ellis, G. (1987). Theory w/o tears--A friendly introduction. Unpublished manuscript.

Epstein, N. B., Baldwin, L. M. & Bishop, D. S. (1983). The McMaster family assessment device. Journal of Marital and Family Therapy, 9, 171-180.

Falzer, P. R. (1986). The cybernetic metaphor: A critical examination of the ecosystemic epistemology as a foundation of family therapy. Family Process, 25, 353-364.

Fish, V. (1993). Poststructuralism in family therapy: Interrogating the narrative/conversational mode. Journal of Marital and Family Therapy, 19, 221-232.

Fisch, R., Weakland, J., & Segal, L. (1982). The tactics of change. San Francisco: Jossey-Bass.

Flaskas, C. & Humphreys, C. (1993). Theorizing about power: Intersecting the ideas of Foucault with the "problem" of power. Family Process, 32, 35-48.

Foucault, M. (1975). The birth of a clinic: An archaeology of medical perception. New York: Vintage/Random House.

Foucault, M. (1980). Power/knowledge: Selected interviews and writings. New York: Pantheon Books.

Foucault, M. (1988). On power. In L. Kritzman (Ed.), Michel Foucault: Politics, philosophy: Interviews and other writings, 1977-1984. New York: Routledge.

Friedman, S. (Ed.). (1993). The new language of change: Constructive collaboration in psychotherapy. New York: Guilford Press.

Gale, J. & Newfield, N. (1992). A conversation analysis of a solution-focused marital therapy session. Journal of Marital and family therapy, 18, 153-166.

Gay, L. R. (1987). Educational research: Competencies for analysis and application (3rd ed.). Columbus, OH: Merrill Publishing Company.

Geertz, C. (1983). Local knowledge. New York: Basic Books.

Gergen, K. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 266-275.

Gergen, K. (1991). The saturated self. New York: Basic Books.

Goolishian, H. (1990). Therapy as a linguistic system: Hermeneutics, narrative and meaning. The Family Psychologist, 6, 44-45.

Goolishian, H. & Andersen, H. (1987). Language systems and therapy: An evolving idea. Journal of Psychotherapy, 23, 529-538.

Green, R. J., & Herget, M. (1989a). Outcomes of systemic/strategic team consultation: I. Overview and one-month results. Family Process, 28, 37-58.

Green, R. J., & Herget, M. (1989b). Outcomes of systemic/strategic team consultation: II. Three-year followup and a theory of "emergent design". Family Process, 28, 419-437.

Green, R. J., & Herget, M. (1991). Outcomes of systemic/strategic team consultation: III. The importance of therapist warmth and active structuring. Family Process, 30, 321-336.

Griffith, J. L., & Griffith, M. E. (1992). Speaking the unspeakable: Use of the reflecting position in therapies for somatic symptoms. Family Systems Medicine, 10, 41-51.

Griffith, J. L. & Griffith, M. E. (1994). The body speaks: Therapeutic dialogues for mind-body problems. New York: Basic Books.

Griffith, J. L., Griffith, M. E., Krejmas, N., McLain, M., Mittal, D., Rains, J., & Tingle, C. (1992). Reflecting team consultations and their impact upon family therapy for somatic symptoms as coded by structural analysis of social behavior (SASB). Family Systems Medicine, 10, 53-58.

Gurman, A. S., & Kniskern, D. P. (1978). Research on marital and family therapy: progress, perspective and prospect. In S. Garfield & A. Gergin (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. (2nd ed.). New York: Wiley.

Gurman, A. S., & Kniskern, D. P. (Eds.). (1981). Handbook of family therapy. New York: Brunner/Mazel.

Gurman, A. S., & Kniskern, D. P. (Eds.). (1991). Handbook of family therapy: Volume II. New York: Brunner/Mazel.

Guttman, H. A. (1991). Systems theory, cybernetics and epistemology. In A. S. Gurman & D. P. Kniskern (Eds.). Handbook of family therapy: Volume II. New York: Brunner/Mazel.

Haley, J. (1976). Problem-solving therapy: New strategies for effective family therapy. San Francisco: Jossey-Bass.

Haley, J. (1980). Leaving home: The therapy of disturbed young people. New York: McGraw-Hill.

Haley, J. (1987). Problem-solving therapy (2nd ed.). San Francisco: Jossey-Bass.

Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. Family Process, 33, 19-36.

Heatherington, L., & Friedlander, M. L. (1990). Couple and family therapy alliance scales: Empirical considerations. Journal of Marital and Family Therapy, 16(3), 299-306.

Heppner, P. P., & Peterson, C. H. (1982). The development and implication of a personal problem-solving inventory. Journal of Counseling Psychology, 29, 66-75.

Hill, D. J., & Bale, R. M. (1980). Development of the mental health locus of origin scales. Journal of Personality Assessment, 44, 148-156.

Hoffman, L. (1988). A constructivist position for family therapy. The Irish Journal of Psychology, 9(1), 110-129.

Hoffman, L. (1990). Constructing realities: An art of lenses. Family Process, 29, 1-12.

Hoffman, L. (1991). A reflexive stance for family therapy. Journal of Strategic and Systemic Therapies, 10(3 & 4), Fall and Winter, 4-17.

Hoger, C., Temme, M., Reiter, L., & Steiner, E. (1994). The reflecting team approach: Convergent results of two exploratory studies. Journal of Family Therapy, 16, 427-437.

Horvath, A. O., & Greenberg, L. (1986). The development of the working alliance inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 529-556). New York: Guilford Press.

Issac, S., & Michael, W. B. (1983). Handbook in research and evaluation (2nd ed.). San Diego, CA: Edits Publishers.

Jenkins, D. A. (1992). The theory and practice of a reflecting team approach to family therapy: A delphi study. Unpublished doctoral dissertation, Florida State University.

Joanning, H., Newfield, N. & Quinn, W. H. (1987). Multiple perspectives for research using family therapy to treat adolescent drug abuse. Journal of Strategic and Systemic Therapies, 6(1), 18-26.

Kassis, J. P. & Matthews, W. J. (1987). When families and helpers do not want the mirror. Journal of Strategic and Systemic Therapies, 6(4), 33-43.

Keeney, B. P. (1982). What is an epistemology of family therapy? Family Process, 21, 153-168.

Keeney, B. P. (1983). Aesthetics of change. New York: Guilford Press.

Kiser, D. J., Piercy, F. P., & Lipchik, E. (1993). The integration of emotion in solution-focused therapy. Journal of Marital and Family Therapy, 19(3), 233-242.

Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). A client-based description of family therapy. Journal of Family Psychology, 3, 310-321.

LaViolette, P. A. (1981). A systems view of man. Boulder, Colo: Westview Press.

Lax, W. D. (1989). Systemic family therapy with young children and their families: Use of the reflecting team. Journal of Psychotherapy and the Family, 5, 55-73.

Lipchik, E. (1992). A "reflecting interview". Journal of Strategic and Systemic therapies, 11(4), Winter, 59-76.

Lussardi, D. & Miller, D. (1991). A reflecting team approach to adolescent substance abuse. In T. Todd & M. Selekman, (Eds.). Family therapy approaches with adolescent substance abuse. New York: Allyn and Boyd.

Madanes, C. (1981). Strategic family therapy. San Francisco: Jossey-Bass.

Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Toward the validation of the California therapeutic alliance rating system: Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1(1), 46-52.

Mashal, M., Feldman, R. B., & Sigal, J. J. (1989). The unraveling of a treatment paradigm: A followup study of the Milan approach to family therapy. Family Process, 28, 457-470.

Maturana, H. (1975). The organization of the living: A theory of the living organization. International Journal of Man-Machine Studies, 7, 313-332.

Maturana, H. (1980). Autopoiesis: Reproduction, heredity and evolution. In M. Zeleny (Ed.), Autopoiesis, Dissipative Structures, and Spontaneous Social Orders. Boulder, Co: Westview Press.

Maturana, H., & Varela, F. J. (1980). Autopoiesis and cognition: The realization of living. Boston: D. Reidel.

Maturana, H., & Varela, F. J. (1987). The tree of Knowledge: The biological roots of human understanding. Boston: Shambhala.

Mackinnon, L. (1983). Contrasting strategic and milan therapies. Family Process, 22, 425-438.

McAdams, D. P. (1993). The stories we live by: Personal myths and the making of the self. New York: William Morrow & Company.

McCarthy, I. C. & Byrne, N. O. (1988). Mis-taken love: Conversations on the problem of incest in an Irish context. Family Process, 27, 181-199.

Meyerhoff, B. & Ruby, J. (1982). In J. Ruby, (Ed.). A crack in the mirror: Reflexive perspectives in anthropology. Philadelphia: University of Pennsylvania Press.

Miller, D. & Lax, W. (1988). Interrupting deadly struggles: A reflecting team model for working with couples. Journal of Strategic and Systemic Therapies, 7(3), 16-22.

Minuchin, S. (1974). Families and family therapy. Cambridge, Mass: Harvard University Press.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1990). Family therapy and qualitative research. Journal of Marital and Family Therapy, 16, 357-374.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1991). On balance and synergy: Family therapy and qualitative research revisited. Journal of Marital and Family Therapy, 17, 187-192.

Morris, J., Gawinski, B. A., & Joanning, H. (1994). The therapist-investigator relationship in family therapy research. Journal of Systemic Therapies, 13(2), 24-28.

Newfield, N. A., Kuehl, B. P., Joanning, H. P., & Quinn, W. H. (1991). We can tell you about "psychos" and "shrinks": An ethnography of the family therapy of adolescent drug abuse. In T. C. Todd & M. D. Selekman (Eds.), Family Therapy Approaches with Adolescent Substance Abusers (pp. 277-310). Needham Heights, Mass: Allyn and Bacon.

Nichols, M. P. (1987). The self in the system: Expanding the limits of family therapy. New York: Brunner/Mazel.

Olson, D. H., McCubbin, H., Barnes, H., Larsen, A., Muxen, M., & Wilson, M. (1982). Family inventories. St. Paul, Minn: Family Social Science, University of Minnesota.

Olson, D. H. & Ryder, R. (1978). Marital and family interaction coding system (MFICS): Abbreviated coding manual. St. Paul, Minn: Family Social Science, University of Minnesota.

Orlinsky, D. E., & Howard, K. I. (1967). The good therapy hour: Experiential correlates of patients' and therapists' evaluations of therapy sessions. Archives of General Psychiatry, 16(5), 621-632.

Parry, A. & Doan, R. E. (1994). Story re-visions: Narrative therapy in the postmodern world. New York: Guilford Press.

Patton, M. Q. (1987). How to use qualitative methods in evaluation. Newbury Park, CA: Sage.

Penn, P. & Sheinberg, M. (1991). Stories and conversations. Journal of Strategic and Systemic Therapies, 10(3 & 4), Fall and Winter, 30-37.

Pinsof, W. M. (1980). The family therapist coding system (FTCS) manual. Monograph, The Family Institute of Chicago, Chicago.

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple, and individual therapy scales. Journal of Marital and Family Therapy, 12, 137-151.

Prest, L. A., Darden, E. C. & Keller, J. F. (1990). The fly on the wall: Reflecting team supervision. Journal of Marital and Family Therapy, 16(3), 265-273.

Redekop, F. (1995). The "problem" of Michael White and Michel Foucault. Journal of Marital and Family Therapy, 21(3), 309-318.

Reichelt, S. & Christensen, B. (1990). Reflections during a study on family therapy with drug addicts. Family Process, 29, 273-287.

Roberts, M., Ceasar, P. L., Perryclear, B., & Phillips (1989). Reflecting team consultations. Journal of Strategic and Systemic Therapies, 8, 38-46.

Robinson, C. A., Wright, L. M., & Watson, W. L. (1994). A nontraditional approach to family violence. Archives of Psychiatric Nursing, 8(1), 30-37.

Rosenwald, G. C. & Ochberg, R. L. (Eds.). (1992). Storied lives: The cultural politics of self-understanding. New Haven, Conn: Yale University.

Saunders, S. M., Howard, K. I., & Orlinsky, D. E. (1989). The therapeutic bond scales: Psychometric characteristics and relationship to treatment effectiveness. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1(4), 323-330.

Searight, H. R. & Young, R. (1994). Qualitative research and Family systems medicine: A Natural Fit. Family Systems Medicine, 12(2), 117-132.

Sells, S. P., Smith, T. E., Coe, M. J., Yoshioka, M., & Robbins, J. (1994). An ethnography of couple and therapist experiences in reflecting team practice. Journal of Marital and Family Therapy, 20(3), 247-266.

Sells, S. P., Smith, T. E., & Sprenkle, D. H. (1995). Integrating qualitative and quantitative research methods: A research model. Family Process, 34, 199-218.

Selvini, M. (Ed.). (1988). The work of Mara Selvini Palazzoli. Northvale, NJ: Jason Aronson.

Selvini Palazzoli, M. (1986). Toward a general model of psychotic family games. Journal of Marital and Family Therapy, 12(4), 339-350.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. (1978). Paradox and counterparadox. New York: Jason Aronson.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. (1980). Hypothesizing-circularity-neutrality: Three guidelines for the conductor of the session. Family Process, 19, 3-12.

Sheinberg, M. (1992) Navigating treatment impasses at the disclosure of incest: Combing ideas from feminism and social constructionism. Family Process, 31, 201-216.

Shilts, L., Filippino, C., & Nau, D. S. (1994). Client-informed therapy. Journal of Systemic Therapies, 13(4), Winter, 39-52.

Shilts, L., & Knapik-Esposito, M. (1993). Playback of the therapeutic process: He said, she said, they said. Journal of Marital and Family Therapy, 12(2), 41-54.

Shilts, L., Rudes, J., & Madigan, S. (1993). The use of a solution-focused interview with a reflecting team format: Evolving thoughts from clinical practice. Journal of Systemic Therapies, 12, Spring, 1-10.

Simon, G. M. (1992). Having a second-order mind while doing first-order therapy. Journal of Marital and Family Therapy, 18(4), 377-387.

Simon, R. (1985). Structure is destiny: An interview with Humberto Maturana. The Family Therapy Networker, 9, 32-45.

Sluzki, C. E. (1983). Process, structure and world views: Toward an integrated view of systemic therapy. Family Process, 22, 469-476.

Sluzki, C. E. (1992). Transformation: A blueprint for narrative changes in therapy. Family Process, 31, 217-230.

Smith, T. E., Sells, S. P., & Clevenger, T. (1994). Ethnographic content analysis of couple and therapist perceptions in a reflecting team setting. Journal of Marital and Family Therapy, 20(3), 267-286.

Smith, T. E., Winton, M., & Yoshioka, M. (1992). A qualitative understanding of reflective-teams II: Therapists' perspectives. Contemporary Family Therapy, 14(5), October, 419-432.

Smith, T. E., Yoshioka, M., & Winton, M. (1993). A qualitative understanding of reflecting teams I: Client perspectives. Journal of Systemic Therapies, 12(3), 28-43.

Spradley, J. (1979). The ethnographic interview. New York: Holt, Rinehart & Winston.

Spradley, J. (1980). Participant observation. New York: Holt, Rinehart & Winston.

Sprenkle, D. H., & Bischof, G. P. (1994). Contemporary family therapy in the United States. Journal of Family Therapy, 16, 5-23.

Stiles, W. B. (1980). Measurement of the impact of psychotherapy sessions. Journal of Counseling and Clinical Psychology, 48, 176-185.

Strauss, A. L. (1987). Qualitative analysis for social scientists. Cambridge, UK: Cambridge University Press.

Tjersland, O. A. (1990). From universe to multiverse-and back again. Family Process, 29, 385-398.

Tomm, K. M. (1984a). One perspective on the Milan systemic approach, part I: Overview of development theory and practice. Journal of Marital and Family Therapy, 10, 113-124.

Tomm, K. M. (1984b). One perspective on the Milan systemic approach, part II: Description of session format, interviewing style and interventions. Journal of Marital and Family Therapy, 10, 253-271.

Tomm, K. M. (1987a). Interventive interviewing: Part I. strategizing as a fourth guideline for the therapist. Family Process, 26, 3-13.

Tomm, K. M. (1987b). Interventive interviewing: Part II. reflexive questioning as a means to enable self-healing. Family Process, 26, 153-183.

Tomm, K. M. (1988a). Interventive interviewing: Part III. intending to ask lineal, circular, reflexive and strategic questions?. Family Process, 27, 1-15.

Tomm, K. M. (1988b). Seminars held as part of the 1988 family therapy externship program. University of Calgary, Family Therapy Program. Calgary, Alberta, Canada.

Touliatos, J., Permutter, B. F., & Straus, M. A. (Eds.). (1990). Handbook of family measurement techniques. Newbury Park, CA: Sage Publications.

Tracey, T. J., & Kokotvic, A. M. (1989). Factor structure of the working alliance inventory. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1(3), 207-210.

Von Glasersfeld, E. (1984). An introduction to radical constructivism. In P. Watzlawick (Ed.), The invented reality. New York: W. W. Norton.

Walsh, F. (1991). Promoting healthy functioning in divorced and remarried families. In A. S. Gurman & D. P. Kniskern (Eds.)., Handbook of family therapy: Volume II. New York: Brunner/Mazel.

Walter, J. L. & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner/Mazel.

Wangberg, F. (1991). Self-reflection: Turning the mirror inward. Journal of Strategic and Systemic Therapies, 10(3 & 4), Fall and Winter, 18-29.

Watson, W. L., & Lee, D. (1993). Is there life after suicide? The systemic belief approach for "survivors" of suicide. Archives of Psychiatric Nursing, 7(1), 37-43.

Weber, R. P. (1990). Basic content analysis (2nd ed.). Newbury Park, CA: Sage.

White, M. (1986). Negative explanation, restraint and double description: A template for family therapy. Family Process, 25, 169-183.

White, M. (1988). The process of questioning: A therapy of literary merit?. Dulwich Centre Newsletter (Australia), Winter, 8-14.

White, M. (1988-1989). The externalization of the problem and the re-authoring of lives and relationships. Dulwich Centre Newsletter (Australia), Summer, 3-20.

White, M. (1991). Deconstruction and therapy. Dulwich Centre Newsletter (Australia), Autumn, 21-40.

White, M. (1995). Re-authoring lives: interviews and Essays. Adelaide, Australia: Dulwich Centre Publications.

White, M. & Epston, D. (1989). Literate means to therapeutic ends. Adelaide, Australia: Dulwich Centre Publications.

Wiener, N. (1967). The human use of human beings: Cybernetics and society. (2nd ed.). New York: Avon.

Wynne, L. C. (1988). An overview of the state of the art: What should be expected in current family therapy research. In L. C. Wynne (Ed.), The state of the art in family therapy research: Controversies and recommendations. New York: Family Process Press.

Zimmerman, J. L. & Dickerson, V. C. (1993). Separating couples from restraining patterns and the relationship discourse that supports them. Journal of Marital and Family therapy, 19(4), 403-413.

APPENDIXES

Appendix A

AGENCY AND CLIENT

SOLICITATION LETTERS

Administrator's name
Agency
Agency address
Agency address
Date:

Dear:

My name is Terry McGovern and I am the coordinator of outpatient marital and family therapy services at North Care Community Mental Health Center. I am also working on a doctorate in family relations at Oklahoma State University.

Since 1987, I have participated in and have used a reflecting team model to work with couples and families at our agency one day a week. This has been used as a less intrusive way to use an observing team in family therapy and as a way to acknowledge family strengths and to offer some possble alternative ideas to families. Our reflecting team has also been used to give our agency's graduate students exposure and experience in working with families within the framework of a nonpathology based model of family therapy.

At this time, I am developing a small study for my dissertation and plan to use couples/families that our program works with at North Care. My faculty advisor for the study is Dr. David Fournier of the department of Family Relations and Child Development at OSU. I would also like to include some willing couples/families from other agencies that employ a family therapy team in working with clients. Including couples/families from other agencies would make the study more valid and more generalizeable in that it would provide for the comparison of two family team models in a variety of clinical settings and wouldn't be solely dependent on how the team process is used at my agency.

It is for this reason that I am writing your agency. I have been quite impressed with your agency's family therapy program and would like to explore the possibility of using some of the couples/families that will be seen in the near future by your family therapy team in my small study. This is a process study where I am very interested in couples/families perceptions of their experience of family therapy when an observing team is used as part of the treatment process. I plan to compare clients' experience of their therapy using a reflecting team model and a more traditional structural/strategic family therapy team model. The study will employ both quantitative and qualitative measures to analyze clients perceptions of their experience of family therapy.

The quantitative measures include asking couples/families to fill out some self-report instruments or scales just prior to their initial interview and right after their fourth family therapy session. The scales include: a measure of the family's stress level and motivation to change using Olson's Family Issues Scale;

a measure of the family's problem solving ability using Olson's Family Coping Style Scale; a measure of the family's problem solving confidence using a revised version of Heppner & Peterson's Problem-Solving Inventory; a measure of how the family communicates using Olson's Family Communication Scale; a measure of the family's level of satisfaction with current family life using Olson's Family Satisfaction Scale; a measure of the family's overall health using Epstein's et. al. McMaster Family Assessment Device; a measure of the family's perception of the origin of change using a revised version of Hill & Bales Mental Health Locus of Control Scale; a measure of the family's perception of the therapy process using Pinsof & Catherall's Family Therapy Alliance Scale and a measure of the family's postsession perceptions and feelings of their fourth session using Stile's Session Evaluation Questionnaire.

The qualitative measure will be a brief ethnographic interview with the couple/family after the fourth family therapy session asking the clients about their perceptions of the therapy process using open-ended questions. The last part of the study will include, when permissible, the audio or videotaping of the first and fourth family therapy sessions which would be coded by two independent observers looking at the couples/families responses to the different ways of intervening employed by the two team models in question.

I realize that asking your staff and clients to participate in a study is an imposition but I believe there are some benefits as well. Since this is a process study, it gives some of your client couples/families the opportunity to evaluate and give feedback to your agency about the family therapy treatment that they are receiving. This type of client program evaluation may be quite useful for the family therapy staff. The self-report instruments used in the study can provide useful information to both the clients and the family therapists for both assessment and treatment. Information gained when the clients fill out the instruments after their fourth session can help the clients and family therapist to decide whether to continue the current focus of treatment or to shift the focus early enough in the treatment process to optimally use the remaining number of family therapy sessions.

If, your agency is willing to consider being a part of the study, I would need the following:

1. Background data on the clients willing to participate in terms of age, family type, income, race, education, etc..

2. Education level and training experience of the family therapy staff involved.

3. Couples/families willing to participate would need to fill out the initial questionnaire while completing intake forms prior to the first interview (see enclosed yellow form).

4. After the fourth session, these couples/families would need to fill out the postsession questionnaire (see enclosed blue form).

5. After the fourth session, these couples/families would need to be willing to have a brief interview with me where they would be asked a few open ended questions concerning their experience of the therapy process. It would take about 20 minutes and could be either face to face or by telephone.

6. If possible, the couples/families and the family therapist would need to agree to have the first and fourth therapy session either audio or videotaped.

7. After the fourth session, the family therapist would need to fill a brief scale on their perceptions of the alliance between the family and the therapist which would take 5 minutes.

In closing, I want to say thank you for taking the time to read this letter and reviewing the enclosed questionnaires. I hope that you will consider participating in the study which will hopefully be beneficial not only to me in completing my study but also for your family therapy program as well.

Sincerely,

_____
Terry McGovern, ACSW

_____
David G. Fournier, PhD.
Faculty Advisor
Oklahoma State University
(405) 744-8351

Dear Couple or Family:

Thank you for taking the time to fill out the initial questionnaire forms prior to this first appointment for either marital or family counseling at this agency. I am asking you to take the time to read this letter in order to invite you to participate in a small research study involving couples and families who are working on their issues or concerns in marital or family counseling. The study is being conducted by Terry McGovern as part of the requirements needed to complete his doctorate in Family Relations at Oklahoma State University.

The purpose of this study is to get feedback or information from couples and families about their perceptions and experience of two types of marital and family counseling. I believe your experiences, thoughts, and ideas about the counseling process are very important and valuable. By sharing your thoughts and experience of this marital or family counseling, you will be giving the counselors/therapists important information about the services they offer to other couples or families like yourselves. So, your thoughts about your counseling can possibly have a positive impact on how these services are offered in the future. By getting feedback, we can look at our work as marital and family counselors through your eyes which will help us to improve our skills in working with couples and families.

Besides helping us to improve our program, participation in the study will possibly provide you and your counselor with useful information that can help all of you to work together on the issues that are important to your family. The questionnaire that you are asked to fill out will give you and your counselor information on how much stress your family is experiencing, on how your family problem solves, on how much confidence your family has in solving problems, on how your family communicates, on how satisfied you are with family life, on the general functioning of your family now, and on how hopeful each of you feels about resolving important issues that you plan to work on in counseling.

If, you are willing to participate in this study, I would ask you to agree to the following:

1. To fill out the enclosed questionnaire on yellow paper that is part of the initial forms that you are currently filling out. This questionnaire will probably take about 30 minutes to complete.

2. To fill out a similar questionnaire after your fourth counseling appointment which will also take about 30 minutes to complete.

3. To talk with the researcher for about twenty minutes after your fourth appointment where he will ask you a few questions about how you feel about your marital or family counseling experience up to that point in time.

4. To agree to have your first and fourth counseling sessions either audiotaped or videotaped so that the researcher can compare the two appointments. The tape will be kept locked and confidential and after the researcher has coded the sessions, the tape will be erased. This is a common practice for family researchers and family counselors to tape their work so that they can view how they work in order to improve their skills in helping families.

It is very important that I inform you that participation in this study is totally optional or voluntary on your part and if you decide not to participate in this study you will receive our normal marital or family counseling services and declining to participate will not have any impact on the type or quality of service that you and your family receive. If you decide to participate in the study and then choose to withdraw from the study you will then receive the normal marital or family counseling services at this agency.

If, you are willing to participate in the study, please sign the enclosed consent form. And, please remember that the information that you share will remain confidential and the taping of any counseling session will be erased after it is viewed by the researcher.

Thank you for taking the time to read this letter!

Sincerely,

_____

Terry McGovern, ACSW
Licensed Marital and Family Therapist
Licensed Clinical Social Worker

_____

David G. Fournier, PhD.
Faculty Advisor
Oklahoma State University
(405) 744-8351

Appendix B

Comparison of Reflecting Team Studies

COMPARISON OF REFLECTING TEAM STUDIES

Author	Type of study	Sample selection	Number of subjects
Griffith et al., 1992	Quantitative study: observational coding of initial session.	Referrals by physicians: no time frame or client mortality issues mentioned.	12 Families.
Smith et al., 1992	Qualitative study of therapists perceptions.	Presession discussion determined which clients were to seen by reflecting team.	3 Therapists that were doctoral students.
Smith et al., 1993	Qualitative study of clients' perceptions.	Clients chosen over 3 month period: no mention of mortality or declining participation issues.	8 Cases: 5 individuals & 3 couples
Hoger et al., 1994	Quantitative outcome study -single group design.	Therapist impression at intake of which families may benefit from reflecting team.	59 Families at start & 35 families at posttest period.
Sells et al., 1994	Qualitative study of clients & therapists perceptions.	Opportunistic sample.	7 Couples & 5 therapists.

Author	Type of study	Sample selection	Number of subjects
Smith et al., 1994	Qualitative study of clients & therapists perceptions.	Opportunistic sample.	11 Couples & 5 therapists.

(Continued)

Author	Measurement	Comparison/ control group	Outcome
Griffith et al., 1992.	Pre-post observational coding using SASB.	None.	Improved family communication after RT.
Smith et al., 1992.	Qualitative questions using iterative method: 9 questions.	None.	Positive and negative aspects of reflecting team.
Smith et al., 1993.	Qualitative questions using iterative method: 9 questions.	None.	Positive and negative aspects of reflecting team.

Author	Measurement	Comparison/ control group	Outcome
Hoger et al., 1994.	Combination of observational coding, self-report scale & semi structured interviews; validity & reliability not established.	None: two different sites for treatment group.	At follow-up: two thirds of clients had symptom improvement & 80% were satisfied (35 families).
Sells et al., 1994.	Domain analysis of 8 qualitative questions.	None.	Six domains of reflecting team practice.
Smith et al., 1994.	Content analysis of 8 qualitative questions.	None.	Contrasting of clients & therapists perspectives on reflecting team process.

Appendix C

DATA COLLECTION ISSUES

DATA COLLECTION ISSUES

Initially, all couples and families that were scheduled for intake interviews with the family therapy team were asked if they would be willing to participate in the proposed study. While the couple/family system were filling out the agency's intake questionnaire forms in the waiting room, they were asked by the researcher if they would participate in the study. At that time, they were given the additional paperwork and consent forms that were related to the study in question.

Before continuing, it may be helpful to explain the intake process at the study site, North Care Center. After one member of the client system phones in to request marital/family therapy, the system is placed on a waiting list for marital/family therapy and is given an intake time when an openning occurs in the family therapy team's schedule. Determination of who is offered an intake time is based on length of time on the waiting list and severity of the system's problems. When a couple/family system comes in for an intake interview, they are asked to come in 30 to 60 minutes prior to the actual appointment time to fill out the agency's intake questionnaire packet which is 6 to 7 pages long and includes demographic data, health/medication history, client bill of rights, consent for treatment and

AIDS education information. The intake packet needs to be completed on all members of the client system who will be participating in treatment. After the initial forms have been completed, the couple/family is seen by the agency's reimbursement officer to discuss and set the fee for the marital/family therapy. The therapist then meets the couple/family for an initial interview. The therapist is required to go over the AIDS education information with the client system and to develop an initial treatment plan with the couple/family that they are required to sign during the initial interview.

While the couple/family were in the waiting room filling out the required agency forms, they were asked to review the additional forms that explained the nature and purpose of the proposed study. The general response seemed to be that the additional paperwork and explanation of the study overwhelmed the couples/families seeking services. The client systems were already in a crisis state in their efforts to cope with the presenting problems and the additional forms and request to participate in the study tended to increase the stress that the client systems were experiencing. Generally, couples/families are not told about the use of a family therapy team or the possibility of videotaping therapy sessions until they were in the interview room with the therapist. At that time, the process of working with an observing team was explained and

those client systems that were uncomfortable with the observing team were then seen by the therapist without the use of the team. However, when the couples/families were asked to participate in the study during the form filling stage, the combination of participating in a study, being observed by a team, videotaping and coding of their therapy sessions, filling out additional questionnarires and having a qualitative interview with the researcher all of this tended to increase the already normal anxiety that the couple/family was experiencing in coming in for therapy. The response by the couples/families was to either to decline to participate in the study or agree to participate and then back out later in the treatment process. Those couples or families who chose to not participate in the study were still seen by the family therapy team and would receive the normal service at the agency but this would tie up the limited time slots available for the therapy team which is where the data for the study was collected.

There has been a long standing concern by the therapists at the agency that the intake process of filling out forms, checking for insurance and setting fees and the signing of treatment plan forms has not been "client friendly" and we have wondered often whether the clients feel that the agency's needs were more important than their social and emotional needs. The prospect of proposing the study and adding additional paperwork for the couple/family

at the time of intake tended in this therapist's view to do the following: add to the system's stress and anxiety, increased the perception that the agency's needs took priority over their needs and it added to the already difficult task for the therapist to connect/join with the client system given the constraints already in place within the context of this agency setting.

A few alternative approaches were tried to propose participation in the study by couples/families being seen by the family therapy team. One alternative was to inform people over the phone while scheduling the intake appointment that the appointment time slot given was reserved for couples/families participating in the study and if they accepted that particular appointment time slot they would need to be willing to be in the study. The family member would usually agree to participate in the study over the phone and then would develop "cold feet" when they came in for the actual appointment and decide not to participate in the study. Despite that change of mind, the family would still be seen by the family theapy team since they were still in need of therapy and because the primary mission of the agency is one of provision of services rather than a primary focus on education, training or research.

Given the initial difficulty in getting client participation in the study during the intake process, the introduction of the client system to the possibility of

participating in the study was delayed until the third or fourth therapy session with the family therapy team. The assumption was that by that time in the treatment process, the therapist had joined/connected with the client system and that the system had become more comfortable with an observing team and the possibility of videotaping of the therapy sessions and would be more likely to consider participation in the study. Over the course of the data collection period, this therapist found that it was best to propose participation in the study during the session in which the data was to be collected. In this study, postsession data was usually collected immediately after the fourth therapy session. It was found that some client systems who agreed in the second or third therapy session to participate in the study would change their mind and decline to participate when postsession data collection was attempted at the end of the fourth family therapy team session. It should be pointed out that at any point in the process, client systems had the right to not participate or to withdraw their participation in the study but these systems continued to be seen by the family therapy team and would thus tie up potential slots available with the team. It was found that some of the client systems that had become comfortable with the team process and had agreed with participating in the study when it was introduced in the second or third interview, would decline to participate in

the fourth session because they were too uncomfortable with being videotaped and having segments of their interactions coded by outside raters. At other times, client systems would agree to participate and their fourth session would be videotaped and at the end of the session, they would have the qualitative interview. Given the length of the therapy session and the qualitative interview, some couples/families could not stay longer at the agency and would take the self-report questionnaire home. Some subjects would complete the questionnaire at home and others would not do so despite reminders by the therapist. Another client system agreed to participate in the study and their fourth session was videotaped for the coding of their interactons but given time constraints they asked to complete the remaining postsession data at their next interview. In that session, they learned that the therapist would be leaving the agency and they did not return for their next interview. Some other client systems agreed to the study but had changes in their schedule which prevented them from continuing to be seen by the family therapy team.

Given this trial and error process of data collection within the context of an agency whose primary mission is service provision and given the limited research in the literature on the study's focus of inquiry, it was decided to continue to make efforts to collect data as proposed in the original study design when possible but it was also

decided to collect whatever data was possible by loosening the study design as well. It was argued that given the lack of research in this area and the data collection restraints within the agency that a pilot study design was possibly an acceptable study design for the proposed study. Since it was difficult to get enough of a sample size with the original study design due to the agency constraints, limited family therapy team time slots and limited staff resources, couples/families who were receiving therapy without the use of the observing team were also asked if they would be willing to participate in the study. For example, a couple being seen by the researcher for marital therapy for four sessions was asked at that point in the treatment process if they would participate in the study. The couple agreed to be in the study and the fifth and sixth sessions were with an observing team. The postsession data was collected at the end of the sixth session. It is clearly evident that the treatment effect of the team process is much less clear and less easy to measure since the couple had four sessions prior to being seen with the therapy team. But, it was felt that as long as the treatment process was documented that some possible confounding data is better than no data at all. Couples/families that were being seen in therapy without the use of the team were asked at the end of the second session or at wherever they were in the treatment process if they would participate in the study. A few

client systems did agree to participate but the vast majority of the couples/families already being seen without the observing team either didn't want to participate in the study because it involved observers or were willing to participate but their schedules did not permit them to come when the family therapy team was available.

Over the past year, there has been between two to three family therapy team time slots available each week at the agency. In general, most couples/families who work with an observing team like the process and decide to continue working with the team. This ties up some of the family therapy team slots while the client system is in therapy and at any given week, one to three of the available team time slots are being used with client systems who do not wish to participate in the study. This use of team time slots by couples/families not participating in the study occurs due to a couple of factors. One factor is that the agency is a service agency and couples/families who choose to not be in the study are still entitled to receive services at the agency. Another factor is that the primary purpose of the family therapy team is to provide training for the practicum students at the agency in marital and family therapy. Generally, the students are involved in therapy as both observers and cotherapists. When a couple/family has been seen by the family therapy team, there is usually a student who is a cotherapist. When a couple/family chooses to not

participate in the study, the student cotherapist and the students on the observing team are already involved as part of the treatment system. Given scheduling constraints on the family, the staff therapist and the students it is usually not possible to try to see non-study couples/families at a different time and day when they wouldn't use up a team time slot. In general, the moving of the therapy to a different day or time disrupts both the treatment process for the family and the training process for the student who is the cotherapist. And, it has been difficult to transfer the non-study couples/families to other staff due to caseloads being full and the other outpatient family therapist leaving the agency this year. Basically, the order of priorities is providing the service to the couple/family first, then provide a training experience for the students and then collect data if possible.

Appendix D

PRETEST CLIENT QUESTIONNAIRE

DIRECTIONS: THE STATEMENTS BELOW ASK YOU TO THINK ABOUT ISSUES THAT ARE OF CONCERN TO MANY COUPLES AND FAMILIES TODAY. YOU MAY FIND THAT YOU AGREE WITH SOME OF THE STATEMENTS AND DISAGREE WITH OTHER STATEMENTS. AFTER READING EACH STATEMENT, PLEASE PLACE THE NUMBER TO THE RESPONSE OR ANSWER THAT IN YOUR OPINION FITS YOU AND YOUR FAMILY'S SITUATION THE BEST AND PLACE THE NUMBER ON THE LINE TO THE LEFT OF THAT STATEMENT. THE POSSIBLE RESPONSES FOR THIS SECTION OF STATEMENTS ARE:

1	2	3	4	5
Almost Never	Occasionally	About Half The Time	Often	Very Often

For statements 1 to 20, please read the following sentence and then place the response that fits each statement best to the left of the statement. "In the past year, how often have these issues created stress in your family?"

____ 1. Arguments between parent(s) and child(ren).
____ 2. Parent(s) away from home on business.
____ 3. Too much money is charged on credit cards.
____ 4. Physical illness or death of a family member(s).
____ 5. Child(ren) fail to adequately complete chores.
____ 6. Conflicts tend to go unresolved.
____ 7. Difficulty paying monthly bills.
____ 8. Difficulty with child care.
____ 9. Emotional problem(s) with family member(s).
____ 10. Child(ren) fail to do schoolwork.
____ 11. Issues with parent(s), in-laws or relatives.
____ 12. Household tasks are left undone.
____ 13. Child(ren) fails to act their age.
____ 14. Concern about alcohol and/or drug use.
____ 15. Difficulty managing child(ren).
____ 16. Problems regarding who does what chores.
____ 17. Issues because of pregnancy or recent baby.
____ 18. Lack of time to relax and unwind.
____ 19. Moving created problems or adjustments.
____ 20. Family obligations create stress.

- -

For statements 21 to 30, please read the following sentence and then use the same response choices as above to respond to each statement. "When there is stress in your family, how often does the following happen?"

____ 21. We make decisions quickly and without much discussion.
____ 22. We become more isolated and independent.
____ 23. There is little cooperation among family members.
____ 24. We become more disorganized.
____ 25. We have trouble finding new ways to solve our problems.
____ 26. One person's bad mood makes the whole family feel down.
____ 27. The parent(s) become more strict and controlling with the child(ren).
____ 28. We tend to stay out of the person's way who is under stress.
____ 29. We find it difficult to have privacy and think things over.
____ 30. We share our feelings about the issue.

RESPONSES OR ANSWERS

1	2	3	4	5
Almost Never	Occasionally	About Half The Time	Often	Very Often

____ 31. We are satisfied with how family members communicate with each other.
____ 32. Family members are good listeners.
____ 33. Family members express affection to each other.
____ 34. Family members avoid talking about important issues.
____ 35. When angry, family members say things that would be better left unsaid.
____ 36. Family members discuss their beliefs and ideas with each other.
____ 37. When we ask questions of each other, we get honest answers.
____ 38. Family members try to understand each other's feelings.
____ 39. We can calmly discuss problems with each other.
____ 40. We express our true feelings to each other.

For statements 41 to 50, please respond to the following sentence: "How satisfied are you with?" by placing one of the following six responses to the left of each statement.

1	2	3	4	5	6
Very Disatisfied	Dissatisfied	More Dissatisfied Than Statisfied	More Satisifed Than Disatisfied	Satisfied	Very Satisfied

____ 41. The degree of closeness between members of your family?
____ 42. Your family's ability to cope with stress?
____ 43. Your family's ability to be flexible?
____ 44. Your family's ability to share positive experiences?
____ 45. The amount of arguing that occurs between family members?
____ 46. Your family's ability to resolve conflicts?
____ 47. The amount of time you spend together as a family?
____ 48. The way problems are discussed?
____ 49. The fairness of the criticism in your family?
____ 50. Your family's concern for each other?

For statements 51 to 63, please respond by placing one of the six responses to the left of each statement.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree More Than Agree	Agree More Than Disagree	Agree	Strongly Agree

____ 51. I have been able to come up with creative and effective alternatives to solve the problem(s) that effect our family.
____ 52. Initially, no solutions were immediately apparent, but I now believe that we as a family have the ability to solve the problem.
____ 53. The problem(s) that we came to counseling with seem too complex for us to solve.

RESPONSES OR ANSWERS

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree More Than Agree	Agree More Than Disagree	Agree	Strongly Agree

____ 54. The plans that we have made to solve the problem(s) I am almost certain that we can make them work.
____ 55. I am now more able to trust my ability to solve the problem(s).
____ 56. At this time, I do not believe that we will solve our problem(s).
____ 57. I am now more confident that we will be able to handle future problem(s) that may arise.
____ 58. The decisions that we make as a family tend to end in their expected outcomes.
____ 59. I am still unsure whether we can handle the problem situation(s) in our family.
____ 60. I still uncertain exactly what our problem is.
____ 61. My view of the problem has changed in a way that makes the problem seem more manageable.
____ 62. Now, when I try to think up possible solutions to our problem(s), I am still not able to come up with too many alternatives.
____ 63. I have become more confident that our own ideas will help us solve our problem(s).

- -

For statements 64 to 75, please respond by placing one of the <u>four</u> responses to the left of each statement.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

____ 64. Planning family activities is difficult because we misunderstand each other.
____ 65. In times of crises we can turn to each other for support.
____ 66. We cannot talk to each other about the sadness we feel.
____ 67. Individuals aare accepted for what they are.
____ 68. We avoid discussing our fears and concerns.
____ 69. We can express feelings to each other.
____ 70. There are lots of bad feelings in the family.
____ 71. We feel accepted for what we are.
____ 72. Making decisions is a problem for our family.
____ 73. We are able to make decisions about how to solve problems.
____ 74. We don't get along well together.
____ 75. We confide in each other.

- -

Statements 76 to 91 ask you to decide whether each statement is <u>TRUE</u> or <u>FALSE</u>, please place a <u>T</u> or <u>F</u> to the left of each statement.

____ 76. We look forward to the future with hope and enthusiasm as a couple/family.

True or False statements continued, please place a T or F to the left of each statement.

____ 77. We might as well give up trying to resolve our couple/family problem(s) because we can't make things better for ourselves.
____ 78. When things are going badly, we are helped by knowing they can't stay that way forever.
____ 79. I can't imagine what our family will be like in 10 years.
____ 80. In the future, I expect that we will successfully resolve the important concerns that we have in our family.
____ 81. The future of our couple/family relationships seems dark to me.
____ 82. As a family, we just don't get the breaks, and I see no reason to believe that this will change for our family in the future.
____ 83. Our past experiences in resolving couple/family issues will prepare us well to respond to new couple/family issues in the future.
____ 84. As I look into the future, all I can see for the family is stress and conflict rather than communication and harmony.
____ 85. I really don't believe or expect to get my needs met within our couple/family relationships.
____ 86. In the future, I believe that as a couple/family, we will be happier than we are now.
____ 87. As a couple/family, things just won't work out the way I would like them to.
____ 88. I never get what I want within our couple/family relationships so its foolish to expect to get what I need from my partner or my family.
____ 89. When I look into the future, the stability of our couple/family relationships seems rather vague and uncertain to me.
____ 90. As a couple/family, we can look forward to more good times than bad times.
____ 91. There's no use in really trying to change things for the better because our couple/family problems will just continue or get worse.

Appendix E

POSTTEST CLIENT QUESTIONNAIRE

DIRECTIONS: THE STATEMENTS BELOW ASK YOU TO THINK ABOUT ISSUES THAT ARE OF CONCERN TO MANY COUPLES AND FAMILIES TODAY. YOU MAY FIND THAT YOU AGREE WITH SOME OF THE STATEMENTS AND DISAGREE WITH OTHER STATEMENTS. AFTER READING EACH STATEMENT, PLEASE PLACE THE NUMBER TO THE RESPONSE OR ANSWER THAT IN YOUR OPINION FITS YOU AND YOUR FAMILY'S SITUATION THE BEST AND PLACE THE NUMBER ON THE LINE TO THE LEFT OF THAT STATEMENT. THE POSSIBLE RESPONSES FOR THIS SECTION OF STATEMENTS ARE:

1	2	3	4	5
Almost Never	Occasionally	About Half The Time	Often	Very Often

For statements 1 to 20, please read the following sentence and then place the response that fits each statement best to the left of the statement. "When there is stress in your family, how often does the following happen?"

____ 1. We make decisions quickly and without much discussion.
____ 2. We become more isolated and independent.
____ 3. There is little cooperation among family members.
____ 4. We become more disorganized.
____ 5. We have trouble finding new ways to solve our problems.
____ 6. One person's bad mood makes the whole family feel down.
____ 7. The parent(s) become more strict and controlling with the child(ren).
____ 8. We tend to stay out of the person's way who is under stress.
____ 9. We find it difficult to have privacy and think things over.
____ 10. We share our feelings about the issue.
____ 11. We are satisfied with how family members communicate with each other.
____ 12. Family members are good listeners.
____ 13. Family members express affection to each other.
____ 14. Family members avoid talking about important issues.
____ 15. When angry, family members say things that would be better left unsaid.
____ 16. Family members discuss their beliefs and ideas with each other.
____ 17. When we ask questions of each other, we get honest answers.
____ 18. Family members try to understand each other's feelings.
____ 19. We can calmly discuss problems with each other.
____ 20. We express our true feelings to each other.

For statements 21 to 30, please respond to the following sentence: "How satisfied are you with?" by placing one of the following six responses to the left of each statement.

1	2	3	4	5	6
Very Dissatisfied	Dissatisfied	More Dissatisfied Than Statisfied	More Satisifed Than Disatisfied	Satisfied	Very Satisfied

____ 21. The degree of closeness between members of your family?
____ 22. Your family's ability to cope with stress?
____ 23. Your family's ability to be flexible?
____ 24. Your family's ability to share positive experiences?
____ 25. The amount of arguing that occurs between family members?
____ 26. Your family's ability to resolve conflicts?
____ 27. The amount of time you spend together as a family?
____ 28. The way problems are discussed?
____ 29. The fairness of the criticism in your family?
____ 30. Your family's concern for each other?

For statements 31 to 44, please respond by placing one of the six responses to the left of each statement.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree More Than Agree	Agree More Than Disagree	Agree	Strongly Agree

____ 31. Since beginning family therapy, I have been able to come up with creative and effective alternatives to solve the problem(s) that effect our family.
____ 32. Initially, no solutions were immediately apparent, but I now believe that we as a family have the ability to solve the problem.
____ 33. The problem(s) that we came to counseling with seem too complex for us to solve.
____ 34. The plans that we have made to solve the problem(s) I am almost certain that we can make them work.
____ 35. Compared to when we first came for family therapy, I am now more able to trust my ability to solve the problem(s).
____ 36. Even with our time and effort in therapy, I do not believe that we will solve our problem(s).
____ 37. After beginning family therapy, I am now more confident that we will be able to handle future problem(s) that may arise.
____ 38. After beginning family therapy, the decisions that we make as a family tend to end in their expected outcomes.
____ 39. In the problems that have come up since beginning family therapy, I am still unsure whether we can handle the problem situation(s) in our family.
____ 40. After being in family therapy, I still uncertain exactly what our problem is.
____ 41. Since being in family therapy, my view of the problem has changed in a way that makes the problem seem more manageable.
____ 42. Now, when I try to think up possible solutions to our problem(s), I am still not able to come up with too many alternatives even with family therapy.
____ 43. Since beginning family therapy, I have become more confident that our own ideas will help us solve our problem(s).
____ 44. Since beginning family therapy, I have become more confident that the therapist's ideas will solve our problems.

For statements 45 to 56, please respond by placing one of the four responses to the left of each statement.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

____ 45. Planning family activities is difficult because we misunderstand each other.
____ 46. In times of crises we can turn to each other for support.
____ 47. We cannot talk to each other about the sadness we feel.
____ 48. Individuals aare accepted for what they are.
____ 49. We avoid discussing our fears and concerns.
____ 50. We can express feelings to each other.
____ 51. There are lots of bad feelings in the family.
____ 52. We feel accepted for what we are.
____ 53. Making decisions is a problem for our family.
____ 54. We are able to make decisions about how to solve problems.
____ 55. We don't get along well together.
____ 56. We confide in each other.

Statements 57 to 72 ask you to decide whether each statement is TRUE or FALSE, please place a T or F to the left of each statement.

____ 57. We look forward to the future with hope and enthusiasm as a couple/family.
____ 58. We might as well give up trying to resolve our couple/family problem(s) because we can't make things better for ourselves.
____ 59. When things are going badly, we are helped by knowing they can't stay that way forever.
____ 60. I can't imagine what our family will be like in 10 years.
____ 61. In the future, I expect that we will successfully resolve the important concerns that we have in our family.
____ 62. The future of our couple/family relationships seems dark to me.
____ 63. As a family, we just don't get the breaks, and I see no reason to believe that this will change for our family in the future.
____ 64. Our past experiences in resolving couple/family issues will prepare us well to respond to new couple/family issues in the future.
____ 65. As I look into the future, all I can see for the family is stress and conflict rather than communication and harmony.
____ 66. I really don't believe or expect to get my needs met within our couple/family relationships.
____ 67. In the future, I believe that as a couple/family, we will be happier than we are now.
____ 68. As a couple/family, things just won't work out the way I would like them to.
____ 69. I never get what I want within our couple/family relationships so its foolish to expect to get what I need from my partner or my family.
____ 70. When I look into the future, the stability of our couple/family relationships seems rather vague and uncertain to me.
____ 71. As a couple/family, we can look forward to more good times than bad times.
____ 72. There's no use in really trying to change things for the better because our couple/family problems will just continue or get worse.

For statements 73 to 90, please respond by placing one of the following six responses to the left of each statement.

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree More Than Agree	Agree More Than Disagree	Agree	Strongly Agree

____ 73. Couple/family counseling is for couples/families who can't resolve their own issues and need someone stronger than themselves to lean on.
____ 74. For our family to recover from serious problems, we must be willing to temporiarly give all the responsibility for solving our problems to the marital/family counselor.
____ 75. Couples/families with problems should play a large part in planning their own treatment and solutions.
____ 76. Couples/families in counseling should not make any important decisions without seeking advice.
____ 77. When a couple/family is trying out new behaviors, the marital/family counselor should decide which behaviors they should try first.
____ 78. The decision as to when to end marital/family counseling should be taken by the couple/family rather than the counselor.

RESPONSES OR ANSWERS

1	2	3	4	5	6
Strongly Disagree	Disagree	Disagree More Than Agree	Agree More Than Disagree	Agree	Strongly Agree

____ 79. The lives of couples/families with problems are so complicated that it is almost impossible for them to figure out what they should do to make things better.
____ 80. If, couple/family counseling is like building a house, a good counselor should not only give you the tools but should design the house for you.
____ 81. Couple/family counselors should tell the couples/families that they work with how to lead healthier lives instead of waiting to see if they find out for themselves.
____ 82. Couples/families should try hard to accept their counselor's opinion as to what is right and wrong.
____ 83. When a couple/family goes to a counselor for help they should expect to take most of the responsibility for getting better.
____ 84. In couple/family counseling what the counselor thinks is less important than what the couple/family thinks.
____ 85. The goals of couple/family counseling should be set by the couple/family rather than the counselor.
____ 86. The aim of any couple/family that gets into couple/family counseling is to seek the advice of an expert and to act on it.
____ 87. As a general rule, couple/family counselors should feel o.k. about making decisions on behalf of their clients.
____ 88. A good couple/family counselor expects the couple/family to decide for themselves what they should do.
____ 89. Going to a professional to discuss your couple/family problems is better than talking to friends because the advice of a professional is more valuable.
____ 90. When a couple/family experiences interpersonal problems the ones least likely to come up with solutions are the family members themselves.

- -

For statements 91 to 120, please respond by placing one of the <u>seven responses</u> to the left of each statement.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Disagree More Than Agree	Neutral	Agree More Than Disagree	Agree	Strongly Agree

____ 91. The therapist cares about me as a person.
____ 92. The therapist and I are not in agreement about the goals for this therapy.
____ 93. I trust the therapist.
____ 94. The therapist lacks the skills and ability to help my family.
____ 95. All the other members of my family feel accepted by the therapist.
____ 96. The therapist does not understand my family.
____ 97. The therapist understands my goals in therapy.
____ 98. Some of the other members of my family are not in agreement with the therapist about the goals for this therapy.
____ 99. All the other members of my family care about the therapist as a person.
____ 100. The therapist does not understand my family's goals for this therapy.
____ 101. All the other members of my family are in agreement with the therapist about the way the therapy is being conducted.

RESPONSES OR ANSWERS

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Disagree More Than Agree	Neutral	Agree More Than Disagree	Agree	Strongly Agree

____ 102. The therapist does not understand me.
____ 103. The therapist is helping my family.
____ 104. I am not satisfied with the therapy.
____ 105. The therapist understands the goals that all the other members of my family have for this therapy.
____ 106. I do not feel accepted by the therapist.
____ 107. The therapist and I are in agreement about the way the therapy is being conducted.
____ 108. The therapist is not helping me.
____ 109. The therapist is in agreement with my family's goals for this therapy.
____ 110. The therapist does not care personally about some of the other members of my family.
____ 111. The therapist has the skills and ability to help me.
____ 112. The therapist is not helping some of the other members of my family.
____ 113. All the other members of my family are satisfied with the therapy.
____ 114. I do not care about the therapist as a person.
____ 115. The therapist has the skills and ability to help all the other members of my family.
____ 116. Some of the other members of my family distrust the therapist.
____ 117. The therapist cares about my family.
____ 118. The therapist does not understand some of the other members of my family.
____ 119. The therapist does not appreciate how important my relationships with some of the members of my family are to me.

For statements 120 to 141, please place an 'X' in one of the seven spaces on each line based on how you feel about today's marital or family counseling session. For example, in statement # 120, if you felt today's marital or family session was not very good or was bad, then you would place the 'X' in one of the spaces closer to the adjective "bad" or if you felt today's session was good then you would place the 'X' in a space closer to the adjective "good". Remember to put only one 'X' on the line for each statement.

This session was:

120.	bad	____:____:____:____:____:____:____	good
121.	safe	____:____:____:____:____:____:____	dangerous
122.	difficult	____:____:____:____:____:____:____	easy
123.	valuable	____:____:____:____:____:____:____	worthless
124.	shallow	____:____:____:____:____:____:____	deep
125.	exciting	____:____:____:____:____:____:____	calm
126.	unpleasant	____:____:____:____:____:____:____	pleasant
127.	full	____:____:____:____:____:____:____	empty
128.	slow	____:____:____:____:____:____:____	fast
129.	special	____:____:____:____:____:____:____	ordinary
130.	rough	____:____:____:____:____:____:____	smooth

Right now I feel:

131.	happy	____:____:____:____:____:____:____	sad
132.	angry	____:____:____:____:____:____:____	pleased
133.	confident	____:____:____:____:____:____:____	afraid

Please continue placing an 'X'in one of the seven spaces on each line based on how you feel about today's marital or family counseling session. Please remember to place only one 'X' on each line.

Right now I feel:

134.	uncertain	____:	____:	____:	____:	____:	____:	____ definite
135.	involved	____:	____:	____:	____:	____:	____:	____ detached
136.	ugly	____:	____:	____:	____:	____:	____:	____ beautiful
137.	powerful	____:	____:	____:	____:	____:	____:	____ powerless
138.	tense	____:	____:	____:	____:	____:	____:	____ relaxed
139.	friendly	____:	____:	____:	____:	____:	____:	____ unfriendly
140.	weak	____:	____:	____:	____:	____:	____:	____ strong
141.	sharp	____:	____:	____:	____:	____:	____:	____ dull

Appendix F

CLIENTS' QUALITATIVE INTERVIEW QUESTIONS

QUALITATIVE INTERVIEW QUESTIONS FOR CLIENTS' PERCEPTIONS OF THEIR EXPERIENCE WITH AN OBSERVING THERAPY TEAM

1. What are your thoughts about the type of marital/family counseling you are receiving?

2. If, you had previous marital/family counseling, how does this current therapy compare to it?

3. How optimistic are you now that the problem will be reduced or resolved?

4. What is positive and negative about this therapy experience?

5. What are your perceptions of the therapist(s)?

6. How do you think the therapist views or sees you in your efforts to solve or cope with the problems that brought you to seek counseling?

7. If, the therapy involves the use of a team what are your thoughts about having a team as part of your therapy?

8. How do you think the team sees you in your efforts to solve or cope with the problem that led to your seeking therapy at this time?

9. Has your view or understanding of the problem changed during this counseling?

10. Have any new ideas or solutions developed as a result of the counseling?

11. If, you now have some new ideas concerning the resolution of the presenting problem, where did these ideas come from?

Appendix G

THERAPISTS' QUALITATIVE INTERVIEW QUESTIONS AND A DESCRIPTION OF THERAPISTS RATING SCALE

QUALITATIVE INTERVIEW QUESTIONS FOR THERAPISTS PERCEPTIONS OF THEIR EXPERIENCE WITH THE OBSERVING THERAPY TEAM*

1. Are reflecting teams useful?

2. How does the team work?

3. When doesn't the team work?

4. What kind of things do you learn from the team?

5. What would you change about how the team works?

6. What relationship do you expect will exist between you and your team?

7. Does it matter whether your team is predominately male or female?

8. What does it mean to you when team members disagree?

9. How can the team be disruptive?

Other Qualitative Questions Developed by Author:

10. What is your experience participating as a member of a team observing a marital/family therapy session/conversation?

11. Is there any difference in your experience of and participation in an observing team when a reflecting team is used vs. when a strategic team is used? If, your experience is different, how is it different? How is your experience the same whether a reflecting team or a strategic team is used?

12. What is your experience as a therapist when you work with an observing team? Is your experience as a therapist different when a strategic team is used as compared to when a reflecting team is used?

13. Do you think families that you work with perceive or experience any difference when a reflecting team is used compared to when a strategic team is used?

14. Is there any difference in how your ideas/observations are listened to or are valued when a strategic team is used as compared to when a reflecting team is used?

15. Do you experience any difference in the amount of cooperativeness between team members vs. the amount of competiveness between team members in their efforts to have their ideas or views heard and implemented when a reflecting team is used as compared to when a strategic team is used?

16. Do you experience any difference in what you focus on when you are observing a therapy session as a member of a strategic team as compared to when you are a member of a reflecting team?

17. Do you have a preference to use a reflecting or a strategic team model?

18. Do you experience any difference in your ability to focus on solutions, on the family's strengths and exceptions to the problem when a strategic model is used vs. when a reflecting model is used?

19. Is there any difference in the amount of cooperativeness among team members when a reflecting team is used vs. when a strategic team is used?

20. Is there any difference in your ability to attend to and focus on the therapy session/conversation when a strategic team is used vs. when a reflecting team is used?

21. Is there any difference in the pressure or anxiety that you feel to come up with ideas/interventions for the family when a reflecting team is used vs. when a strategic team is used?

22. Do you notice any difference in the hierarchical or professional distance between the family and the therapy team when a strategic team is used vs. when a reflecting team is used?

23. Is there any difference in how active an observer you are when a reflecting team is used vs. when a strategic team is used?

24. When you have been the therapist has there been any difference in the support you felt from the therapy team or whether you felt judged by the team when a strategic team is used vs. when a reflecting team is used?

25. Is there any difference in the connection with or your alliance with the clients when a reflecting team is used vs. when a strategic team is used?

26. Is there any difference in your perception of the family's ability to focus on their own ideas and solutions to their problems when a strategic team is used vs. when a reflecting team is used?

27. Is there any difference in your perception of the client's comfort level and sense of ease with the team process when a reflecting team is used vs. when a strategic team is used?

28. Is there any difference in your perception of the usefulness and effectiveness of the team process when a strategic team is used vs. when a reflecting team is used?

*Questions 1-9 are taken directly from Smith, T. E. et al., 1992. A qualitative understanding of reflective-teams II: Therapists' perspectives, Contemporary Family Therapy, 14(5), October.

THERAPIST/TEAM MEMBERS RATINGS OF THE TWO TEAM TREATMENT MODELS FOR VARIOUS CLINICAL PROBLEMS

DESCRIPTION: Therapists/team members were asked to use a 7-point Likert type scale to rate the use of the two team treatment models with various clinical problems commonly encountered in clinical practice. (Response choices were: 1-strongly disagree, 2-disagree, 3-disagree more than agree, 4-neutral, 5-agree more than disagree, 6-agree, 7-strongly agree).

METHOD: At the end of the qualitative interview with the therapist/team member, the researcher explained and showed the Likert-type scale to the respondent and then, the respondent was shown a written list of 12 clinical problems. The respondent was then asked how comfortable they felt using each team treatment model with each clinical problem. The respondent's numerical response to using each treatment model with each clinical problem was then recorded by the researcher.

Appendix H

OBSERVATIONAL CODING SYSTEM AND OBSERVATIONAL CODING SHEET

POSSIBLE BEHAVIORAL EXAMPLES OF THEORETICAL CONCEPTS FOR CODING OF VIDEOTAPE INTERACTIONS

-Below are some suggestions of behaviors and interactions that one might look for in observing and picking out concepts from the videotaped segments of the marital/family interviews. These examples of each concept are not the only ones possible, so please use your own judgement as well in determining if these concepts are found in the videotaped interactions.

-To evaluate the concept of the couple/family's Use of Own Solutions, one might observe the following behaviors:

1. Does a family member(s) mention/discuss new idea or behavior to try out?
2. Does a family member(s) mention or discuss results of trying out idea or new behavior in recent past?
3. Does a family member(s) mention different view of problem that hadn't been considered before?

-To evaluate the concept of Change of One's View Of The Problem, one might observe the following behaviors:

1. Does a family member(s) make statements that they see the problem differently?
2. Does someone make a statement that other members, stressors, situations are now a part of the problem?
3. Does someone make a statement that more than just the identified patient's behavior is involved in the problem?

-To evaluate the concept of a Sense of Curiosity, one might observe the following behaviors:

1. Does a family member(s) make statements of "I don't understand fully" or "That's interesting but tell me more"
2. Does someone make statements like "that's an interesting idea" or "I like what you said"?
3. Does a family member(s) look interested (attentive nonverbally)?

-To evaluate the concept of a Sense of Creativity, one might observe the following behaviors:

1. Does a family member make statements like "I was thinking of this idea" or "that idea made me think of this"?
2. Are family members discussing possible ideas or behaviors to try out?

-To evaluate the concept of the Family Appears Reflective in Session, one might observe the following behaviors:

1. Does a family member(s) make statements like "I was thinking about this idea", or "I was wondering about what you said", or "I thought about this issue during the week and..."?
2. Does a family member(s) stop and think before answering questions (pause)?
3. Does a family member(s) make statements like "I was looking at my behavior/feelings and ..."?

-To evaluate the concept of Sense of Hopefulness, one might observe the following behaviors:

1. Does a family member(s) verbally like new idea or behavior?
2. Do you observe nonverbal behavior of smiling and nodding as new idea or behavior is discussed by some family members?
3. Do family member(s) make positive statements to each other or to therapist (e.g. "things are better", "that's a good idea", "he/she is doing better", "I feel listened to or understood, etc.").

-To evaluate the concept of a Sense of Trust, one might observe the following behaviors:

1. Does a family member(s) make statements of agreement with other members, the therapist or the team?
2. Does a family member make "I statements" when talking to other family members or therapist?
3. Does a family member(s) talk about what he/she thinks/feels instead of talking about what another member thinks or feels?
4. Is there nonverbal behavior of attentiveness and openness (e.g. eye contact, nodding, laughter, open posture or looks relaxed)?

-To evaluate the concept of a Sense of Humor, one might observe the following behaviors:

1. Does a family member(s) smile or laugh?
2. Does someone make a comment about self or a situation in a humorous manner?
3. Does someone make a statement and another member responds by making a humorous comment or laughs (sees the lighter side of an issue)?
4. Does someone make a statement like "you have to laugh sometimes"?

-To evaluate the concept of a Sense of Connection/Affiliation, one observe the following behaviors:

1. Does a family member(s) touch another family member?
2. Does someone make statements like "I understand you", or "I feel closer to you", or "we are seeing things more the same way or more together now"?
3. When one member talks, does another member agree or nod head?

To evaluate the concept of a Sense of Manipulation, one might observe the following behaviors:

1. Does a family member(s) make negative statements about the therapist or the teams comments?
2. Does someone look confused, have a blank stare, looks away, or nods their head "no"?
3. Does someone loudly verbalize disagreement with an idea or says "I don't understand"?

-To evaluate the concept of Blaming Comments, one might observe the following behaviors:

1. Does a family member(s) make negative statements to other members?
2. Is there an absence of "I statements" where someone is talking about another member in a blaming way or implying that "I am right and you are wrong"?

-To evaluate the concept of Controlling the Conversation, one might observe the following behaviors:

1. Does only one member talk?
2. Does someone interrupt other family member(s) or the therapist?
3. Does someone suggest that only their view is right or correct?

-To evaluate the concept of a Sense of Being Comforted, one might observe the following behaviors:

1. Does a family member(s) or therapist repeat or paraphrase what another member says?
2. Does a family member(s) seem to hear supportive, positive statements from others or the therapist or team?
3. Does someone reach out to touch another person?

-To evaluate the concept of Interest in Therapy Session, one might observe the following behaviors:

1. Is someone verbally active with other family members and/or the therapist?
2. Does a family member(s) nonverbal behavior suggest or imply listening (e.g. eye contact with other family member or therapist, nodding of head, leaning forward, etc.)?
3. Therapist doesn't have to repeat questions or comments?
4. Does a family member(s) make comments spontaneously that are related to the current discussion?

-To evaluate the concept of being Cooperative with the Therapist and Team, one might observe the following behaviors:

1. Does a family member(s) verbalize agreement with the therapist or the teams ideas?
2. Does a family member(s) nonverbally smile and nod head when therapist is talking or after team intervention?
3. Does a family member(s) make statement like "I(we) haven't thought of that before, let me think about it some more"?
4. Does someone state that he/she will try out new idea or behavior?

-To evaluate the concept of the Family's Overall Perception/Reaction To the Team Intervention, one might observe the following behaviors:

1. Does a family member(s) state they agree or disagree with the team's comments?
2. Do family member(s) look puzzled or confused (e.g. nod head to indicate disagreement)
3. Do family member(s) nod head in agreement or state we can try out that idea or behavior?
4. Is overall mood positive or negative about the team intervention?

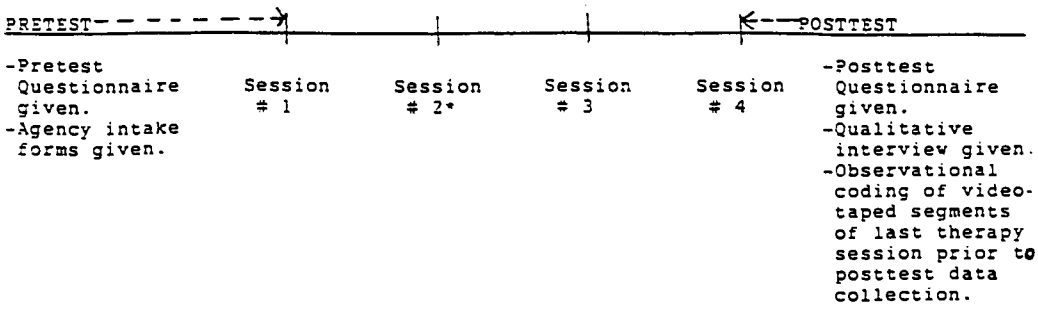
OBSERVATIONAL CODING SHEET

CONCEPTS	FREQUENCIES	CLINICAL IMPRESSION				RATER CONFIDENCE IN RATING		
		Very Low	Low to Medium	Medium to High	Very High	Low	Mid	High
Family Use of Own Solutions/Ideas								
Change in View of Problem(s)								
Sense of Curiosity								
Sense of Creativity								
Family appears Reflective in Session								
Sense of Hopefulness								
Sense of Trust								
Sense of Humor								
Sense of Connection/ Affiliation								
Sense of Being Manipulated								
Blaming Comments								
Controls/ Dominates Conversation								
Sense of Being Comforted by Another Member								
Interest in Therapy Session								
Cooperative with Therapist and Team								
Family's Overall Perception/reaction to Team Intervention								
Overall, how accurate do you think this segment was as a representation of this family's overall behavior? (Write in comments)								
Any additional comments about your observation of this segment of the couple/family session?								

Appendix I

DATA COLLECTION TIME LINE

DATA COLLECTION TIME LINE # 1: SAMPLE COUPLES/FAMILIES RECEIVING TREATMENT ONLY WITH AN OBSERVING TEAM (EITHER STRATEGIC OR REFLECTING)



*Due to scheduling conflicts one couple had posttest data collected after the second session

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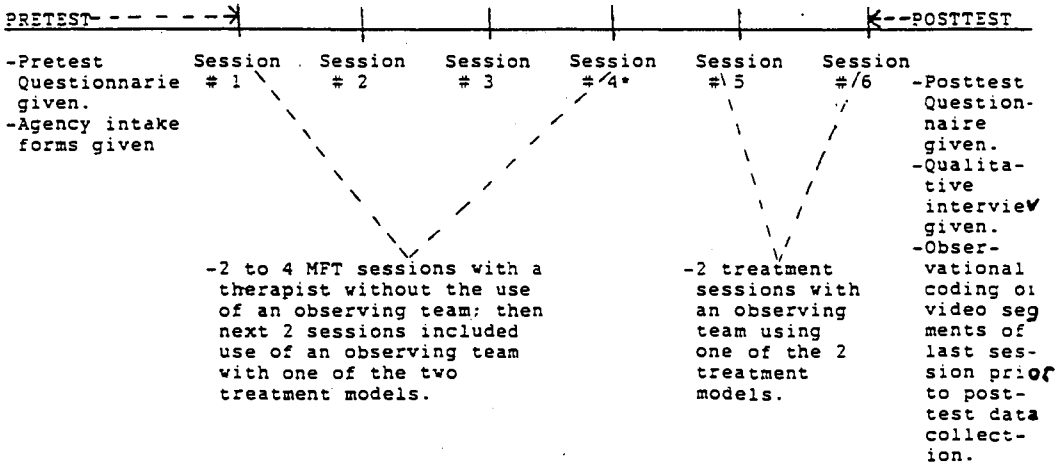
DATA COLLECTION TIME LINE # 2: SAMPLE COUPLES/FAMILIES WHO HAVE RECEIVED INDIVIDUAL MARITAL/FAMILY THERAPY SESSIONS PRIOR TO THE USE OF THE OBSERVING TEAM (EITHER STRATEGIC OR REFLECTING TEAMS)



*One family was terminating therapy and were referred to the reflecting team for their last session. This family had 11 prior sessions with their individual family therapist. The last session (# 12) included a reflecting team. Posttest data was collected after the 12th and concluding session.

Appendix J

REFLECTING TEAM CLIENTS' QUALITATIVE INTERVIEW DATABASE

Qualitative Questions	RT Family # 1	RT Family # 2	RT Family # 3
Q#1: What are your thoughts about the counseling you are receiving?	1a: get feedback, more pts. of view, diff. people perceive diff. things; put diff views together.	1b: like it, air our feelings/thoughts that we don't discuss at home	1c: get insight on things you said you might not have realized; gives me more understanding of myself
Q#2: If, you had previous counseling, how does this counseling compare to it?	2a: .we don't have a comparison.	2b: didn' t like previous counseling, 2 members wouldn't go then, this is much better	2c: before it was 1-on-1, you wondered if you're getting anywhere, this is more of a group-like
Q#3: How optimistic are you now that the problem will be reduced?	3a: feel a lot better about it	3b: very optimistic	3c: feel good about the counseling, some worry about my situation; prob will be reduced
Q#4: What is positive and negative about this counseling experience?	4a: in crisis it's easier to see negatives, here people give you positive feedback.	4b: experience is positive	4c: most comments are good, some not so good but still pos.-you find out more about self
Q#5: What are your perceptions of the counselor?	5a: female counselor is quiet, male counselor looks deeper to find out what's going on.	5b: like both counselors	5c: like the counselor; don't know
Q#6: How do you think the counselor views you in your efforts to solve your problem?	6a: hope seen as a family unit trying to deal with & resolve a crisis	6b: view us objectively-listen to us-very interested in us	6c: not sure how counselor sees us but daughter & I feli more of a closeness
Q#7: What are your thoughts about having a team in your counseling?	7a: like letting you hear views from team & getting diff. aspects of it; shifts in team membership neg..	7b: like it, listening to them they have totally diff ideas than what I was thinking in there-like it	7c: it helps us understand more; like team better than 1-on-1 counseling
Q#8: How do you think the team view you in your efforts to resolve the problem?	8a: see us as genuinely trying to struggle with, sort through & deal with the prob-pos. view of us	8b: team pays attention to what we're saying, give us fresh viewpoints	8c: they are pretty pos. about our trying to solve our prob.; uplift to leave with different thoughts
Q#9: Has your view of the problem changed during this counseling?	9a: prob. isn't controlling me but varies with stress; it's not quite so big a mtn.,it's climbable	9b: yes; look at it now as not just one person's prob. but all our prob.-all need to work	9c: yeah, somewhat; it has changed pretty much
Q#10: Have any new ideas or solutions developed from the counseling?	10a: express feelings more, tell each other how we feel; accept each other's feelings	10b: yes, keep mom out of our business-let sisters deal with it; it keeps dad at home more	10c: okay to deal with anger;have diff ideas about my mother-good way to find out things
Q#11: If, you have new ideas about the problem, where did they come from?	11a: input by different people helpful, my perception of problem in state of change & resolution.	11b: from team & counselor; understood more hear team discussion; team has some fresh view;	11c: counselor; the team comments & maybe the counselor but the team helps a lot

Qualitative Questions	RT Family # 4	RT Family # 5	RT Family # 6
Q1: What are your thoughts about the counseling you are receiving?	1d: some insight into what's going on; some confusion why daughter sees other counselor	1e: more used to 1-on-1 therapy; not what I expected; team talking helps; still kind of uncertain.	1f: have some doubts, need to stick with it, learn something, not ready to give up yet
Q2: If, you had previous counseling, how does this counseling compare to it?	2d: we've never had any other counseling	2e: seen different ways of doing counseling, each type is different, not similar	2f: previous alcohol counseling with boyfriend-upsetting, getting more out of this
Q3: How optimistic are you now that the problem will be resolved?	3d: prob. been reduced a lot but full resolution is years down the road	3e: trying a bit more, getting along better, at times a couple just needs to stop & look at it different	3f: with all of us working together, we will get results
Q4: What is positive and negative about this counseling experience?	4d: pleased , made us think more about our probs.-helped us let go of adult children's probs	4e: positive-we're ready to take the challenge of getting some things worked out-neg. is cost	4f: neg.-is the girls don't want to cooperate but hopeful they will change, feedback is good
Q5: What are your perceptions of the counselor?	5d: able person-pleased; surprised things counselor & team pick up on that I don'	5e: straight forward but wish he was more so; seems interested , has willingness to help	5f: helpful, takes time out to listen to all of us, like him personally
Q6: How do you think the counselor views you in your efforts to solve your problem?	6d: he thinks we're going in the right direction & working on the problems	6e: sees us as confused, nothing major wrong-some things to learn	6f: has more faith in us now than we have in ourselves
Q7: What are your thoughts about having a team in your counseling?	7d: they evaluate in a manner we're not accustomed to-their conclusions solidify in us	7e: felt funny standing back watching team talk about me; sparks thoughts that I want to talk about.	7f: learn a lot from listening to team talking, something to just sitting back and listening
Q8: How do you think the team views you in your efforts to resolve the problem?	8d: team felt like we are trying to solve our prob.; making progress; still had a ways to go	8e: sees us as strong & making an effort: you guys saw something in us differently than we se	8f: think we will get it resolved, have diff. ideas, they can see the end of the tunnel
Q9: Has your view of the problem changed during this counseling?	9d: learned to let go of our daughter-not a child anymore-turn me loose too-stay out of problem now.	9e: viewing of it yes but the prob. itself hasn't changed-it's 1st part of the road	9f: have doubts some days wondering if it will work, still have hope that it's not for nothing.
Q10: Have any new ideas or solutions developed from the counseling?	10d: yes, I stay out of the middle; don't cover up that makes it worse, commnunicate	10e: open up more, we're in this together, diff than my individual counseling-together in it	10f: .being more patient with the girls & time out from each other: I've learned more than the girls.
Q11: If, you have new ideas about the problem, where did they come from?	11d: from the counseling; guidance from people with a little more experience.	11e: from my other counselor; don't know, we could have talked and counseled ourselves	11f: from all of us talking it out as a whole, it;s not just me, it is all of us-all together-discussing

Appendix K

STRATEGIC TEAM CLIENTS' QUALITATIVE INTERVIEW DATABASE

Qualitative Questions	ST Family # 1	ST Family # 2	ST Family # 3
Q#1: What are your thoughts about the counseling you are receiving?	1a: pleased, brings up issues that wouldn't be brought up; learning things about what my beh. is like	1b: like it, been in therapy before, it's something I need	1c: going to help, needed to talk with someone other than wife to listen & give input; pleased
Q#2: If, you had previous counseling, how does this counseling compare to it?	2a: better experience than had in previous counseling	2b: before it was 1-on-1, boys need this for awhile, don't worry about team watching now	2c: in prior therapy didn't benefit from the marital therapy but did benefit from individual therapy.
Q#3: How optimistic are you now that the problem will be resolved?	3a: very optimistic: but was optimistic to start with; optimistic about the counseling.	3b: fairly optimistic but past experience is that it gets worse before getting better,	3c: pretty optimistic, more so than when I fist came in, I'm not sure that the therapy caused it.
Q#4: What is positive and negative about this counseling experience?	4a: positive-think & examine self, like tasks to do outside, I consider her feelings more now.	4b: it's kind of a gathering for the family, shows boys something is important	4c: counselor has talked to others in same shape we're in so feel confident about help
Q#5: What are your perceptions of the counselor?	5a: like him, thought I'd sit here & not say a darn thing but brings out some things	5b: like them, seem interested, happy here.	5c: like her, has warmth & true feelings; compassionate, had feeling for my story
Q#6: How do you think the counselor views you in your efforts to solve your problem?	6a: sees us as boring, others have worse probs; sees me as a person he's trying to help in any way	6b: first felt they didn't feel we were ready for therapy-with the boys being quiet but still useful for them.	6c: see I'm making an effort, see that I'm going at it the right way, says I'm courageous
Q#7: What are your thoughts about having a team in your counseling?	7a: nervous but get more feedback; they stay in line-all agree but bring out different options	7b: like idea-kind of different-liked having more than one person helping out	7c: with more people get more insight & advice; 1st felt strange not seeing team but it helps
Q#8: How do you think the team sees you in your efforts to resolve the problem?	8a: about the same as the male counselor does-boring; just as a person	8b: not sure how team sees us-hope they see us positive& ready to work.	8c: usually not aware of team but they think I'm making an effort.
Q#9: Has you view of the problem changed during this counseling?	9a: I would say yes; yes	9b: some changes but not sure what they are, problem isn't solved yet but somewhat hopeful.	9c: a little, stronger belief I have to put this behind me, verbalize feelings more.
Q#10: Have any new ideas or solutions developed from the counseling?	10a: yes, on verge of happening; I'm changing some of my techniques in communicating with him	10b: prob still there but more optimistic, unsure if any new ideas have developed	10c: stop the argument right there, female counselor said I don't have to be selfish or selfless.
Q#11: If, you have new ideas about the problem, where did they come from?	11a: weren't given the ideas but given opportunities, thinking was promoted.	11b: learning something, getting feedback, unsure of whether any new ideas are coming from them	11c: just months of trial & error, son saw us fight got upset-we decided to do things differently

Qualitative Questions	ST Family # 4	ST Family # 5
Q1: What are your thoughts about the counseling you are receiving?	1d: there's hope, therapist can be more subjective with team, not intimidated; pleased	1e: like it, all in here together, we are all communicating
Q2: If, you had previous counseling, how doe this counseling compare to it?	2d: this is far superior; like opp. sex co-therapy get male and female point of view	2e: haven't had it before, tried to get in put couldn't
Q3: How optimistic are you now that the problem will be resolved?	3d: feel better than when 1st came in, optimistic, more relaxed, both more open	3e: prob will be reduced a lot, it helps coming here and talking about everything
Q4: What is positive and negative about this counseling experience?	4d: only neg. is paperwork, don't do homework, overall positive	4e: everything is positive, counselor listens & team watch & give input-I like that
Q5: What are your perceptions of the counselor?	5d: diff. than in past-relate well to both counselors; no judgement from counselors or team	5e: like him, not only talks to me but to the boys, I like that
Q6: How do you think the counselor views you in your efforts to solve your problem?	6d: both are pleased with our efforts; we're coming along , they see pos. easier than us	6e: as trying to cope, keep my head above water, tells boys they're trying-doing little bett
Q7: What are your thoughts about having a team in your counseling?	7d: good approach, more people involved & more viewpoints	7e: better than 1-on-1, more input, different people have diff. thoughts, can get together for a solutic
Q8: How do you think the team sees you in your efforts to resolve the problem?	8d: think team appreciates their effort to change	8e: see me as really trying
Q9: Has your view of the problem changed during this counseling?	9d: more hope, know each others backgrounds well-need help in how to deal with thes	9e: boys see it differently-it has changed-one son didn't hardly do any work at school-impro
Q10: Have any new ideas or solutions developed from the counseling?	10d: we are both coming-shows we want to resolve it	10e: they tell me to do something for myself-it's hard , feel selfish when I do things for me
Q11: If, you have new ideas about the problem, where did they come from?	11d: from the therapists; they caused us to think about some things they suggested to us	11e: some from male counselor & the team, a lot came from Jesus Christ-I pray a lot

Appendix L

THERAPISTS'/TEAM MEMBERS' QUALITATIVE INTERVIEW DATABASE

Qualitative Questions	Team Member 1	Team Member 2	Team Member 3	Team Member 4
Q1: Are Reflecting teams useful?	1: Families appreciate all the feedback; useful as a training tool-practice skills in asking tentative questions.	1a: Very useful; different people notice different things; families can relate to what was said by the team.	1b: It re-enforces what they have learned & sheds light on things that they did not see or hear in the session.	1c: A lot of use in them; give people information in a team that you can't give in1 on 1 therapy.
Q2: How does the team work?	2: Nondirective way of working with families-they are the expert on their problem not the therapist.	2a: Building of cohesiveness& confidence of team was gradual; useful in giving clients a variety of ideas.	2b: Dynamics different within the team depending on who's there-we build on each other's ideas.	2c: Observe the therapy then team discusses it to give clients feedback about what we think.
Q3: When doesn't the team work?	3: Seen clients refuse the team due to # of therapists, overwhelms them, paranoid persons don't do well.	3a: Few times team had only 1 member, felt isolated & alone without other team members.	3b: When session seems at standstill, I think back there of ideas to move clients but not sure if they hear ideas.	3c: Wouldn't work if client was so paranoid they couldn't manage the team context.
Q4: *What kind of things* do you learn from the team?	4: Observe each other's therapy style, focus on team process & pay more attention to metaphors.	4a: Observe *better*, learned watching therapists interact with clients & see what is picked by the clients.	4b: *Learn other's* perspectives & notice that I didn't think the same way, it changes my whole view.	4c: *Useful to* get different feedback & alternative ways of seeing people's problems-clients are more in control.
Q5: What would you change about how the team works?	5: I don't have a lot to say to change it, I like the way it has been done.	5a: More consistency in membership; continue consultation for the team to build trust & cohesion.	5b: Allow more time for the family to process what the team has said-kind of a double reflection.	5c: Wouldn't change anything-it's very powerful to me & looked that way to clients from my view.
Q6: What relationship do you expect will exist between you & your team?	6: Nobody is working against each other; hearing our ideas helps us jell together & be harmonious.	6a: respect each other, have warmth & friendly feelings with each other, a feeling of working well together.	6b: Sort of a united team in the therapeutic process of finding clues, exceptions & unique outcomes.	6c: Be supportive of one another & if disagree with a team member expand on idea & not argue.
Q7: Does it matter whether your team is predominantly male or female?	7: Only matters at times to clients, like a couple seeing a female therapist with a all female team.	7a: Team was more female, better if equity distributed, the men did notice different things but not a big issue.	7b: It does matter to some clients, difficulties identifying with a team that is all of the opposite sex.	7c: Helpful to have a mix.
Q8: What does it mean when team members disagree?	8: Just new insight, we each pick up on what clients say differently due our own individual experiences.	8a: sometimes there was different viewpoints but was accepted well by everybody-it was healthy.	8b: It's a difference of opinion, disagreeing is good sometimes, it makes you think & try differently.	8c: Have different ways of looking at things& different ways of communicating with clients.
Q(: How can the team be disruptive?	9: Sometimes there may not be enough time to have a reflection-it may feel disruptive to the therapy process	9a: Clients who are extremely sensitive & vulnerable (i. e. suicidal client) may see team as intimidating.	9b: When not much is going on in session, we loose attention & don't listen as hard, need to listen all the time.	9c: Strong disagreements or emphasizing client's weakness would by disruptive.
Q10: What is your experience as a team member of an observing team?	10: Family appreciative that they are going to get more information than just therapist can provide.	10a: my first therapy experience with families; useful to be part of a team; could pick up theoretical concepts	10b: Positive-uplifting to be part of process & have input-your ideas could make a difference in what clts. think.	10c: Gave large amount of feedback & suggest things I would not think appropriate in individual therapy.
Q11: Is there a difference in your experience on the team when a reflecting team or a strategic team is used?	11: More on the spot with reflecting team, have to come up with ideas; get to visit more with strategic team.	11a: Big difference, less pressure to come with ideas in reflecting team, more with strategic team to get 1 idea.	11b: Strategic team seems to force instead of moving at a pace-intrusive, like reflecting team better.	11c: Prefer RT-it's more effective; ST gives therapist more control-don't share all team says; RT gives clients choice

Qualitative Questions	Team Member 1	Team Member 2	Team Member 3	Team Member 4
Q12: What is your experience as a therapist with a team? Is it different with a RT vs. a ST team?	12: Other eyes & ears working with me; in ST call in can be disruptive; RT more supportive.	12a: Due to student status felt pressure as therapist with team observing but provided useful feedback.	12b: Difficult to answer when I was therapist, clts. requested team leave.	12c: Being new I wondered like the clts. what team thought of the job I was doing.
Q13: Do you think families experience any difference when a strategic vs. a reflecting team is used?	13: They are complimentary of RT-saying they think about it when they go home; few comments on ST.	13a: On RT, once they saw how supportive it was they liked the attention of team; in ST harder to see the helpfulness.	13b: Differs with each family, if family has been therapy before either model is okay-if new ST may feel abrupt.	13c: RT offers alternatives, ST maybe discomforting to clts. wondering what team is saying
Q14: Is there any difference in how your ideas are listened to when a ST vs. a RT is used?	14: More opportunity to be heard on RT, all contribute in ST but it gets reduced to a phone call; RT you say ideas outright.	14a: Easier in RT to say ideas & build on them; ST never felt not heard but listening in tight room limited it.	14b: More teamwork in RT-more of a flow; in ST everyone has questions to ask, hard to decide which to call in.	14c: I don't think so-my ideas were accepted in both teams.
Q15: Do you experience any difference in the cooperativeness in a RT vs. a ST?	15: More teamwork in ST-talking together to get consensus; RT in being quiet, a team member may say your idea 1st.	15a: Not competitive in either; even ST with coming up with a unified idea nobody pushed their own views.	15b: Cooperative in RT; competitive in ST given time factor, if not forceful you'll use someone else's ideas.	15c: Competitive in ST; RT was pretty open , everyone had opportunity-no need to be competitive.
Q16: Do you experience any difference in what you focus on as a member of a strategic vs. a reflecting team?	16: Really don't see a difference even though my response is going to be different-I take same kind of notes.	16a: No difference.	16b: Questions I'd ask are different-in ST more looking at what happened that moment; in RT more going back ov	16c: Saw more negatives in ST & worked harder on the positives in RT.
Q17: Do you have a preference to use a reflecting or a strategic team model?	17: Prefer RT- I try to see it from clients view, RT more helpful; see ST as more directive & authoritative.	17a: Like RT better; clts. have more options, they liked it too even if it seemed initially intimidating.	17b: Feel biased, prefer the RT but probably just not enough experience with the ST.	17c: Prefer RT-gives clt. more information in nonthreatening manner; ST does not give as much information.
Q18: Do you experience any difference in how you focus on solutions & strengths in a RT vs. a ST model?	18: Easier to see strengths in RT but more pressure to say positives; ST focuses on solutions-directive.	18a: RT provides more emphasis on family strengths.	18b: Focus more on RT, knowing the family will be viewing it, different than if an anonymous voice calls in.	18c: In RT experienced more positive approach-looked more for strengths & less for what's the problem.
Q19: Any difference in the cooperativeness in members when a ST vs. RT is used?	19: More cooperative in ST due to sharing ideas to get a consensus; RT don't share prior to reflection.	19a: No difference.	19b: Small degree of difference-more cooperative in RT just because of how it works.	19c: Both are highly cooperative.
Q20: Any difference in your ability to attend & focus in a reflecting vs. a strategic team?	20: Easier in ST since you're not worried about going in to reflect in front of clients; rehearse more with RT.	20a: I don't think so.	20b: I think it would be fairly equal.	20c: Easier in RT- team would tell therapist what they were thinking about; ST worry more what team will say.
Q21: Any difference in the pressure you feel to come up with ideas for families in a RT vs. a ST?	21: More behind the scenes in ST; more on the spot in RT to come up with ideas ; therapist has to do more work in ST?	21a: More pressure in ST-like a quota to come up with 2 suggestions; in RT other's ideas gave me ideas?	21b: Less presure in ST, someone will have an idea; in RT I have to go in front of clients-more pressure.	21c: More pressure in ST to be in control of the direction; in RT know clts. will get team exposure & have own agenda
Q22: Any difference in the dierarchical distance between the family & the team in a RT vs. a ST?	22: Don't see distance in RT-clts. are comfortable seeing & hearing team; in ST family doesn't know the team.	22a: ST more distant, don't get to see you interact with family; closer when can see & hear comments in RT.	22b: ST-ideas from team go thru therapist so clts. may notice team less than in RT, so more hierarchical in RT.	22c: Don't have a feeling for this so no difference but felt ST was more critical in my view.

Qualitative Questions	Team Member 1	Team Member 2	Team Member 3	Team Member 4
Q23: Any difference in how active an observer you are when a reflecting vs. a strategic team is used?	23: RT have to prepare to talk, so pay more attention but on the spot; easier to be attentive in ST-no pressure to talk.	23a: No difference in how active an observer I am in either model.	23b: More active in RT; in ST when team is smaller more of what I think is heard than if team is larger in size.	23c: No difference-worked hard on both teams.
Q24: When you have been the therapist has there been any difference in the support you felt in a RT vs. a ST model?	24: Always felt support in RT-less experience in ST but feel therapist more out there by self in ST.	24a: Not asked this question.	24b: Not asked this question.	24c: May have some feelings on that but the team was supportive in both models.
Q25: Any difference in the connection or alliance that you had with clients as the therapist with a RT vs. a ST model?	25: More connection with clts. in RT sitting with them during reflection; in ST have to leave clts. to talk with tear	25a: Felt more involved with the RT clients.	25b: Not asked this question.	25c: I felt the same connection with either model.
Q26: Any difference in your perception of how the family focuses on own ideas & solutions in a RT vs. a ST?	26: RT suggests clts. are the experts about their problem; in ST ideas come from therapist & team.	26a: Feel not enough information to answer.	26b: Not asked this question.	26c: Clts. get more from RT & able to pick up their own solutions & alternatives better that way.
Q27: Any difference in your perceptions of clients comfort level with a reflecting team vs. a strategic team model?	27: Feel clts. are more comfortable in RT; haven't heard them complain about ST but see differences in gestures.	27a: More comfort with the RT.	27b: Not asked this question.	27c: Yes & no; clts. may have some discomfort in both; felt ST made clts. more uncomfortable.
Q28: With the reflecting team vs. a strategic team, any difference in their effectiveness & usefulness?	28: RT, clts. hear so much-so many different voices, say they'll take it home to think; in ST don't hear that.	28a: Difficult to say due to few families seen over time by team-can't make a comparison.	28b: It would depend on the family and the problem.	28c: RT much more beneficial to clts., gave them many viewpoints & could pick their own solutions.

Qualitative Questions	Team Member 5	Team Member 6	Team Member 7	Team Member 8
Q1: Are Reflecting teams useful?	1: From my experience, I would say yes; reflecting teams seem useful.	1a: Real useful tool in families because it helped them hear a lot of ideas from a lot of therapists.	1b: Very useful-get a variety of ideas; the reflection lets one member build on another's ideas, get synergy.	1c: I believe reflecting teams are useful.
Q2: How does the team work?	2: Observe session, then team switches places & reflects upon what we heard, then family reflects on ideas.	2a: Watch family then family watches team brainstorm about perceptions of what's going on, lots of opinions.	2b: Recruiting an audience for clts. where they hear about impovements & strengths from a new perspective.	2c: Team listens to session then switches places & reflects on their thoughts, insights then clts. discuss it
Q3: When doesn't the team work?	3: May not be as effective if team membership flucuates better for team to be stable in membership.	3a: Clients with personal issues like sex abuse & severe depression may have difficulty with a team observing.	3b: May not work with clts. with extreme anxiety or suicidal ideation-not comfortable with observers.	3c: At times, when clts. are really sensitive to being observed due to certain issues or if they are somewhat paranoid
Q4: What kind of things do you learn form the team?	4: How clts. interpret what you say, if you say something that is taken differently, learn to express self clearer.	4a: Learn many ways people approach problems, so therapists get a lot of experience observing others.	4b: Learned different ways of thinking, different ways of conceptualizing problems & interventions.	4c: We see things differently, reflection brings out differences & similarities, process helps therapist.
Q5: What would you change about how the team works?	5: Have a team set up for a particular family, so they would have the whole background.	5a: I can't think of anything; it is a pretty effective tool.	5b: Streamline the switching process; RT invites us to be energetic & creative but may overwhelm clients.	5c: Contracting with families to show up; frustrating when ready to do it & family doesn't show.
Q6: What relationship do you expect will exist between you and your team?	6: Listening together, a camaraderie develops on team on a personal level, easier to then reflect-have trust.	6a: Begin to be able to read each other's comments & body language, anticipate the direction.	6b: Creates a bond; difficult 1st as a therapist-felt on stage; once I learned other's styles had a bond.	6c: Camaraderie role together with same goal to assist clients; everyone seems to enjoy doing it.
Q7: Does it matter whether your team is predominately male or female?	7: Don't see it as a problem unless the family sees it as a problem.	7a: May matter for clts. but not for team, clts. with an issue like sex abuse, harrassment or other gender issues	7b: We think differently by gender-a mixture would be effective: males may be uneasy with female team.	7c: Better to have gender mix to get different viewpoints , doesn't matter how many but just a mix.
Q8: What does it mean to you when team members disagree?	8: It is enlightening; other points of view make the team work-it is a positive thing.	8a: Means they don't have the same ideas; can be productive if people don't take it personally	8b: We're looking thru a different lens; no one way to see things-multiple realities; can learn from difference.	8c: That we see things differently & can show clts. it's okay to disagree & see things differently, role modeling.
Q9: How can the team be disruptive?	9: When not taking it seriously-gets too playful or doesn't want to be there then it's disruptive & not therapeutic.	9a: If they try to be too directive or controlling or if they did take things personally & get into arguments.	9b: With conflict on team & transparent, or getting disparaging with remarks to clts., or overload of ideas.	9c: By offending clts., there are sacared areas that you go gently with such as religion or sensitive areas-sex abuse.
Q10: What is your experience participating as a member of an observing team?	10: Beneficial, more helpful if there longer, listening to other viewpoints helps me to see other views.	10a: Good learning process, scary at 1st because I wasn't able to really learn the process well enough.	10b: Real learning experience for new therapist to watch others; exciting, see ideas used & not used.	10c: Give different viewpoints-your observing but still involved; pick up on things therapist can't see.
Q11: Is there a difference in your experience on the team when a reflecting team or a strategic team is used?	11: ST easier to not pay as close attention-look to others to come up with ideas; RT pay more attention.	11a: RT less of a mystery to clts. than ST-grew to see strengths in ST get to prepare ideas & call in.	11b: RT-we keep ideas to ourselves, in ST-had discourse & called in-liked this, but as a therapist liked RT.	11c: Took time to get interventions in ST & didn't always agree-difficult to find spot to call in; RT easier process.

Qualitative Questions	Team Member 5	Team Member 6	Team Member 7	Team Member 8
Q12: What is your experience as a therapist with a team? Is it different with a RT vs. a ST?	12: Not asked that question.	12a: Intimidating having observers, want to say right thing at right time, shouldn't matter which model.	12b: Can miss some cues as therapist with team-in ST the call in can be disruptive-at times meaning is missed.	12c: Nervous at 1st but got easier; in ST quick feedback-on edge awaiting call; RT more in control, focused.
Q13: Do you think families experience any difference when a ST vs. a RT is used?	13: If I was a family member I would prefer the RT because it's kind of even-get to see & hear each other.	13a: If, my family want to know who's on team but in ST not seeing team gives them a little magic.	13b: Clts. react positive to both models but see validation clts. get hearing view understood in reflection.	13c: RT get to see team not faceless people behind mirror-less threatening than ST-in ST kind of wait for the call in.
Q14: Is there any difference in how your ideas are listened to when a ST vs. a RT is used?	14: Ideas listened to differently on ST, work together to get one answer; in RT all of us verbalized own ideas.	14a: Thought of more ideas in RT to have something to say; in ST when calling in ideas felt done for awhile.	14b: In ST a leader emerges & ideas filter through the leader; in RT your kind of in charge of your own voice.	14c: Sometimes ST limited in ideas so task came from therapist; in RT clts. heard directly what team saw.
Q15: Do you experience any difference in the cooperativeness in a RT vs. a ST?	15: In RT, team pays attention due to having to reflect; in ST don't think it's competitive-want to work together.	15a: No, but I was real fortunate to have a good group of people on the team.	15b: Both are cooperative, ST little more competitive; RT more free flowing.	15c: Both cooperative, ST discuss more behind mirror; in RT more discussion during reflection.
Q16: Do you experience any difference in what you focus on as a member of a ST vs. a RT?	16: ST listen to get intervention-so different cues than in RT listen to everything due to reflection.	16a: Subtle differences; try to brainstorm in RTas opposed to coming up with specific directive in ST.	16b: More free to converse in ST, what others noticed influenced what I focused on.	16c: RT look more for general patterns; in ST focus more on specifics due to being able to talk with team
Q17: Do you have a preference to use a reflecting team vs. a strategic team model?	17: Prefer the RT since my experience with the ST is limited.	17a: Prefer RT-real productive model, more uses to the therapist but with clts. with small kids ST may be better.	17b: Pros & cons to both models; but prefer RT, it seems more human & more of a contact with different people.	17c: Prefer RT-more fair for family to see/hear team ideas; in ST some difficulty deciding who will call in idea
Q18: Do you experience any difference in how you focus on solutions & strengths in RT vs. ST?	18: Easier in RT due to doing reflection; ST looking more for some place we could put an intervention.	18a: Not particularly.	18b: In ST-team talking can lead to negative focus; in RTeasier to see solutions-some differences.	18c: ST can talk more & disagree-discuss what you see better ;RT do it when reflecting-benefits family more.
Q19: Any difference in the cooperativeness in members when a RT vs. a ST is used?	19: I didn't see any difference.	19a: Little difference, at times, in ST some would back off & leave ideas up to those more interested	19b: ST has more competition & cooperation-no clt. audience; RT cooperative but less freedom.	19c: Cooperate in both differently-in ST do so whole time to come up with ideas ;RTdo it reflecting, benefits clts. more.
Q20: Any difference in your ability to attend & focus in a reflecting vs. a strategic team?	20: Easier in RT; in ST easier to lose attention & focus after team came up with the intervention.	20a: Attended more in RT-thinking of multiple things to say; in ST focused more on when to help therapist.	20b: Initially, didn't trust my formulations in RT; in ST critical comments made solution focus difficult.	20c: ST don't worry about missing a lot due to other members; RT not as focused others back you up.
Q21: Any difference in the pressure you feel to come up with ideas for families in RT vs. a ST?	21: Less pressure on RT-others have ideas; in ST if don't come up with idea it doesn't work as a group.	21a: ST more pressure due to intervention; thought more broadly in RT-clt. focus in RT & in ST a therapist focus.	21b: More pressure in RT-you & clts. no separation; liked ST due to free flow of ideas without being observed.	21c: Early on, harder in ST trying to get consensus; RT if you didn't have idea could support someone else's.
Q22: Any difference in the hierarchical distance between the family & the team in a RT vs. ST?	22: ST-in not seeing team may see team more as authority figure than in RT, where see normal people talking.	22a: Didn't pick up on any differences between models	22b: ST more hierarchical-team not being seen; RT see team is human & more than one way to see things.	22c: ST may make clts. feel humble with faceless voice on phone; in RT seeing team has clts. on equal level.

Qualitative Questions	Team Member 5	Team Member 6	Team Member 7	Team Member 8
Q23: Any difference in how active an observer you are when a reflecting vs. a strategic team is used?	231: ST-easier don't have to be seen by family-less on spot; RT more attentive-talk in front of family.	23a: More active in the reflecting team model.	23b: After initial period, equally active in both models-early on more active in ST because it was safer.	23c: Varies-depends on people involved; more watchful in RT-see patterns coming; ST less alert due to team.
Q24: When you have been the therapist has there been any difference in the support you felt in a RT vs. a ST model?	24: I don't know.	24a: Maybe little more threat in ST due to team calling in ideas. to therapist-may feel not going right way.	24b: More support with RT-more dialogue with team & use team ideas more freely-ST call in felt disruptive.	24c: Both have some judgement being observed-ST waiting for call in; RT-some support have backup.
Q25: Any difference in the connection or alliance that you had with clients as a therapist with a RT vs. a ST model?	25: RT-more alliance as therapist with clts.-sit with them during reflection; ST more linked to authority of team.	25a: I don't think so.	25b: More of an alliance in RT-taking the mystery out of it-reenforces humanness of team members & clts.	25c: RT-more bond-therapist with clts. during reflection-bond with team too-comments can go to therapist.
Q26: Any difference in your perception of how family focuses on own ideas in RT vs. ST?	26: Didn't see a difference; not sure families make that distinction.	26a: RT gives clts. more options to think-occurs after the reflection-don't see differences before this time.	26b: More opportunity to foster clts. own abilities when have more human to human contact in RT.	26c: More open in RT & clts. can focus more-hearing team's comments; ST ideas filter thru therapist.
Q27: Any difference in your perceptions of clients comfort level with a reflecting team vs. a strategic team model?	27: Feel family is more comfortable during the reflecting process than in the strategic process.	27a: I think there would be a little more comfort with the reflecting team.	27b: In ST clts. may forget team until call in; RT being able to see team increases clts. comfort level.	27c: RT-more camaraderie seeing & hearing team's ideas; ST still that distant voice calling in-less connnection
Q28: With the reflecting team vs. a strategic team, any difference in their effectiveness & usefulness?	28: RT more useful process for the team due to paying more attention; less attentive in ST after intervention given.	28a: First, I thought RT was much stronger but did begin to see times the ST was very effective.	28b: Easier for communication to break down or be misconstrued in ST.	28c: Both positive & negative-ST more immediate & interruptive; RT get more detail but not immediately.

Qualitative Questions	Team Member 9	Team Member 10	Team Member 11	Team Member 12
Q1: Are Reflecting Team Useful?	1: uesful, not a mysterious team, they saw us & we became real to them-gave ideas empowered clts.	1a: Yes, reflecting teams are useful.	1b: Useful with collaboration; I'm a visual person-helped me that some ideas on RT were visual.	1c: Useful-believe RT most usueful with families with less pathology; with more pathology need to be directive
Q2: How does the team work?	2: Liked the team as far as process & the other clinicians & liked the empowering of the clients.	2a: The team is effective & I felt it was useful to be a part of that reflective team.	2b: Team listens then clts. & therapist listen to team & clts. get last word; clts. have "ah-hah" experience.	2c: Team listens & formulates own ideas & perceptions individually then reflect to clts.
Q3: When doesn't the team work?	3: If a team member monopolized the reflection or maybe with certain clt. problems such as mental retardation.	3a: May have trouble in abuse issues where woman is hesitant to tell-may be more difficult for her with a team.	3b: If clt. was traumatized by past therapy, 1st time clts. that are very anxious or clts. with low cognitive ability.	3c: Team works less well if members aren't familar with process, better the more experience the team has.
Q4: What kind of things do you learn from the team?	4: How important wording is & how to change it around; how to influence & motivate people to action.	4a: Learn there are many facets to observing clts.-can't see it all, enlightening to see what other's see.	4b: Many ways of viewing problem-in individual therapy can't focus on everything the team sees.	4c: That "groupthink" occurs when team talks together-reach joint consensus-RT get divergent views.
Q5: What would you change about how the team works?	5: Have a large therapy room so team could be in room during session & actually be part of system.	5a: Theoretically liked it-wouldn't change it, sometimes wanted to check out observations prior to reflection.	5b: Might combine the ability to phone in interventions with the team reflection.	5c: Keep the implementation of it-would training course in it prior to doing it by those experienced in it.
Q6: What relationship do you expect will exist between you & your team?	6: Experience was supportive & no competitiveness, blending of team member & therapist good for me.	6a: Relationship with team grows just based on what is said in reflections; opened up possibilities.	6b: Very supported by team; it was a partnership with equal pairs of eyes and ears.	6c: Mutually very supportive-better if had more time together; people supportive of divergent opinions.
Q7: Does it matter whether your team is predominatelly male or female?	7: Same gender team shouldn't matter but we think differently so a blend would be the ideal situation.	7a: If you are dealing with a family, I think it helps to have a pretty equal mix.	7b: It does matter depending on issue presented-a balance of genders & cultures would be good.	7c: Best to have a mix; different viewpoints by gender-with sex abuse better to have females on the team.
Q8: What does it mean when team members disagree?	8: It's going to occur-in reflection clts. can see disagreement-gives sense there are several ways to go.	8a: There are just more possibilities.	8b: It's great since clts. disagree & as therapist offer it back to clts. that there is more than one solution.	8c: Sign of health & comfort in team; tolerate divergent opinions; disagreements always peaceful.
Q9: How can the team be disruptive?	9: Making comments damaging to family especially if team agrees with comments-giving it more weight.	9a: If team focuses on selves not clts.; triggers response to personal issues instead of focusing on family.	9b: Focusing on the clock as therapist when I knew I had to get a reflectin in, sometimes want to keep going instead.	9c: Team member had personal difference with the therapist or if team didn't feel safe to offer divergent views.
Q10: What is your experience as a team member of an observing team?	10: Enjoyed it-lot of positive strokes or values associated with team; want to continue doing this type of therapy.	10a: Very energizing-you never knew what would be spawned by interaction, moved to observe.	10b: Felt rich to work with others of different backgrounds; learned something each time.	10c: Learning experience to observe as well as to do therapy-frees you up see what can't see in session
Q11: Is there a difference in your experience on the team when a reflecting vs. a strat	11: Liked RT better; everyone had equal billing & got chance to share-ST use only some ideas; useful to hear all.	11a: More anxiety in ST, more time pressure ,didn't like calling in as authority-felt unfair to clts. not to see team.	11b: ST more direct in interrupting clts. patterns & giving something new; RT subtle clts. pick & choose what to use.	11c: Less pressure in RT to come up with idea that would work-gentler process-ST busy trying to fit idea in.

Qualitative Questions	Team Member 9	Team Member 10	Team Member 11	Team Member 12
Q12: What is your experience as a therapist with a team? Is it different with a RT vs. a ST?	12: Team picked up on what I didn't see; not sure if I remember a difference between models.	12a: Uneasy at first but they could see things I couldn't see-after getting used to team helpful to have RT.	12b: More rigid with team following a model-less so without team; not a directive therapist, uncomfortalbe in ST.	12c: RT-more comfortable-observe with clts. & get information at same time; in ST pressure to call in.
Q13: Do you think families experience any difference when a ST vs. a RT is used?	13: RT-less threatening-not the expert-some ideas aligned with clts. ideas-in ST team seen as experts.	13a: Time for closure in RT-in ST you call in-interrupts & not sure clts. are ready for interruption.	13b: Clts. commented more in RT & liking RT; ST seemed less personal to clts. & talked less about ST.	13c: My opinion that clts. enjoyed RT more due to moving from ones observed to ones observing the team.
Q14: Is there any difference in how your ideas are listened to when a ST vs. a RT is used?	14: Don't think any difference-if you had a good comment it was valued regardless of which model.	14a: ST-have to reach consensus-some pressure to make intervention; RT each response validated.	14b: ST-it seemed more directive ideas listened to & used; felt more listened to in RT-I don't tend to be real directive.	14c: Not more or less valued-in ST if called in own ideas team would use them-RT-ideas there for the taking.
Q15: Do you experience any difference in the cooperativeness in a RT vs. a ST?	15: No difference in competitiveness; ST some anxious to call in their idea; RT some pressure to speak in reflection	15a: More competition in the ST because you had to screen out certain ideas.	15b: ST-team more aggressive in ideas since clts. wouldn't all ideas-more suggestions-more brainstorming.	15c: ST-more competition to have idea heard; RT everything you say is heard-less competition.
Q16: Do you experience any difference in what you focus on as a member of a ST vs. a RT?	16: No I didn't; if I thought something was important, I would bring that up whether it was a ST or a RT.	16a: Didn't notice that much difference in focus; felt pressure to come up with a verbal idea in ST.	16b: No I don't think I made a distinction between that.	16c: RT-less pressure-less censorship-more observations about clts. qualities; ST more problem focus
Q17: Do you have a preference to use a reflecting or a strategic team model?	17: Prefer RT-clts. can choose what fits for them-more non threatening-team becomes more a part of the family.	17a: Prefer RT-spontaneous, incidental comments may spark something, this is missed in ST	17b: Prefer RT-focus on positives not on pathology-more upbeat-left options open for clts., did not give directions.	17c: Prefer RT, feel clts. preferred it more-feel anything that could occur in ST could be given in RT.
Q18: Do you experience any difference in how you focus on solutions & strengths in RT vs. ST?	18: RT allows clts. to go a # of different ways; in ST-tell clts. what to do so really don't have option-like RT more.	18a: ST-more pressure & intense; easier to focus on solutions in RT-small things can be magnified as solution in RT.	18b: ST-more restricted due to having to come up with 1 prescription; RT more open-all on team had own views.	18c: RT-more positive focus on strengths; ST-some focus on strengths gets filtered out-shift to help fix problem.
Q19: Any difference in the cooperativeness in members in a ST vs. a RT?	19: I think everyone was cooperative in either model.	19a: RT-cooperative & easier to be responsible; ST-easier to give up responsibility, let others call in.	19b: ST-more competitiveness & more cooperation in that competitiveness was cooperating.	19c: Not that I noticed.
Q20: Any difference in your ability to attend & focus in a reflecting vs. a strategic team?	20: No difference, my focus was pretty much the same.	20a: RT-focused better-responses evolved in front of clts.-so much more open focus.	20b: Behind mirror more focus on subtleties, tone & body language-in ST during call in was distracted-too much.	20c: ST-more effort to give clts. alternative direction-with this pressure was sharper in noticing clt. interactions.
Q21: Any difference in the pressure you feel to come up with ideas for families in a RT vs. a ST?	21: No difference.	21a: Felt more pressure to come up with a focus when the ST was used.	21b: RT-more pressure in being more accountable to clts.; ST-more annonymous-real different feeling.	21c: ST-more pressure due to having to offer intervention to call in.
Q22: Any difference in the hierarchical distance between the family & team in RT vs. ST?	22: Not totally sure of meaning of the question but didn't see any difference in how therapy came across.	22a: RT-more comfortable; ST-might not be comfortable with call in-like God calling in-distant.	22b: In RT got image from clts. that team was people just like them; in ST more like the voice from Wizard of Oz.	22c: I didn't notice much of a difference.

Qualitative Questions	Team Member 9	Team Member 10	Team Member 11	Team Member 12
Q23: Any difference in how active an observer you are when a RT vs. a ST is used?	23: RT-attention sharper since I was going to reflect; ST-less sharp since not going to reflect.	23a: ST-easier to be negligent-someone else calling in ideas; RT-attended more to details for reflection.	23b: ST-more focused due to being able to talk to members; in RT due to small room & not talking more distracting.	23c: ST-more interchange-worke d harder to watch carefully but more effective observer in RT-being quiet.
Q24: When you have been a therapist has there been any difference in the support you felt in a RT vs. a ST model?	24: No difference.	24a: ST-more uncomfortable due to interruption with call in-highlighting what you missed as a therapist.	24b: ST-felt tug on whether team was the expert didn't feel that in RT due to having more options generated.	24c: ST-more supported & judged due to direct contact with team with calls in to therapist, interaction direct.
Q25: Any difference in the connection or alliance that you had with clients as a therapist with a RT vs. a ST model?	25: No difference in alliance but if ST intervention doesn't go with your line of thinking may have less strong alliance.	25a: Think that clts. might wonder who was behind the mirror and be somewhat mistrusting.	25b: Didn't feel a difference but closer to family in RT-more human contact since they can respond back.	25c: I don't think so; RT just seemed like a more relaxed way.
Q26: Any difference in your perception of how family focuses on own ideas in a RT vs. a ST model?	26: RT-more different views so clts. more willing to accept this since there are different ways to go.	26a: RT-clts. would at times disagree with team or interact around a team idea , focused more on strength to solve it.	26b: RT-clts. more comfortable disagreeing with team; ST-ideas taken more as a command.	26c: RT-clts. more easily focus on own issues/problems, free to pick & choose ideas-give own ideas weight.
Q27: Any difference in your perceptions of clients comfort level with a reflecting team vs. a strategic team model.	27: When clts. got used to either, there wasn't any difference in their comfort level.	27a: Initially less comfortable with RT but evolves to being more comfortable with RT-the relationship.	27b: Almost equal-some were really uncomfortable being watched, others would be at ease seeing team.	27c: RT-more comfortable for family & more enjoyable than ST, true for therapist too.
Q28: Any difference in the usefulness or effectiveness of team in a RT vs. a ST?	28: RT-more effective but may be my own thinking or bias, helps empower family by giving more options.	28a: ST-effective but prefer RT due to being more interactive, open ended.	28b: Both effective-depend on type of problem-personally prefer the RT.	28c: RT-rather use it-have members with different approaches to offer good idea-foster clts. ideas too.

Appendix M

INSTITUTIONAL REVIEW BOARD

APPROVAL PAGE

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
FOR HUMAN SUBJECTS RESEARCH

Proposal Title: Qualitative Differences Between Family Perceptions of Therapy From a Systemic Model of Family Therapy vs. a More Directive Model of Family Therapy

Principal Investigator: Terry McGovern

Date: 11-18-91 IRB # HE-92-015

This application has been reviewed by the IRB and

Processed as: Exempt [ ] Expedite [X] Full Board Review [ ]

Renewal or Continuation [ ]

Approval Status Recommended by Reviewer(s):

Approved [X] Deferred for Revision [ ]

Approved with Provision [ ] Disapproved [ ]

Approval status subject to review by full Institutional Review Board at next meeting, 2nd and 4th Thursday of each month.

Comments, Modifications/Conditions for Approval or Reason for Deferral or Disapproval:

Please continue to send any other agency approvals as you receive them.

Signature: _____ Date: 1-20-92
Chair of Institutional Review Board

VITA

Terence J. McGovern

Candidate for the Degree of

Doctor of Philosophy

Thesis: QUANTITATIVE AND QUALITATIVE DIFFERENCES BETWEEN THE REFLECTING TEAM MODEL AND THE STRATEGIC TEAM MODEL IN FAMILY THERAPY: A COMPARATIVE STUDY

Major Field: Human Environmental Sciences

Biographical:

Personal Data: Born in New York, New York, June 20, 1952, the son of John and Anne K. McGovern.

Education: Received Bachelor of Science Degree in Economics from Manhattan College in May, 1974; received the Master of Social Work Degree at Rutgers University in May, 1979; completed requirements for the Doctor of Philosophy degree at Oklahoma State University in May, 1996.

Professional Experience: Family therapist at Advantage Health, P. C., Grand Rapids, Michigan. Behavioral science faculty in Grand Rapids Family Practice Residency Program and adjunct faculty in College of Human Medicine, Michigan State University at Grand Rapids campus, May, 1993 to present.

Outpatient Marital and Family Therapy Coordinator, North Care Center, Oklahoma City, Oklahoma and adjunct faculty in School of Social Work and Department of Psychiatry and Behavioral Sciences, University of Oklahoma, April, 1990 to April, 1993.

Director of Case Management Training Program and Family Therapist, North Care Center, Oklahoma City, Oklahoma and adjunct faculty in School of Social Work, University of Oklahoma, April, 1989 to April, 1990.

Director of Aftercare Services and Family Therapist, North Care Center, Oklahoma City, Oklahoma and adjunct faculty, School of Social Work, University of Oklahoma, Sept., 1986 to Feb., 1989.

Clinical Social Worker and Family Therapist, North Care Center, Oklahoma City, Oklahoma, July, 1984 to September, 1986.

Director of Case Management Services, Pathways, Inc., Ashland, Kentucky, April, 1982 to May, 1983.

Clinical Social Worker, Pathways, Inc., Ashland, Kentucky, August, 1981 to August, 1982.

Clinical Social Worker, National Health Service Corps, United States Public Health Service based at Kanawha Charleston Health Department, Charleston, West Virginia, August, 1979 to August, 1981.

Continuing Professional Education: Clinical Social Work Fellow, Department of Psychiatry and Behavioral Sciences, University of Oklahoma, Oklahoma City Campus, July, 1983 to 1984. Marriage and Family Therapy Training Program for Community Practitioners, The Menninger Foundation, Topeka, Kansas, September, 1984 to June, 1986. Systemic Family Therapy Externship Program, College of Medicine, University of Calgary, Alberta, Canada, August, 1988. Advanced Systemic Family Therapy Externship Program, College of Medicine, University of Calgary, Alberta, Canada, August, 1989. Divorce Mediation Training Program approved by the Academy of Family Mediation, Norman, Oklahoma, December, 1990. Narrative Therapy Training Program, Evanston Family Therapy Center, Evanston, Illinois, October, 1993 and September, 1995.

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