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# The Training and Supervision of Family Therapists in the Republic of Ireland

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# THE TRAINING AND SUPERVISION OF FAMILY THERAPISTS IN THE REPUBLIC OF IRELAND

by

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# VITA

The author, James William Moran, was born in Ballina, County Mayo, Ireland on August 17, 1932.

For his primary education he attended the Convent School Ballina and Rehin's National School. His secondary education was received at Mungret College, Limerick, 1946 to 1951.

In 1951 he entered the Society of Jesus and studied philosophy 1955-1958, and theology 1961-1965, in the Jesuit Houses of Studies in Ireland.

He obtained an M.Ed. degree in 1978 and in 1981 an M.A. in Counseling Psychology, both from Loyola University of Chicago. In 1980-81 and 1982-83 he attended the Family Institute of Chicago, which was followed by an externeship at the Mental Research Institute, Palo Alto, in 1983-84. He is currently completing his studies at Loyola University of Chicago.

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## HISTORICAL BACKGROUND AND OVERVIEW

### Historical Background

While many changes have taken place in western European countries in recent decades, the changes which took place in Irish culture were more dramatic and significant because Ireland had remained relatively isolated from the mainland of Europe (Clancy 1985, Burke 1985, and Peillon 1982). Irish culture is understood to be the way that Irish society behaves. (Kane 1983). Tobin (1978) holds that these transitions in Irish life have been influenced by the evolution taking place in technology, in the economic structure, in religion, in education, and in the values and attitudes of the people. From the time of national independence in 1922 until the early 1960's Ireland remained in large part outside the mainstream of European and world affairs and development. As a consequence, it remained a rather closed and static society.

Coogan (1980) stated that the conviction dawned upon a people long-conditioned to the belief that things could only get worse that in fact they could be improved and changed.

factors which were instrumental in the national awakening were external and internal (Lee 1984), and these were to have a profound effect upon Irish family life.

Television has been mentioned by many commentators as playing a large part in bringing about change in Irish society. (Chubb 1984). It was only in January 1962 that Ireland received its own television network. The whole country began to receive not only the home-produced programs but many from the United Kingdom and the United States as well. As Irish television matured, it started producing programs that uncovered issues for the Irish family that had seldom been addressed previously (Gibbons 1984), and it also gave its support to the modernizing impulses of the economy at large. (McLoone 1984). All attempts to measure precisely its influence on the changes taking place must remain at best speculative. (Farrell 1984). It is particularly unfortunate that its influences on social and cultural change since the 1960's cannot be measured with any degree of accuracy (O'Tuathaigh 1984).

In 1972 Ireland's entry into the European Economic Community (E.E.C.) brought about not only a major change in trading patterns and technology, but also had political ramifications as well. Political and economic isolation became history and Ireland was now tied to the mainland of Europe.

Perhaps related to the increased economic prosperity which resulted from E.E.C. membership, the population which had been declining since the famine of the 1840's increased dramatically in the 1970's by as much as 400,000 and stood at an estimated 3.5 million in 1985. (World Almanac 1985). Dublin's population grew by over 17% between 1971 and 1978 (Whyte 1980), and Peillon (1982) considered this rate of growth to be of crisis proportions.

Other demographic changes were equally spectacular. Between 1961 and 1974 marriages per 1,000 of the population grew from 5.4% to 7.4%. Married women in the work force rose from 5.2% in 1961 to 17.4% in 1981, and women attending third level educational institutes rose from 36.5% in 1971 to 43.6% in 1981 (Burke 1985).

Secondary education was made freely available to all children in 1967 and grants to third level institutes were likewise made available to students from poorer families. In an eleven year period, 1965 to 1976, the percentage of students from "working class" families increased from 10.7% to 16.3%, and the highest number of full time students who were grant holders formed 23.5% of the student body in 1975-76. (MacHale 1978). The state expenditure for education rose from 3.45% of the gross national product in 1964 to 6.29% in 1974. (Whyte 1980).

An American looking at Ireland described the changes which he saw taking place as a move from inertia to ferment (Connery 1968), and another commentator on the Irish scene saw a transition to frankness of discussion and less sensitivity to outside criticism. (Bestic 1969). An Irishman commented that the transformation of the people was a growth toward frankness and moral maturity. (MacCarthy 1968).

By the end of the 1960's there was a consensus that the transformation of the Irish was psychological in that they were more optimistic, more adventurous, more self-reliant and more ready to accept criticism from themselves and others. (Whyte 1980). A Frenchman describing the state of the country called what he observed as "not so much transition as a profound mutation." (Peillon 1982). A contrary view of the country helps to give balance to the picture painted above and this found Ireland to be conservative despite the many changes. This very conservatism is what marks Ireland off from the rest of Europe. "It is conservative in religion, in morality, in politics, in views on work, and marriage and the family." (Ryan 1984).

Ireland remains the only nation in the E.E.C. in which couples cannot obtain a divorce. A change in this law can only be accomplished by a national referendum. In June 1986 the government held such a referendum. The proposal to introduce divorce was defeated by 63% to 36% and in rural

areas the margin of defeat was as much as eight to one. (Time, July 7, 1986).

While these changes were taking place on the national level other modifications were occurring within the domestic domain of married and family life. A random sample of headlines from "The Irish Times" for the first few months of 1985 gives some idea of how domestic issues were discussed openly. "Divorce Law Needed - Rabbi," "Lower Marriage Age Urged" (Jan. 24, 1985); "Parents, Not Counsellors, Shocked By Reports" (Jan. 28, 1985); "Child Management Courses For Parents" (Feb. 4, 1985); "I Can't Wait For The Illegitimacy Bill" (Feb. 25, 1985); "Divorce Group Protests In Dublin" (Mar. 11, 1985); and "Over Half Of Mothers Under 20 Were Unwed" (Apr. 8, 1985).

The Constitution of 1937 specifically recognized the family as "the natural and fundamental unit of society and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law." Bunreacht Na h-Eireann, Article 41(1). Faced with the reality of marriage breakdown the Government appointed a Select Committee to consider the "protection of marriage and family life, and to examine the problems which follow the breakdown of marriage." [Report of Joint Committee on Marriage Breakdown (COMB Report)]. The investigation was initiated in July 1983 and published its findings in March

1985. The COMB Report exposed the anomaly that exists in Ireland where divorce in unconstitutional and at the same time the Catholic Church grants annulments and permits second marriages. Such actions are technically in conflict with the law of the land. In 1983 there were 631 applications for annulments with 94 orders of annulment granted by the Catholic church.

The "family" referred to in the Constitution is the family that is founded on the institution of marriage which means a valid marriage under the law for the time in force in the State. Since the State does not recognize divorce no provision is made for the extramarital unions which are occurring, or for persons who have their marriage annulled and those who have "remarried within the Church, persons who have obtained divorces abroad which are not recognised by the State, and have purported to remarry, are all in varying degrees living in extra-legal unions, enjoying only limited legal recognition and protection." (COMB Report).

There exists no source which can delineate objectively the total number of persons whose marriages have broken down. In 1983 the Labour Force Survey showed that out of a population of 2.45 million there were 21.1 per thousand who were deserted, had marriages annulled, and were legally separated or divorced. (COMB Report).

Because little research has been carried out into the incidence of marriage breakdown, possible causes must remain a matter of speculation. (Duncan 1982). Personal factors such as intrapsychic states of one or both partners, and environmental factors such as unemployment, poor housing, shift in the traditional authority and power of the male as head of the family unit, and the increased number of married women working outside the home, are all offered as possible factors in marriage breakdown by the COMB Report. Similar possible factors are given for the breakdown of marriage and the family in Pastoral Care (1982). In a research project carried out by the National Opinion Research Center in the United States, poverty and not modernization was given as the main cause for the collapse of family ties. Greeley (1979) suggests that both theorists, theologians, and even law makers would be well advised to look at the contexts and correlates of social change before making statements about their meaning.

In a country where 95% of the population is Catholic, where the weekly church attendance in the Dublin area was given as 89.7% (MacGreil 1977) and the nationwide weekly attendance at 82% (The Irish Report of the European Value Systems Study 1984), neither the Catholic Church nor the State seems capable of coping adequately with marriage and family problems, and Brady (1978) states that there seems to

exist a "fundamental ambivalence about the attitude of both Church and State to the question of marriage."

Concern for marriage breakdown has not waited for any Government report to suggest what might be done to help families with problems. A preventive effort was made in the mid-1970's, both north and south of the border, with the establishment of a national organization whose primary aim was to help engaged couples prepare for marriage. It is known as the Catholic Marriage Advisory Council (CMAC), and all its helpers work on a voluntary basis. It has widened its scope over the years and now includes marriage counseling, marriage enrichment, school-work and family planning (CMAC Progress Report 1980). In 1982 the National Conference of Priests requested the Episcopal Conference to establish on a national level a Pastoral Institute for the Family which would come to the support of Christian families by analysis, research and education and practical initiatives (National Council of Priests of Ireland 1982). The same Council focused on the christian family today in its 1984 national conference. A call to include the families of young drug-prone people in their treatment was also made (Power 1984). Concern that pastoral care be extended beyond the premarital stage to newly married couples and to the family at the different stages of development was expressed by the Catechetical Association of Ireland (1980). The most

notable State expression of concern was the issuing of the COMB Report already mentioned.

Interest in and research on family issues have been demonstrated by the Family Studies Unit at University College, Dublin, in recent publications: The Changing Family (1985) and Whose Children (1985) by Richardson.

Outside the ecclesiastical, educational or government endeavors there began in the mid-70's a very significant development in family therapy. The beginnings were quiet. It was through the insight and enthusiasm of the Eastern Region Committee of the Irish Association of Social Workers that family therapy was initiated. This "Core Group" chose "The Family" as its theme for the year 1975-76 and sponsored lectures, seminars and meetings on its preferred topic. In May 1976 a small group of social workers went out on their own and from them evolved the Family Therapy Network which officially came into existence in 1980. In their first stage of development (1975-80), peer supervision groups were functioning throughout the country in Cork, Galway, Sligo, Donegal and Dublin. In 1980 the Network expanded to allow other professionals to join its ranks. From 1978 to 1981 it sponsored introductory courses for six weeks each year. In 1982 and 1983 it ran twelve-week introductory courses which were later organized by the Child Guidance Clinic at the Mater Hospital. During the initial period of family therapy

development the most frequent and energetic visitor was Fred La Belle from Montreal who conducted workshops throughout the country. During these years Satir, Minuchin, Bloch and Walrond-Skinner also conducted workshops (McCarthy 1980).

In 1980 after the formal establishment of the Family Therapy Network of Ireland (FTNI) the same policy of inviting renowned family therapists was continued with second visits from Satir, Minuchin and Bloch, and with first visits from Hoffman, Nagy, Framo, Williamson and Taggart. In this same year the first formal training program was initiated at the Department of Child and Family Psychiatry at the Mater Hospital (McCarthy 1980). In 1982 the Dublin Institute of Family Therapy was founded and in late 1983 disbanded and reconstituted as the Marriage and Family Institute (MFI). In September 1984 it began its first year of a proposed three year program in family therapy training.

The first ten years of family therapy in Ireland divides equally into two parts. In the first stage the focus was on becoming familiar with the main theories and theorists in the field, and in the second stage the main concentration of effort has been on training and supervision. The two stages overlap but are distinct in themselves.

## Objectives of Study

The overriding purpose of this study is to present a picture of family training and supervision in Ireland. This picture will be more similar to a time-lapse presentation than a still photograph. Incorporated into this study are not only relevant developments of the very recent past which help in a fuller understanding of the present, but also indications of directions which training and supervision may take in the immediate future. It will be the present trainers and supervisors, who only a few short years ago were the first family therapists in the field, who will define the current status of training and supervision. No clearer definition can be obtained at this stage of development than what the current trainers and supervisors say it is (Bloch & Weiss 1981). There are three distinct objectives of this study.

### Objective I

The first objective is to survey the current practitioners, trainers, and supervisors in order to obtain the backgrounds of this first generation of family therapists and the effects that their training had on them. This information will form a valuable and integral part of a

complete understanding of the present state of training and supervision because it is this first generation which is responsible for the more formal training and supervision programs that are now in place. To achieve this objective the following variables will be examined:

Demographics of Respondents

1. Primary work setting
2. Influence in becoming a family therapist
3. Professions and qualifications
4. Methods and modalities of supervision
5. Theoretical orientations
6. Readings that were helpful
7. Personal issues after training
8. Institutional issues after training

## Objective II

This objective is the most important one of the study, which is to survey in the greatest possible detail the family therapy training programs and other facilities where some aspect or degree of family therapy is taught or supervised. To achieve this objective the variables to be examined in the various institutes are as follows:

Family Therapy Training Centers

1. Programs offered by centers

2. Theoretical orientations
3. Integrating new approaches with the old.
4. Facilities
5. Training
6. Assessing skills of potential trainees
7. Goals for trainees
8. Assessing progress in training
9. Division of time in training
10. Supervision
11. Formal recognition of supervisors
12. Ongoing education of family therapists
13. Ongoing education of other professionals
14. Ongoing education of the general public

Universities, Clinical Psychology and Social Work

1. Written responses
2. Degrees/diplomas offered
3. Didactic elements
4. Practice
5. Supervision
6. Research
7. Theoretical orientation

Psychiatric Residency Training

1. Written responses
2. Titles of programs

3. Theoretical orientation
4. Supervision

## Objective III

This objective strives to gather opinions from all sources as to the directions that family therapy training should take in the coming years and to learn the commitment to expansion of all the training programs in the immediate future. To achieve this object the following variables will be examined:

The Future

1. Respondents' need for further training
2. Formal training
3. Informal training
4. Respondents' opinions on future training programs
5. Academic programs in family therapy
6. Theories and topics for future training
7. Teaching therapy to non-mental health professionals
8. The future development in training centers
9. The future development in clinical psychology departments
10. The future development in social work departments
11. The future development in residency programs

## Significance of the Study

The many and various transitions that occurred in Irish life since the early 1960's may have spawned some of the problems facing that society today, especially problems resulting from the breakdown of marriage and family relationships. It is not the purpose of this study to attempt to establish a causal relationship between these transitions and family problems. All that can be stated with any certainty is that there has been a concurrence of these transitions and an increase in problems in marital and family relationships. Family therapy, from its first introduction into Ireland, has availed itself of the theories, practices and research which characterize its status in the United States and in Europe. Because of family therapy's unique theoretical orientation it has been able to deal with problems in families more efficiently, and perhaps more effectively, than the established individual psychotherapies. After almost a decade of learning about and practicing family therapy and establishing training programs, it now seems appropriate to take a first look, nationally, at the state of the art of training and supervision and attempt to present a modest definition of that area of activity in the field. The benefits of such a study are manifold.

First: This study will be the first national survey of any aspect of the family therapy field in Ireland, and it will make available data never previously available from any other source. It will provide professionals with information which should assist them to define more accurately and modify, if such be necessary, their methods and approaches to the training and supervision of future family therapists.

Second: Training and supervision cannot be critically evaluated or examined without clarity of the conceptual framework from which it operates (Gurman & Kniskern 1981). This study will attempt to provide the theoretical underpinnings of training and supervision in Ireland.

Third: Since feedback is considered essential for the growth and development of any system, this study will provide the current trainers and supervisors with data from the first generation of Irish therapists, on their reactions, negative and positive, to the training and supervision which they received.

Fourth: At this stage of development family therapy concepts and practices are receiving recognition in the psychiatric community. This study will demonstrate the degree and extent to which these concepts and practices are being integrated into the training of social workers, clinical psychologists and psychiatric registrars.

Fifth: This study will make known to educators topics in which practitioners would like to receive additional training. Besides this, it will also discover the types of programs and theoretical orientations which in the opinion of respondents should be presented to future trainees.

## Limitations of the Study

The ERIC and PSY ABSTRACTS show no study of this topic. Literature dealing with the field of family therapy in Ireland is practically non-existent, which makes a comparison of this study with a similar one in the Irish context impossible.

This is a descriptive cross-section of study of the broad issues in family therapy training and supervision that need to be defined before an examination of specific hypotheses can occur. Goldman (1976) contends that counseling psychology research needs to be broader in scope and possess more external validity than the present norms of experimental studies provide. This study meets Goldman's criteria for valuable counseling psychology research, which is to push forward the frontiers of knowledge and help professionals function more effectively. A review of the field in Ireland in the mid-1980's will make such a contribution both pragmatically and conceptually beneficial. The examination of the field is being done through self-report

(Babbie 1973). The data that will be obtained in this study will be accurate only to the degree that self-perceptions of those responding are accurate (Goldman, 1976; Clarkin, Tanitor & Warburg, 1980).

The development of the field is at such an early stage that a broad definition has not been carried out up to the present time. Theories, hypotheses, concepts, themes and practices have yet to emerge and be presented in a systematic way. The self-report has been used on many occasions in national surveys. The GAP Report (1970) utilized a survey questionnaire to understand the functioning of the growing field of family therapy in the United States in 1966-67. In different but related fields of group therapy training and supervision, Dies (1980) also employed the self-report method when surveying 100 group therapy trainers to study the state of the art. Bloch (1980), Cooper, et al. (1981), Sugarman (1981) and Saba (1984) all used the self-report method in carrying out national surveys in the field of family therapy. Following such self-report surveys the areas for further investigation can become clearer. The GAP Report (1970) was identified as being helpful in clarifying models of family therapy (Guerin 1976), tracking the popularity of these models, examining their paradigm shift from an intrapersonal to an interpersonal orientation, exploring the importance of history, diagnosis and affect in

therapy (Foley 1986) and therapists' primary treatment goals (Gurman & Kniskern 1978b).

Kniskern & Gurman (1979) found research in the United States on family therapy training was lacking in most regards and that the field represents empirical ignorance about the subject. The suggestion has been made (Saba 1984) that the reason why the present experimentally related investigations of family therapy training are so few and disjointed is that there has not been a general definition of the field by those who comprise it. The contention in this study is that once the field can define itself then more experimentally relevant hypotheses will emerge to be examined.

It remains uncertain at this early stage of development whether the instruments used will produce the desired information or that they are the best to create and accurate picture of the Irish scene.

While every effort has been made to be as inclusive as possible of all mental health professionals who in any way may be doing family therapy, there lingers a doubt in the author's mind that some may have been omitted who are involved with family therapy. Awareness of these possible omissions will be important when analyzing the results.

## Definitions

Family Therapy

A theoretical system that thinks in terms of family and works toward improving the family system.

Family Therapist

An individual who works with a family and thinks in terms of family with the objective of improving that family system.

Family Therapy Training

The comprehensive teaching of family therapy theory and techniques without specifically focusing on a student's clinical skills. Trainers are concerned with the general transmission of conceptual and clinical knowledge but not on teaching the clinical skills.

Family Therapy Supervision

An ongoing relationship between a student or students and a teacher which focuses on the specific development of the student's or students' therapeutic abilities within the context of treating clients.

Family Therapy Field or The Field

These terms will be interchanged throughout the study and intended to cover theoretical thinking, family research and family therapy as they have evolved

together and as they continue to grow in therapeutic thinking and practice.

Counselling Centers

This is a generic term and is intended to cover child guidance clinics, outpatient units of hospitals, or privately administered centers where families, couples and individuals receive help with their problems.

Psychiatric Registrars

These are qualified medical doctors who are in training either in general or specialty psychiatry. In the United States they are termed "residents."

Consultants

These are qualified psychiatrists with hospital or health appointments. They may also be supervisors and tutors of registrars.

Ireland

This term indicates the part of the island that is officially known as the Republic of Ireland and which is an independent country. It is distinguished from Northern Ireland which is part of the United Kingdom. One reason for not including both parts of the island in this study is the fact that there exist two different kinds of structures in supplying mental health services.

# CHAPTER II

## REVIEW OF RELEVANT LITERATURE

The growth and development of family therapy over the past thirty years can be gauged by the outpouring of literature on the subject. There exist almost four hundred books and reference volumes on family therapy (Framo & Green, 1980), and in the decade of the 1970's over two hundred of these books were published (Olson, Russell & Sprenkle, 1980). At present there are about twelve different family therapy journals being published in English, and the same amount in foreign languages (Nichols, 1984 and Kolevzon & Green, 1985). From this mass of literature only a limited proportion of these volumes focus on the topic of training and supervision (Walrond-Skinner, 1979), and among these volumes relatively little can be found on the topic of selection of candidates for training, and the personal characteristics of the trainees that would produce the best possible family therapists (Liddle, 1982).

## Selection of Candidates

In the literature there are scattered indications of the variables which need to be considered before candidates are selected for training. Liddle (1982) states that the issue of candidates who can best learn family therapy at a conceptual and pragmatic level has not yet been adequately addressed, while Kniskern & Gurman (1979) write that no research on selection of candidates has been published, and that when it is, they feel it will focus principally on the personal qualities of the trainees rather than on traditional academic qualifications alone. Bloch & Weiss (1981) found that educational prerequisites for admission to family therapy provide only a very general idea of students' backgrounds, and do not indicate the level of experience in the area of family therapy.

### Criteria for Selection

The criteria for a candidate in group training who wishes to become a bona fide member in a patient group are spelled out clearly by Salvendy (1983), and demonstrate most of the elements required of a candidate who seeks admission to the many and various family therapy training programs and institutes. The candidate must always be interviewed by at least two members of the faculty, either through lengthy

correspondence or telephone calls. The criteria which the candidate is expected to meet are: be a mental health professional, have past experience in individual psychotherapy, possess positive mental health, have geographical and institutional flexibility, and be able to finance the entire course. Motives and personality characteristics are also explored.

## Who Should Become Therapists?

The question of who should become family therapists has yet to be addressed. Apart from the traditional mental health professions of psychiatry, psychology and social work, Kramer (1980), and Haley (1976) are in favor of extending family therapy training to other professionals. Kramer holds that the family system's point of view should be basic for physicians in every specialty, nurses, clergymen, teachers, school counselors, lawyers, juvenile officers, recreation workers. In brief anyone who deals with people and their problems. Andolfi (1979) states that the candidate "must bring his full store of technical experience" to the training program and to obtain this experience time is of the essence. Mosher, Reifman & Menn (1977) who worked with non-mental health college graduates in a non-traditional setting treating schizophrenics, found they possessed certain characteristics that allowed them to cope. This optimistic situation should be tempered by Framo's (1979) statement that he has found some people who can never

become family therapists no matter how much training they receive. Minuchin & Fishman (1981) assume that the regular training in institutes is given to people who are already mental health professionals and that when non-professionals attend a different and more intense format is required.

## Life Experience

Life experiences are considered by Sager (1981) and Nichols (1979a) to be necessary in candidates because from these experiences flow wisdom and compassionate understanding of human frailties. An understanding therapist will accept acts and thoughts of clients that do not coincide with his own and will not judge them as reprehensible, pathological or pathogenic. Professional growth in psychotherapy, according to Neill & Kniskern (1982), follows experience and the opportunity for a felt evaluation of this experience. Minuchin & Fishman (1981) hold that too many young therapists go into the healing professions without the life experience to understand the problems in which they are intervening. To overcome this deficiency they should ask the families to educate them in the pertinent matters. Indirectly, personal growth may occur during the process of training but this process is not primarily considered by most family therapy trainers as an occasion of personal growth nor an opportunity for resolving personal problems.

## Personal Characteristics

The main quality of the candidate that is stressed most frequently is flexibility. Haley (1976) defines it on two levels. First, as the ability and willingness to work in different settings so as to become a competent therapist capable of dealing with a wide range of clients in various contexts, and second, to possess the ability to take different stances as the situation in the therapy session dictates, being at times authoritarian, at times playful, at times flirtatious, at times grim and serious, and at times helpless. Flexibility is taught as a skill by Fisch, Weakland & Segal (1982) whose purpose is to maintain the therapist's maneuverability within the therapy session. Learning to orchestrate his internal reactions to the impact of the family allows the trainee to widen his access to his own resources and permits him to be appropriately flexible with a multitude of families. (Kramer, 1980) Getting an addict's family into therapy requires flexibility and a lack of rigidity as these qualities, according to Stanton, Todd et al. (1982) allow the therapist to counter family resistance moves adroitly. Friedman (1985) sees flexibility as enabling the trainee to become a therapist who is more fluid in setting appointments, in dealing with the family, and as helping to avoid burn-out. Liddle, Breunlin, Schwartz & Constantine (1984), hold that therapists who are in training to become supervisors need flexibility and personal

maturity to balance their status of being simultaneously teachers and learners.

One obvious question that must be addressed is the age of the person who presents himself as a candidate for training. In the universities the training programs form part of the master's and doctoral degree programs, and it is a reasonable assumption that these students are in their late twenties or older. Since most of the training institutes require as a minimum a master's degree and some experience in the field, it can be assumed that candidates are thirty or older. Haley (1976) holds that family therapy training should be given to mature students who have been married and who have children. A consideration in dealing with elderly parents is the age of the therapist. A younger therapist's credibility may be immediately discounted by them. When this occurs Stanton, et al. (1982) state that it can be countered by the therapist's specific competence concerning the problem, and he can convey a sense of appreciation of their position simply by listening to them. The advice given by Haley (1976) and Minuchin & Fishman (1981) to the young therapist is that he should not appear wiser than he is, but should utilize his youth as an aid in his therapy. The GAP Report (1970) found that the age group 35-49 formed 55 percent of those who claimed to be family therapists. Stickle & Schnacke (1984) reported the mean age of masters level students to be 27.9 years, and Dowling,

Cade, Breunlin, Frude & Seligman (1982) found the range to be 23-49 years of age for trainee family therapists at an institute, with 31 years of age as the average.

Other characteristics such as imagination, sense of humor and an ability to share others' emotions are considered important (Andolfi 1979; Haley 1976, 1985; and Madanes 1984). The trainee must learn to give up his role as a healer (Bowen 1978). Empathy, respect, warmth, genuineness, self-disclosure and self-awareness are all believed to play some part in therapeutic effectiveness (Kramer, 1980; Crane, Griffin & Hall, 1986). Estimated competence and motivation are considered by Jackson & Bodin (1971) as major considerations for selection in training.

Fisch (1985) holds that candidates should possess a wide variety of interests because those who do not see doing therapy as the be-all and end-all of their lives are most likely to learn best. Sager (1981) states that a therapist's gratifications should come from a satisfying personal life and other interests, while Haley (1976) believes that the quality of a therapist's work is partly the outcome of one's intimate source of support.

## Clinical Experience

Clinical experience is generally considered a prerequisite in training institutes, but not all clinical experience makes this training easy because problems arise with certain professionally qualified people (Novak & Busko,

1974). Physicians may have the most to unlearn and more ambivalence about the switch to working with a group, and persons with a Ph.D. seem to have trouble switching to family therapy because of their lock into research (Whitaker & Keith 1981). Candidates who have had training in rigid classical analysis find training in family therapy difficult because of their preoccupation with intellectual understanding and control of the situation, their emphasis on therapist passivity and neutrality, and their fear of personal exposure (Skynner 1981). According to Gurman & Kniskern (1978a), a high level of experience increases the chance of positive outcome and decreases the drop-out rate, while Haley (1976) holds that increased experience in non-family methods may actually interfere with increasing competence in family therapy.

Whitaker & Keith (1981) look at the human and professional elements in the professional's life when they recommend family therapy training. They consider a background of some powerful existential experience such as a kind of Zen-like explosion or a brief episode of craziness or individual therapy as a prerequisite for training. Professionals with clinical experience as frustrated physicians or battle-fatigued social workers make suitable candidates because both of these kinds of people are acquainted with their own impotence. Haley (1984) holds that even if candidates for family therapy training possess doctoral or masters degrees

in any of the mental health professions, they all must take their places equally on the starter's line. He states that the question of who should be admitted to the training that will lead ultimately to accreditization as family therapists will take years to receive a satisfactory answer.

## Therapy for the Therapist

Opinions are divided on the question of whether the trainee should have individual or family therapy. Those who recommend individual therapy for the trainee come from the psychoanalytic end of the continuum (Liddle & Halpin, 1978). The strongest proponents of therapy for the trainee are Whitaker & Keith (1981), who consider it crucial that the trainee have marital therapy first and then family therapy for at least three generations of his family. Bowen (1978) sees differentiation from one's family of origin which one undertakes with a supervisor as consonant with training. At the Ackerman Institute applicants are expected to have had or be currently involved in their own therapy (La Perriere, 1979). Framo (1981) states that in his judgment the best way to become a family therapist is to have therapy oneself. Burton (1972), a psychiatrist, questions whether the requirement of personal analysis or personal therapy ought to be dropped or at least its rational justification changed. Andolfi (1979), while not directly stating that family therapy is a prerequisite for effective therapy, holds that the therapist's power is considered proportional

to his capacity for self-questioning and his willingness to risk self-exposure. Several theorists have recommended that trainees should have individual therapy, but very few have recommended that trainees should have marital and family therapy with their spouses, families of origin, or family of procreation. But the majority of opinions indicate that it is not an important issue in family therapy training.

Those who are opposed to the idea of the trainee having family therapy claim that there is not a single research study showing that a therapist who has had therapy or understands his involvement with his personal family has a better outcome in his therapy (Haley 1976). Evidence exists that trainees who had a great deal of individual treatment were able to facilitate less change in their patients than were trainees who had had little treatment themselves. Treatment seems to maximize tendencies to self-absorption (Garfield & Bergin 1971). According to Skynner (1981) individual therapy seems to diminish the wide vision, flexibility and spontaneity required for family therapy.

## Theories of Family Therapy Training

Many distinct theories of family therapy have been defined in the literature. Recently there has been much effort devoted to developing parallel theories in the area of training and supervision. In this section an attempt is made to locate in the literature these developing theories and those that well known therapists state to be ideal.

### The Ackerman Institute Approach

#### Theory

When Nathan Ackerman died in 1971 he left behind no unified or firmly teachable theory of family therapy (La Perriere, 1979; Goldenberg & Goldenberg 1980). The Institute which he had founded was named for him after his death. Today it is free-standing, and its current philosophy is that teaching and learning should occur as close as possible to the process of the human experience, so that conceptualizing is never separated from the problems people present.

#### Training/Supervision

The process of training is considered an essential part of the growth and maturing of the trainees in their personal lives. It is held that addressing the issues in their lives facilitates the development of their personal

skills which are seen as capable of being developed as are specific technical skills. In the didactic part of their training there are three clear stages of development: first, the theoretical orientation to family therapy, second, the teaching of specific techniques, their rationale and application, third, special topics, such as divorce therapy and sex therapy. Live supervision is the usual mode with the group and supervisor, and is considered the optimal supervisory method for training in family therapy.

Clear criteria are stated. Trainees must have at least two years of clinical experience, must have had or be in the process of receiving personal therapy, must relate well to others, and must not have a major crisis in their lives. A personal interview is required.

Miscellanea

One noticeable characteristic of the Ackerman approach is the offering of a course for allied professionals who may be lawyers, educators, public health nurses, physicians and clergy, wishing to learn about their own family systems, the family systems of their clients and the relationship between the two of them, and of both with the professional systems of which they form a part. This course brings the importance of a systems view to areas other than family therapy

and allows this approach to be explored and developed (La Perriere, 1979).

## Family Systems Approach

### Theory

Systems thinking is a new theory in the mental health field. The techniques of applying the theory in various therapy situations may vary but the modifications are rather obvious once the theory is well understood by the therapist, and when it becomes influential in the way they live it in their own lives. The method and techniques of family therapy are logical extensions of the theory. Bowen (1978) made the point that innovations in technique grow out of new development in the theory and not the other way around. The theoretical base of systems theory can be reduced to two key variables, first, the organization of the individual in his level of differentiation, and second, the degree of anxiety in the emotional field of which the individual is a part (Kerr 1981).

### Training/Supervision

One of the most important factors influencing acceptance into the program is the mental health professionals' motivation to work on their own lives and their differentiation. In accepting candidates the Georgetown program does not want them to think they are "normal" and that it is the clinical families who have the problem. The trainees who do

least well are those who are oblivious to their own problems and their emotional reactiveness, while those who are capable of recognizing their own reactiveness are more objective about it in others. Unresolved problems in the trainees' lives are the major obstacles to doing effective therapy in the full range of clinical situations. When the trainees come to the recognition of working on their own lives in order to make the theory a part of them, instead of something merely intellectual, the training necessarily becomes longterm.

The better therapists will spend a minimum of three to four years in the formal training program and then structure some more informal longterm contact with people who have a good understanding of the theory. The training program is considered merely an introduction to a process and much can be lost if people do not continue to develop their training. Maintaining differentiation in the professional community after training is every bit as difficult as maintaining it in one's own family. The emotional forces are pushing for agreement and sameness.

Training has a very simple structure. There is a weekly program for people who live in the Washington area and a four times a year program for people living out of town. The teaching time is divided equally between the didactic sessions, clinical supervision, and the focus on the trainees' families of origin. Much of the clinical

supervision is done by reviewing videotapes of the trainees' family therapy sessions. In reviewing these tapes the supervisor's main concern is that what the trainees say to the family reflects their fusion into the emotional system of the clinical family. The isomorphic nature of supervision and therapy is shown in the way the supervisor models the "coach" role with the trainee, so that the trainee in turn may "coach" the family or the individual in their own family of origin work (McDaniel, Weber & McKeever, 1983). When the trainees begin to develop a better level of differentiation in their own families, a review of their work will reflect a greater capacity for differentiation in their clinical families (Kerr 1981).

## Transactional Approach

### Theory

Like Skynner (1981), Framo (1981) expresses the isomorphic nature of therapy and training and his own theoretical approach to the training of family therapists. Although he believes that training methods are usually an extension of the way that one conducts therapy, nevertheless he exposes his students to as many theories and methods as it possible, so that eventually they will develop a style of their own. His main focus in training is to deal with the personal development of the trainee.

Several years earlier he stated that his main theoretical interest was the relationship between the intrapsychic and the transactional (Framo 1970). He holds that in the field of family therapy "there is a diversity of approaches: there is no one way to do family or marital therapy: there is no comprehensive theory: and there is no one way to train" (Framo, 1979, p. 275).

Training/Supervision

It is Framo's belief that family therapists are primarily trained by their original families, and that the formal training they get in institutes or in the universities only refines that lifelong process (Framo 1981). When he fails with families he plays the tapes of these cases so that doing family therapy becomes an ongoing operation which enables him to be always learning and changing (Framo 1979).

He considers intensive supervision by an expert supervisor to be the kernel of the training process which can take place either individually or in groups. Trainees are encouraged to examine their relationships with their families of origin, and to differentiate themselves in appropriate ways. Their training takes place in many forms: students may be asked to conduct family voyages, genealogical searches and family autobiographies. Framo (1979) does not think that trainees should have marital or family therapy with their spouses, families of origin or families of procreation as a requirement, but he personally believes

such experiences to be the best preparation for becoming a family therapist. He stresses the importance of the personal growth of the trainees and their working out things with their own families, and believes these will determine the trainees' effectiveness as family therapists. At the same time he states that trainees must learn skills but places this learning in a secondary position. In his training there are no formal examinations and the only requirement is the writing of a family biography (Framo 1981).

Miscellanea

Framo addresses an issue rarely touched upon by other leaders in the field and that is the training of paraprofessionals in family therapy. In his judgment there are certain kinds of family problems that can be treated effectively by a reasonably intelligent person who is trained in the problem-solving approach. More complex situations require the kind of "natural" who has first been trained as a psychotherapist and afterwards as a family therapist (Framo 1981).

## Contextual Approach

### Theory

The proponents of this approach consider the essential task of the trainee to be a progressive deepening of commitment to the mandate of multidirectional partiality,

with reference both to the family members' lives and to the therapist's own life (Boszormenyi-Nagy & Ulrich 1981). The academic aspect of their ideal program would necessarily include adequate instruction in the psychological and transactional dimensions of their approach. Even the possession of a Ph.D. or an M.D. would not be considered as evidence that a person has covered these dimensions.

> In our view, contextual family therapy is most usefully thought of as not so much as a theory of family therapy as a theory of family therapy theories, i.e., metatheory. Therefore, it seems difficult for the model to describe explicitly the range of specific techniques allowed to contextual therapists. We suggest, therefore, that a very useful contribution to the further growth of contextual therapy would be to explicate which therapist behaviors are consistent with the model and affect the outcome of contextual therapy (Gurman & Kniskern, 1981, p.185).

Training/Supervision

Boszormenyi-Nagy and Ulrich state that they are currently exploring what would constitute an ideal training program for contextual therapists. In such a program major emphasis would be placed on combined didactic-clinical training carried out through seminars and workshops as well as individual and group supervision. Co-therapy would have value for learning because it provides multilaterality of vantage points. This training would be reinforced by practica in applied settings such as family relations court and the protective service branch of state welfare or any setting where momentous decisions about people's lives are

being made and where a multilateral perspective is required.

Personal therapy would be considered important, preferably in a multilateral context whether alone or with other family members. The trainee must engage in guided exploration of self in relationship to his own family.

## The Communications Approach

### Theory

Although Satir has had a very significant influence on the development of family therapy, she was not invited by Gurman & Kniskern (1981) to submit a chapter in their comprehensive review of therapy and training, because they thought her work did not represent any discernible therapeutic method. Satir & Baldwin (1983) state that this approach is not supported by a formal school or training institute to certify therapists. In the early days of family therapy training, variety and flexibility characterized her training at the Mental Research Institute where many forms of teaching methods were used (Bodin 1981).

### Training/Supervision

If Satir does not have a clearly definable method, she does have many followers who are known as the Avanta network, and whose membership consists of those who have attended a four week intensive training program in a residential setting, as well as those whom she considers her peers even if they come from different disciplines. This

four week intensive program combines personal growth with the study of specific skills. There are four main elements in this program. First, trainees gain sensory and bodily awareness of themselves and become aware of cues in others. Second, they develop congruence in communication as well as precision. Third, they learn family reconstruction which consists of revisiting the past and viewing it with new eyes and discarding whatever created problems. Fourth, they learn about the different parts of themselves, get acquainted with them and integrate them into one whole (Satir & Baldwin, 1983).

## Mental Research Institute Approach

### Theory

Fisch, Weakland & Segal (1982) state that the Mental Research Institute (MRI) approach sees theory as necessary for the practice of therapy, but like Whitaker, (1976a); Haley, (1976); and Kaye, (1981) they realize that theory can restrict opportunities for action and lead to difficulties and errors. Weakland, Fisch, Watzlawick & Bodin (1977) held that their theoretical viewpoint focuses on the ways in which problems of behavior and their resolution are related to social interaction. A further elucidation of their theory was given by Fisch, Weakland & Segal (1982) when they wrote:

> Our presentation of theory will be as brief and as simple as possible, and deliberately limited in scope

> and concept....We do not see theory as necessarily something elaborate, complex or final...but, rather, as only a set of relatively general ideas or views which are useful in integrating particulars of observation and action in a systematic and comprehensive way....[W]e are not attempting...to present a comprehensive theory of human nature, of human existence, or the "mind" but only to state our general conception of the nature of problems that people bring to therapists, and the corresponding conception of effective intervention to resolve such problems---a theory as close as possible to practice. (p.6)
>
> Our theory is just a conceptual map of our approach to understanding and treating the kinds of problems therapists meet in daily practice. (p.7)

Training/Supervision

Bodin (1981) states that the ideal program of family therapy training at MRI requires the integration of theory and technique. A description of the precise nature of MRI's training and supervision program cannot be found in the literature, but Bodin gives a very broad description of it:

> Our main emphasis is on helping the trainees arrive at a conceptually clear framework for formulating specific interventions tailored to the problems and participants at hand. Opportunity to observe and give feedback is an essential part of the experience designed to help trainees integrate the theoretical and applied aspects of our externship programs....The application of MRI principles is not as simple as it looks or as the conceptualization would imply. (p.307)

Personal amd family therapy are not required or considered necessary for trainees in this program. Bodin believes that MRI's brief therapy approach is particularly suited for bright paraprofessionals. Co-therapy as a training device is not in use at MRI.

## Strategic Approach

### Theory

Haley (1976) had the following to say about the theory of training in general and his own approach in particular:

> It should be possible to train a therapist in a theoretical framework consistent with the approach to therapy. (p.179)
>
> Therapy training only changes when theories of how to do therapy change, not because of technical advances. (p.169)
>
> As clinical training programs change it is being discovered that a theory of therapy and a theory of training are often synonymous....Some of the parallels between the premises of therapy and the premises of training will be offered here as current training issues. (p.170)

In learning family therapy the students need to develop a coherent theory and take up a clear position when faced with a therapeutic problem or they will fail (Haley 1981). He is adamant that trainees while learning strategic therapy be cut off from other teachers of therapy, so as to avoid conflicting ideas about how to do therapy, because they may end up being so eclectic that they may believe everything is right or nothing is right (Haley 1976).

### Training/Supervision

Candidates for strategic therapy come not only from the areas of social work, psychology and psychiatry, but also emerge from such quite diverse initial backgrounds as clergy, communications, vocational counseling, education,

and paraprofessional fields. Those candidates who have the most problem with learning the strategic approach are those who are accustomed to psychodynamic therapy or experiential groups (Stanton 1981). Certain criteria when met by trainees give hope for more rapid learning and better results in the training process. These are: experience of the real world, a modicum of intelligence added to wide social skills, and only having had one teacher while in training (Haley, 1976; Stanton, 1981).

Strategic therapy is learned by doing. Since theory grows out of action and experience it should be presented later when the trainees can fit what they are doing into a broader model of the field (Stanton 1981). Training is considered to start only when the trainee enters the room with a client and preferably the client's family. Prior to that trainees can be helped by some practice interviewing with simulated families so at least they may conduct a first interview. Techniques should be practiced before they are used in a live interview. Training is done in group so that trainees have helpful support and receive ideas on how to plan strategies. The goal of strategic training is not to produce theoreticians but practitioners. In their simulated therapy the trainees will have to explain to the group what they did and in the process come to think tactically and learn to be articulate about their work.

When the trainees have learned skills as therapists, reading seminars will be beneficial to them in developing a broader model of the field. In strategic therapy, theory grows out of action, not action out of theory, and reading about theory should come after the students have done therapy and have an idea of what they need to know. Motivation in the trainees is maintained by teaching about a problem only after they have come face to face with it in therapy, and are then eager to learn about it (Haley 1976).

Directives are part and parcel of this approach, so students must be taught how to motivate clients to do what they are told, how to give the directives, how to clarify whether they are understood, how to anticipate the clients' reluctance to follow them, and how to check if they have been followed. Practice in simulated situations is helpful in developing these skills (Stanton, 1981; Haley, 1976). A supervisor must observe deficits in the trainees' range of skills and can select future clients to fill out the operational skills of the students. Just as a therapist should design a therapy for a particular client, supervisors should design a training program for a particular student. McDaniel, Weber & McKeever (1983) stress the isomorphic nature of this model of supervision. The consultant role of the supervisor is to intervene only when the trainee becomes stymied in his attempts to resolve the family's problem, just as the trainee only intervenes to block the unproduc-

tive attempted solution which the family has used to solve its problem.

Strategic training incorporates the important element of reviewing outcome. The aim is not to produce therapists who can do outcome research, but to produce therapists who think about the outcome they want to see months or years after the therapy. Trainees are taught to learn how to inquire of a family whether they were satisfied with the therapy, how to determine whether the changes sought have taken place, and how to think about the biases of both therapist and family in reporting on changes. This forces the trainees to orient to change, and to think experimentally. If trainees' outcomes are not satisfactory they can change their procedures to obtain better results (Haley 1976).

Neither previous personal therapy nor working as a co-therapist is considered important by most strategic therapists (Stanton 1981). Haley (1976) considers that requiring personal therapy is demeaning to the trainees, distracts them from the work at hand, is antithetical to the strategic approach in its requirement of "insight" and gives less recognition to the fact that therapists grow with success in their work.

## Symbolic-Experiential Approach

### Theory

Whitaker & Keith stated that in this theory of therapy everything said by the patient is considered symbolically important as well as realistically factual. In this approach the therapist is like a coach or a surrogate grandparent. Both roles demand structure, discipline, and creativity, as well as caring and personal availability. Balance between the two roles comes with experience. The availability of the therapist is different from that of the biological parent in that it does not involve the whole self of the therapist. In the initial sessions the therapist must be especially active (Whitaker & Keith 1981).

### Training/Supervision

Co-therapy is considered the primary model of training which is done as peers. The trainees are invited in as co-therapists not so that they may be provided with an experience, but primarily because they are needed in the therapy process. Equal and heterosexual peers would constitute the ideal co-therapy team, but this rarely occurs. Co-therapy develops a model of pairing which has therapeutic value for the family. It takes time to develop a co-therapy team so that the members can work together and trust each other. The co-therapy team should be embedded initially in a cuddle group of other co-therapy teams.

Readings and seminars are considered the best learning tools to initiate trainees in the new language that goes with family work and helps them to conceptualize about families. Clinical experience can be acquired by observing a family therapist at work, or by seeing families in a context, such as inpatient psychiatry service, or in a medication clinic or social agency. These experiences provide the trainees a look at families where there is no great demand for change.

The next stage in learning family therapy is best done in an outpatient clinic (Whitaker & Keith 1981). Here trainees who are considered capable of becoming family therapists should be able to take a family system history, understand basic systems thinking and the ways in which it complements and is related to clinical work in mental health areas, assess family structure and process and provide crisis intervention for couples and families.

The final stage of training is in the co-therapy team which has definite stages in the process. Mixing up the methods of training is important so that trainees do not become wedded to a given pattern. This flexibility in the training process is obtained by having the trainees watch therapy from behind a one-way mirror, and be watched from behind the one-way mirror, and by the use of videotapes so that they can observe their work after the fact. In Whitaker's approach it is the therapist's responsibility to

confront the family's defensive and protective patterns through the sharing of their unconscious fantasies and personal stories, and in supervision it is the supervisor's task to help the co-therapist to become aware of his unconscious, to integrate the non-rational with the rational, and to possess greater flexibility in dealing with the family. Again, the parallel between therapy and supervision is demonstrated (McDaniel, Weber & McKeever, 1983).

In this approach therapy for the therapists is considered crucial as the trainees are not deemed to be prepared to do therapy unless they have had the experience of being a client. Trainees are recommended to start by having marital therapy and later family therapy with three generations. When family therapy is not available, a study of one's own family with a group of peers who are involved in the same task is recommended (Whitaker & Keith 1981).

## Structural Approach

### Theory

The program presented here is the ideal approach to training structural family therapists as proposed by Aponte & Van Deusen (1981). Theory, knowledge and skills are the goals proposed for this training program. The theory is about the structure in social systems and the forms in which the structure operates in individuals, families and their

social contexts, both from ecological and developmental perspectives. Clinical training aims at preparing trainees to become aware of this structure in current transactions, to hypothesize about them, and to intervene actively and personally in the process of those transactions. The overriding aim of the training is to produce therapists with an integration of theory and technique who can invest themselves purposefully in a free and disciplined manner with families in therapy.

Training/Supervision

Apart from learning and applying the theory of structural family therapy, the trainees must be taught the importance of having informational knowledge about individuals, families and communities to which the theory can be related. This training process is mostly experiential and is closely related to actual tasks and circumstances in which the therapist must perform. In this respect the training parallels the therapy. Reading and the didactic input do not precede the practical training but are given with and as part of the experiential learning. Clinical training takes four basic forms.

Trainees learn initially from observing experienced and skillful therapists. This process is doubly effective when the thinking behind the senior therapist's actions is explained in person or through recorded commentary.

Role-playing is introduced during the time when students are observing the senior therapists. The role-playing trainees can practice with impunity to self and family, while trainees in the role-playing family can feel what it is like to be in the family's place. Under these circumstances the session can be controlled and the interview can be interrupted for feedback from the supervisor, the role-playing trainee and family members. When the trainees have been well grounded in these aspects of the training process they can begin to accept families and receive live supervision from behind the one-way mirror.

The live supervision part of the training is considered real and immediate and the flow of information between family, trainee-therapist and supervisor can contribute to the development of the trainee-therapist's skills. Through this interaction the trainee receives help to observe more clearly, to hypothesize and to act during a therapy session. This may have minor disadvantages for the trainee such as limiting the time for speculation and planning strategies during the session, and may limit the freedom of action because the intervention suggested by the supervisor at any given time may not be what the trainee was planning to do on that occasion. Live supervision requires time after the therapy session for debriefing on the interactions that took place between the trainee and the family, and the trainee and the supervisor.

The best way to review past transactions is by videotape supervision. In this ideal training program videotape supervision begins after the interview and with the same supervisor during the course of training.

Most of the clinical training in structural therapy is done in groups, because this parallels some of the benefits of therapy within a family context. As with a family, the group environment is not always the best circumstance for dealing with personal problems, and because of this the option for individual supervision must be available.

In this approach self-development is believed to take place within the context of training and supervision, enabling trainees to develop the fullest use of self as a therapist. The supervisors are required to draw a profile of the trainees in terms of skills, limitations, difficulties and styles as these are rooted in the persons of the trainees and affect their performances in therapy. It is the responsibility of the supervisors to plan systematically to increase the understanding and skills of each trainee and also to enable them to use his personality purposefully with the families.

The isomorphic nature of therapy and training has been described by McDaniel, Weber & McKeever (1983). The supervisor's role is to focus on unproductive interactions and change them whenever they occur within the supervisory structure which consists of the family, the trainee who

directs the parent who directs the children. There exists a clear hierarchy between supervisor and trainee, and between trainee and the family, and between parents and children. Initially trainees feel secure with the supervisor's interventions and directives, which gradually challenge the hierarchical structure, as do adolescent children with their parents. Even though there is intellectual and emotional cooperation between supervisor and trainee matures, the authority structure remains.

## Problem-Centered Systems Approach

### Theory

The proponents of this approach (Epstein & Bishop 1981) claim a major interest in looking at and altering health care systems. Family therapy training, they argue, offers a vehicle both to broaden the perspective of the delivery base and to upgrade health care professionals' understanding of systems generally. In addition family therapy training offers a treatment modality that reinforces the central function of the family as a unit for the social, psychological and biological development and maintenance of the individual family members. Acceptance of this goal, plus an understanding of the systems functioning of the family unit, allows for important interventions in primary, secondary and tertiary prevention. Their interest in health care delivery systems makes them concerned about cost-

effectiveness and efficiency. This has led them to outcome evaluation which they hold is consistent with their philosophy of evaluating what they do.

This approach to training family therapists involves the mixing of people from many disciplines, including nursing, occupational therapy, social work, psychology, psychiatry, family medicine, pediatrics and the clergy. Mixing the disciplines in groups has worked well when the entering skill level of the trainees was homogeneous, and when there was a reasonable appreciation of the context. The pre-course evaluation allows them, first to place trainees in groups and levels that are commensurate with their competency, second to give trainees and trainers feedback regarding areas of individual strengths and shortcomings on entry, and third indirectly to familiarize trainees with the skill development expectancies for the particular level of training. The use of the pre- and post-training evaluation results allows them to evaluate individual and group progress or deterioration and thereby give more objective feedback to trainees and trainers alike. Through this process it is hoped that indications will develop as to what type of trainee will do best in these training programs.

Training/Supervision

In their training and evaluation approaches they classify family therapy skills in conceptual, perceptual and

executive categories. The conceptual skills are largely cognitive and include an understanding of the definitions and concepts incorporated within the model. These skills are transmitted by the use of a semi-programmed text, reading materials, tutorials for integration and resolution of issues. Seminars are held to explore the concepts in depth.

Perceptual skills include the ability to perceive data, to accurately identify family and treatment behaviors and to integrate them within the conceptual model. These skills are acquired through the use of videotapes, role-playing, transcripts, and written descriptions of families.

Executive skills include the ability to execute treatment. These skills are taught at two levels. The first level focuses on clearer formulations of the conceptual and perceptual skills, on perceptual skills associated with details of the treatment model, and on role-playing experiences in the use of the treatment model.

Candidates are now screened and evaluated to see if they are ready to receive the second stage of training. This is the only known family therapy training program that demands so rigorous a test. At this stage trainees have their skills evaluated through the use of multiple choice instruments regarding concepts of the treatment model. Other methods are used such as transcript assessments, write-ups of videotapes and subjective evaluation based on

training, trainee group and trainer assessments. The final phase involves intensive case supervision based on live, videotape and/or audiotape presentations. Evaluation in the second phase is similar to the first. The final claim for their family therapy training program is that their models of family functioning and treatment lend themselves to effective teaching and evaluation of skill acquisition.

## Open Systems: Group Analytic Approach

### Theory

Skynner's approach encourages the trainees to be exposed to as many theories and techniques as possible, enabling them finally to build an approach to suit their individual capacities (Skynner 1981). In addition to exposure to other orientations the trainees' technical training will be of limited value unless they are put through experiences which clarify their motivation for taking up family therapy, and which put them more deeply in touch with the limitations and deficiencies in their families of origin, their marriages and families of procreation or alternative current personal relationships. The person of the therapist is all important in this approach so that the therapist's personality, values, marriage and family life must actually be in question every time there is contact with the family in treatment. In doing therapy trainees must demonstrate the possibility of facing loss,

growth, change and death by the way they function and the way they change and learn from one session to the next.

Training/Supervision

At present there exists no systematic and comprehensive training program which embodies the central principles that set Skynner's approach off from others (Skynner, 1981). The cornerstone of a full training program must be the treatment of actual families under supervision. He emphasizes that the quality of supervision is obviously more important than the "hardware" and that a second-rate supervisor with the most sophisticated aids may produce less competent therapists than a first-rate supervisor using case discussions alone. The focus of supervision is on the person of the therapist and on the personal difficulties which interfere with the task of therapy.

Skynner states that there is no greater difficulty in teaching from his position than there is in practicing from it in therapy, because if the right model is provided by the teacher it has the same rapid effect on the trainee as the modeling by the therapist has on families. The essence of the requisite training lies in this kind of modeling and the encouraging and supportive interaction of the supervisor.

Personal therapy is deemed desirable for the trainees who have problems over intimacy and separation, but rigid classical analysis tends to give trainees a therapeutic experience that appears more often than not to make it more

difficult for them to learn family therapy subsequently. Rigid classical analysis appears to diminish the wide vision, flexibility and spontaneity that family work demands (Skynner 1976).

## Functional Approach

### Theory

Functional family therapy represents an integration and extension of two major conceptual models of human behavior: systems theory and behaviorism. This integration of the two models, according to Barton & Alexander (1981), generates new theoretical and clinical approaches that do not evolve from either one alone.

### Training/Supervision

The training of functional family therapists is guided by the development of the conceptual basis of the model and by an appreciation of trainees' skill levels. Trainees must be taught to develop an "interaction set" about human behavior, that is, they are shaped to create an inclusive focus on all family members and to approach families with the idea that they must conceptually create links among all of them. Beginning functional family therapists often require: 1) substantial didactic instruction, 2) viewing videotapes, 3) role-playing experiences to help them abandon cause-effect models, and 4) inclusion of the role of all family members in mediating behavior. The authors hold that

conceptually most errors by beginning functional family therapists are errors of omission. Practically speaking trainees are reminded that interaction sequences are not over until everyone's mediating role has been identified, and until a plausible functional outcome or payoff can be posited for each family member.

The therapist's relationship skills are evaluated by both supervisors and peers in a group setting. As a group norm trainees are told that any critical feedback on relationship skills or trainee's style requires a pragmatic solution. Trainees are urged to create either a formal or informal supervision arrangement to enhance their growth in the model and to ameliorate their professional isolation.

## The Milan Approach

### Theory

The Milan approach represents a major new development, not only in family therapy, but also in psychotherapy in general (Tomm 1984a). It is a pattern of clinical practice that was developed by a group of four psychiatrists-psychoanalysts in Milan, Italy: Drs. Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin and Giuliana Prata. They began in 1967 and have continued to evolve their theory and methods right up to the present. In 1980 this team separated amicably with Palazzoli and Prata continuing their therapy and research and with Boscolo and Cecchin focusing

on training (Barrows, 1982; Tomm, 1984a). For the first ten years they collaborated in generating some new systematic concepts and innovative interventions with clinical families. They adopted the Mental Research Institute's (MRI) so-called "Palo Alto" model (Tomm, 1984a; Hoffman, 1981), and slowly developed ideas and techniques that were different from those of the Mental Research Institute.

Their approach to theory is reflexive. Whenever they are confronted with a particular clinical situation, they try to find an idea or concept that fits the behavior pattern and whenever they pick up a theoretical idea, they try to test it by finding a behavioral example. The essence of this approach is its pattern of thinking and the consequent activity of the therapist (Tomm 1984b).

Training/Supervision

Probably one of the most significant contributions of the Milan approach has been the introduction of the five-part session which they initially prescribed for their own working as a team. By describing and demonstrating their method of teamwork to trainees and clinicians interested in their approach, they implicitly prescribed the ritual for others (Palazzoli, Boscolo, Cecchin & Prata, 1978; Hoffman, 1981; Tomm, 1984a; Tomm 1984b). Their five-part session is carefully planned and has specific objectives for each part.

The presession is a discussion about the family among the members of the team, and lasts fifteen to twenty

minutes. The first presession places the emphasis on how the family was referred, who in the family called, what is the presenting problem, how do they construct the situation, what overt and covert expectations do they display. The team discusses and generates some hypotheses and discusses the kinds of questions that could be asked to elicit data to validate or refute these same hypotheses. Thus before the therapist meets the family he has some ideas about how and where to proceed. In the subsequent sessions the team reviews the events of the last session and any interim contacts. Hypotheses are developed about the apparent progress or lack of it and these are developed as a guide for the therapist's inquiries in the interview itself. The main interview may last fifty to ninety minutes. One therapist interviews the family while the rest of the team observes. The therapist's questions at first tend to be general and open-ended, and as the interview progresses he becomes more specific pursuing pertinent issues in depth. He moves fairly rapidly from one member to the next with his questions rarely allowing any member to speak for more than a few minutes at any one time. During this part of the session the therapist usually offers no opinion nor does he attempt to alter family behavior. Substantive change, if it occurs, will take place spontaneously outside the interview. The observers are not passive but are actively hypothesizing about relevant connections in the interpersonal process and

may call the therapist out from time to time, by knocking on the door, to comment on these and make specific suggestions for further inquiry.

The intersession is a discussion among team members while the family waits and this may last from fifteen to forty minutes. The task is to elaborate a systemic hypothesis and to generate an intervention. It is a period of intense brainstorming. The mental energy entailed in synthesizing the data into holistic patterns to form this systemic hypothesis and create an intervention that fits the particular situation is both taxing and exhilarating. While it is better to give the team's intervention on the same day, it may so happen that the team is unable to come up with a clear one. When this occurs the family is requested either to come back within a few days, or they may be told that a letter with the team's instruction will be mailed to them. However, it is preferable to give the intervention on the same day when the information elicited is still fresh in their memories.

The intervention lasts five to fifteen minutes. When the conclusions of the team are delivered to the family by the therapist the rest of the team observes. The nature of the intervention may take many forms, a systemic opinion with or without a prescription for no change, a reframing of family beliefs, a prescription to carry out a detailed ritual, a declaration of therapeutic impotence, or an

analogic enactment. The specific wording and phraseology is carefully chosen and sometimes repeated in a hypnotic fashion. There is usually an element of surprise in the intervention which leaves the family with a certain degree of confusion and complexity. There is minimal further interaction even if the family raises questions.

The postsession is a concluding discussion among the team and lasts five to fifteen minutes. It focuses on the immediate reaction of the family members to the intervention, and to each other's responses. Their verbal and nonverbal feedback is used to test the validity of the hypothesis which served as a basis for generating the intervention. If it is felt that the intervention did not take, alternative hypotheses are discussed. If the team felt the intervention was accepted it will attempt to predict the family's reactions and responses between sessions.

Miscellanea

Palazzoli considers this type of therapy pure therapy research (Barrows, 1982). Palazzoli, et al. (1978) state that a therapeutic team dedicated to research is a delicate instrument, exposed to many hazards, internal as well as external. One of the greatest hazards comes from the families themselves, especially until the team is sufficiently experienced. The trainees may not do any therapy at the Center until the second year of training, but may do family therapy at their Agencies. They are encouraged not

to imitate the work done at the Center but to work within the context of the Agency. Simulated families are used for teaching purposes in the first year (Campbell & Draper 1985).

In Table 1 a summary of the main characteristics of the principal theories of training and supervision is demonstrated. There are some notable differences among them. For example, the older theories stress the importance of didactic input and the need for personal therapy, while the newer ones focus on skills training and reject the need for personal therapy. Agreement is almost universal on the prime importance of live supervision in family therapy training, and most recognize the parallels that seems to exist between doing therapy and supervising trainees.

Table 1

Summary of Approaches to Training/Supervision of Main Family Theorists

| Theories | Training | | Supervision | | | | |
|---|---|---|---|---|---|---|---|
| | Didactic Input | Skills Training | Live | Delayed | Co-Therapy | Personal Therapy | Supervision Parallels Therapy |
| Ackerman Institute | 1 | - | 1 | - | - | 1 | - |
| Family Systems | 1 | - | 2 | 1 | 4 | 1 | 1 |
| Transactional | 1 | 2 | 1 | - | - | 1 | 1 |
| Contextual | 1 | 1 | - | 1 | 1 | - | - |
| Communications | - | 1 | - | - | - | 2 | - |
| Interactional | 1 | 1 | 1 | - | 4 | 4 | - |
| Strategic | 2 | 1 | 1 | - | 4 | 4 | 1 |
| Symbolic/Experiential | 1 | 2 | 1 | - | 1 | 1 | 1 |
| Structural | 1 | 1 | 1 | 2 | - | 3 | 1 |
| Problem Centered | - | 1 | 1 | - | - | - | - |
| Open Systems | 1 | - | 1 | - | - | 2 | 1 |
| Milan Approach | - | 1 | 1 | - | 4 | 4 | - |

1. Primary consideration 2. Secondary consideration 3. Tertiary consideration

4. Intentionally not part of approach

## Training Programs

### Training in Institutes

In a report made by the Group for the Advancement of Psychiatry (GAP report 1970) the status of family therapy in the United States was made known for the first time. There was however a notable omission of one area that concerned the training of family therapists. Six years later Beal (1976) was to write that there are no central or comprehensive sources of information about family therapy training in the United States. Williamson (1973) had attempted to collect information on the training facilities available at that time, but he described his attempt to be an illustrative rather than an exhaustive statement. Van Trommel (1981) in a different approach from Williamson reported on a study-tour which he had made across Canada and the United States during which he visited twenty-six training centers in seventeen cities. His purpose was to gather information on the subjects that were taught in the course of training, and on the ways technical skills were acquired, theoretical knowledge imparted, and opportunities provided for the trainee's personal development.

A partial list of training programs was published by Weiss in Family Process in December 1976 which led to Bloch and Weiss carrying out their comprehensive national study.

The first national comprehensive questionnaire survey was carried out and published by Bloch & Weiss (1981). Another nationwide questionnaire survey on training facilities in graduate programs and institutes was initiated by Joanning, Morris & Dennis (1985) with the intention of fleshing out Bloch and Weiss' study, so that students seeking more complete information would have fuller knowledge of the respective facilities. All the above studies delineated three sources of training in family therapy: free-standing institutes, university departments of social work and clinical and counseling psychology, and the psychiatric residency training program.

## Free Standing Institutes

The family therapy movement grew out of the general field of psychiatry and began almost simultaneously in many parts of the United States by independent-minded therapists and researchers (Broderick & Schrader 1981). Around these individuals or groups of individuals there developed schools of followers who sought training in their particular approaches. The first mental health professionals who came together for research were the Palo Alto group under Bateson in 1954 and these have the strongest claim to be the initiators of family therapy. Some years later this same group evolved into the Mental Research Institute (Nichols 1984).

From that time onward there came into existence the free-standing institute which had its greatest decade of growth in the 1970's when twenty-six were founded, to make the national total forty-five, as reported by Bloch and Weiss.

The picture painted of the free-standing institutes has special characteristics. Berman & Dixon-Murphy (1979) describe them as usually non-degree, post-graduate clinical training programs where working mental health professionals receive specialized training without having to complete another degree. They are unique because they achieve almost complete integration of the clinical and academic. Because they are not subject to university control they are diversified and experiential and offer a variety of models. This freedom from tight academic control allows them to develop new courses and follow new directions as the situation requires. The people who run the clinics are usually the teachers of the courses.

Possessing this freedom brings certain handicaps. First, because they do not exist under the umbrella of a larger institute they must find their financial support from their students and through grants from interested parties. Second, their non-degree status may prove to be a problem to some students who may be seeking a higher degree through their family therapy studies. Beal (1976) states that larger family institutes usually teach multiple theoretical

approaches, while the smaller ones teach the theoretical orientation of one creative individual.

Selection of candidates for the family therapy training institute largely depends upon the particular entrance requirement which each institute sets for itself. The vast majority of institutes require that a candidate have a master's, a Ph.D. or an M.D., or be in the process of completing one before admitting the candidate to their program (Bloch & Weiss, 1981). Generally these institutes require a personal interview as well. No statistics on the numbers accepted or those refused admission nor any indication of the personal characteristics of the candidates are available. Most of these programs last one year, but many extend over two years while some last three years and even longer (Simon & Brewster 1983).

In his study-tour, van Trommel (1981) estimated the worth of the six most outstanding training centers, whether they were free-standing or affiliated with a large institution, by the following characteristics: their formulation of clearly defined aims and goals in training, their emphasis on developing the clinical skills directed at change formation, their focus on live supervision with a one-way mirror and video equipment and with little importance placed on delayed supervision, whether their faculties had written about training in marital and family therapy, whether they only admitted advanced students whose ages were

above average, and whether they paid no attention to personal therapy as part of their training program.

Bloch & Weiss (1981) found entrance into these programs usually requires a master's degree, a Ph.D. or an M.D., or that the candidate be in the process of completing such a degree. In thirty-three institutes surveyed there were forty different programs, six of which offered three year programs, fourteen offered two year programs and twenty offered one year programs. There was a significant variance in the range of hours spent in training, with those in the one year programs having 48 to 333 hours, those in the two year programs having 108 to 1,100 hours, and those in the three year program having 216 to 630 hours.

Joanning, Morris & Dennis (1985) in their study found that a wide variety of models was taught and they classified their findings into three models: systems model (which embraced strategic, structural and communications), behavioral model and psychoanalytic model. Systems models were taught in practically all programs sampled, while behavioral and psychoanalytic models were taught in about half. Training institutes tend to emphasize the systems model, while graduate programs offer a greater selection of approaches.

There are indications of the number of trainees in family therapy training programs. Bloch and Weiss gave the data available to them in 1978-79 and in that year they

estimated a total of 1,050. When broken down this figure shows 278 in one year programs, 552 in two year programs and 220 in three year programs. Joanning et al. give the figure of over 3,000 applying for 1,500 available annual openings.

In their study Joanning et al. grouped the various kinds of programs they surveyed to obtain some information on the importance that training institutes placed on the different elements in their training. As expected the number one priority was training. Theory was in second place and mentioned only half as frequently as training, education came third and was mentioned almost as frequently as theory. In fourth place research was mentioned only half as frequently as theory.

## Training in the Universities

In a national survey of training programs in family therapy Bloch & Weiss, (1981) and Saba (1984) found that about two-thirds of people being trained were receiving that training at the master's or doctoral degree level. The selection of candidates for these programs depends for the most part on students meeting the required academic standard, while personal characteristics are probably a secondary consideration. Piercy & Sprenkle (1984) state that graduate level family therapy has expanded rapidly in recent years with the rise of university programs accredited by the

American Family Therapy Association, going from six in 1980 to seventeen by early 1984.

Social Work Departments

In a national questionnaire survey of all graduate schools of social work and social welfare in the United States, Siporin (1980) reported that 90% of the schools claim that instruction was given on the specific content of family and marital therapy in their required method courses. Bloch & Weiss (1981) likewise state that family therapy forms part of the curriculum in social work education. Most programs include discussion of systems theory and family treatment as a modality in their courses in social work practice. The commitment to family therapy by social workers is reflected in the GAP report (1970) which found that 40% of the respondents who claim to be family therapists were social workers, while psychologists and psychiatrists together made up another 40% of the total. When some family therapists wrote that social work students had to pressure their departments for courses in family therapy, Siporin (1980) was incensed and replied that marriage and family therapy were traditionally basic in social work services. In his survey he found that family and marital therapy continues to form a core element in graduate social work education, although its specific content is included in generic or casework method courses. Bloch & Weiss (1981) found that of the sixteen masters social work degree

programs four claimed to have specialty areas in family therapy, and all the remaining, except one, had two or more courses, while the last program had only one.

Van Trommel (1981) found that when family therapy training programs were embedded in a school of social work it became difficult to delineate the respective training territories. Those responsible for the family therapy training programs seemed unable to make sufficiently clear the precise nature of their training and the way it differed from the larger institution, and failed to put forward arguments for financial help and manpower which would allow them to build a program of their own.

Clinical and Counseling Psychology

In another national survey of programs offering the Ph.D or Psy.D in clinical psychology, Cooper, Rampage & Soucy (1981) found that family therapy training is embedded in larger programs and only ten percent of the universities surveyed identified themselves as primarily family therapy oriented. The master's degree forms the largest group in the universities, hospitals and clinics which represents the entry level to family therapy practice. These programs offer practicum opportunities for clinical experience and supervision in family therapy. The practicum is usually twenty hours per week each semester but the time given to supervision varies (Bloch & Weiss, 1981). Most descriptions of programs in graduate schools tend to neglect a

discussion of family training as a distinct entity within the curriculum separate from child and individual psychology (Tuma & Cerny, 1976).

Cooper, Rampage & Soucy (1981) in a national questionnaire survey of graduate programs offering a doctoral degree in clinical psychology examined the status of family therapy. In this national sample family therapy was found to fall behind adult and child psychology and ahead of group therapy in being considered a part of the graduate clinical curriculum. They also discovered that family therapy training had not reached the status that child therapy training appeared to hold. The results also seemed to suggest that a school's commitment to training in one area was a reliable indication of its commitment to training in other areas. Most programs responding to this survey had as an objective to offer a broad spectrum of child, adult, group and family training, but 21% failed to offer any courses in family therapy. Stanton (1975a) wrote that only recently has acceptance of family systems approach to therapy begun to creep into academic psychology departments.

Framo (1979) predicted the end of clinical psychology when he said "I stress my belief that unless clinical psychology moves in the direction of studying contexts and developing an ecological systems approach to human problems, it is doomed to extinction as a viable profession." Stanton (1975a; 1975b) found that among the professions of social

work, clinical psychology and psychiatry which were a source of family therapists, that clinical psychology lagged well behind the other two. Up to that time the academic departments of psychology had excluded themselves from the family therapy field, but were more recently gradually accepting the family systems approach to therapy. In academic departments the very existence of family therapy depended quite often upon the efforts of one professor, and in others it had the support of a few faculty members. Haley (1971) found that the three professions had been reluctant to accept and adopt a family systems approach either in the clinical training of their students or in their actual practice. Liddle, Vance & Pastushak (1979) in a survey of all American Psychological Association approved doctoral programs in clinical and counselling psychology, and all departments of counselling education granting the doctorate, found 66% of faculty and 78% of students supported marital family therapy training in their departments.

Of ten doctoral programs in clinical psychology, in Bloch and Weiss' 1981 study only seven offered one or two courses in family therapy, while the remaining three offered four, five and six courses respectively, and these had the status of being elective. Because of this fact family therapy was seen as one among other treatment modalities. Across their entire sample Cooper, et al. (1981) found an average of 1.08 family therapy courses offered, preceded by

2.9 for individual adult, and 1.4 for child therapy courses, with 1.0 for group therapy. These two studies agree that a family treatment course was rarely cited as a requirement in a clinical program. Only fifteen out of one hundred two schools required a family treatment course of their students in the study by Cooper, et al. (1981).

Practicum in University Settings

Standards for the field practicum have been left to the individual university faculty. Holloway (1982) in a national survey of counselor education field practicum programs examined three major areas: practicum activities, supervisory activities and supervisor qualifications. He found the two most frequently reported sites were schools (92%) and agency settings (88.2%). Between one and three on-site consultations per term were made between university staff and field staff. Trainees' evaluations of the site were elicited informally and by written feedback on standardized forms. Feedback on trainees' performance was most often obtained by written evaluation using university criteria. Over fifty percent of universities require an on-site supervisor to possess a masters degree as a minimal academic qualification and to be a current counselor as an indicator of experience. Hansen, Robins & Grimes (1982) found research on practicum supervision to be a series of isolated studies that generally do not build on previous

work, and stated that if knowledge of supervision is to advance there must be plans for more comprehensive studies.

## Training in General Psychiatry Residency Programs

Sugarman (1981) stated that few studies have systematically examined the status of family therapy training in general psychiatry residency programs (GPRP). This review will attempt to gather some of the available data on the current state of family therapy training in general psychiatry.

Sugarman, in a nationwide survey of 80 GPRP directors, assessed the practices and attitudes towards family therapy. In his study he found that the trend had shifted noticeably towards placing a greater value on family therapy in residencies, and in making it a part of their programs. A significant number of directors, 47%, felt that not enough family therapy was being taught in their programs. Langsley (1980) wrote "...[T]en years ago we might have debated whether family therapy should be part of the core training in adult psychiatry or child psychiatry. Today we discuss how to do it rather than whether to do it." (p. 9) When family therapy began to evolve in the 1960's it was done in residency programs on a sporadic basis, and was relegated to social workers and sometimes taught at outlying ancillary sites away from the prime training centers (Miyoshi & Liebman, 1969).

The 1986-1987 American Medical Association Directory of Residency Training Programs, Essentials of Accredited Residencies in Graduate Medical Education states: "There must be sufficient variety of qualified faculty members to provide the residents with instruction and supervision in the required types of therapy" (p. 81). Family therapy is specifically mentioned as one of the major types of therapy to be taught (p. 80). Bowden, Humphrey & Thompson (1980) reported that they found 90% of psychiatric educators deemed it as essential that residents in training should possess the ability to systematically assess a family, and 55% thought that residents should be capable of skilled execution of family therapy. The realization of the value of family therapy in general psychiatry is evidenced by the statement in the GAP report (1985): "We believe that the evidence in favor of a family-oriented approach is now so substantial as to mandate its addition to the traditional treatments" (p. 78).

Shapiro (1975) holds that students who have never been exposed to family therapy grasp the central concepts more readily by observing competent therapists at work and thereby having models for developing their own approaches with families, rather than by having didactic elements given them and by reading. These latter are more readily accepted after the experience of observing the competent therapists. Barker (1982) proposes that supervised clinical work should

cover a wide variety of material and should take up to three-fourths of the trainee's time. Theoretical teaching should be tied to actual clinical cases and should be done mainly in the clinical setting. Didactic work not directly related to clinical work should be kept to a minimum. Individual psychotherapy especially the psychoanalytically oriented type should not be emphasized, but focus should be placed on brief psychotherapy, crisis intervention and family therapy.

Beal (1976) and Sugarman (1984) both found that training in family therapy varied along a broad continuum of quantity and quality within GPRP and independent training institutes. Sugarman (1984) reports that the average number of hours of family therapy during residency training is about three hundred. This number is composed of a combination of case demonstrations, didactic and clinical work, seminars and supervision, which come to about 15% of the total psychotherapy training, with a similar percentage given to group therapy, while the remaining 70% of the time is spent on training in individual modalities.

Three years earlier Sugarman stated that 70% of family therapy training takes place in an outpatient unit and less than one-third in an inpatient unit. Clinical work in family therapy occupies about two-thirds of the hours available and the remaining one-third is devoted to didactic presentations and supervision. In one program described by

Harbin (1980) a rough estimate of the time spent in family therapy training divides as follows: 75-85 families were seen in both inpatient and outpatient units, 175 hours were spent in individual supervision, 70 hours in didactic input, and 70 hours in the observation of others.

Sugarman (1981) found that from the second year in the four year programs psychiatry residents spent the following amount of time in various training activities: 43 hours in seminars (range 0 to 152), 72 hours in supervision (range 0 to 280), 171 hours in case load (range 0 to 640), total number of hours 286 (range 0 to 1020).

Kramer (1980), Harbin (1980) and Miyoshi & Liebman (1969) see part of the resistance to family therapy training in residency programs as springing in part from the question of who should teach the residents. Because most of the faculty are non-physicians there are conflicts since residents must learn from them. These conflicts are most evident in the inpatient setting where the younger residents, who feel more insecure about their identity as physicians, have difficulty in accepting directions from a non-physician supervisor. Solutions to these problems have been suggested. Sugarman (1984) states that teaching should focus on quality as opposed to disciplinary credentials. Harbin (1980) sees the solution in having the clinically responsible leader sufficiently experienced and trained in family therapy. Martin (1979) believes that it is necessary

to have appropriate identification models for psychiatric residents.

Sugarman (1984) addresses the problem and proposes a two tier approach similar to the one proposed by Goodrich (1980). He acknowledges that much of the knowledge and expertise in family therapy resides in non-MD's. To exclude these non-physicians from teaching in GPRP would deprive the field of much expertise. The future holds two options. First, have psychiatrists as role model teachers, so that the psychiatric/medical view of family therapy teaching, clinical work, and research will no longer be seen as an ancillary care procedure. Second, maintain the status quo which results in a rich theoretical and clinical field, because to restrict teaching to psychiatrists only could result in a narrow and diluted understanding of the field.

## Supervision in Training

In an extensive review of the training and supervision literature, Liddle & Halpin (1978) wrote: "Formal theories of supervision and training have not crystallized and hence the reader is faced with the task of abstracting personally useful information from the array of literature....There exist no comprehensive reviews of even single dimensions of training and supervision" (p.78).

Everett (1980a) found significant areas of supervision to be virtually non-existent while Kolevzon & Green (1985) stated that no particular theoretical framework provides a comprehensive strategy for the supervisory process. Everett (1980a) divides the supervision process into two main orientations. The first is psychodynamic which sees the supervisory process as obstructed by intrapsychic conflicts and resistances of the trainee and occasionally of the supervisor. Success in this learning process and in the clinical performance of the trainee will depend upon the supervisor's recognizing and overcoming these conflicts. Personal psychotherapy is considered crucial to dealing effectively with these problems.

The second orientation is structural which focuses on the reorganization of family interaction or communication

patterns while the personal problems of individuals are of secondary concern. The supervisee must learn to join the family and at the same time must remain apart so as to recognize and manage the dysfunctional components. Russell (1976) wrote that not enough theory building in family therapy was taking place and felt that it would be useful to narrow the gaps between the very divergent theories about human behavior by unifying efforts. Hess (1980) held that training which exposes one to several orientations will lead a student to embrace eclecticism as a welcome theoretical haven, and added that "to date no unified, deliberate or intentional eclectic theory is compelling" (p. 51).

Family therapy training in both formal academic and free-standing institutes has by and large taken place under the influence of the charismatic leaders in the field whose theoretical orientations have dictated the training and supervisory model (Scratton & Seman, 1982). Everett (1980b) raises the question to what extent supervisors have consistent theoretical models, and to what extent professional education for the field takes place over the teaching of simplistic techniques. His study found that one-third of supervisors do not hold that clinical skills flow from theory and believe that clinical techniques can be taught independently of theoretical orientations.

Some free-standing institutes collectively represent a theoretical model of training which parallels their model of

therapy. They are, according to Liddle (1978), the Philadelphia Child Guidance Clinic, the Milan School, and the Mental Research Institute, all of which emphasize a more directive, symptom focused, prescriptive and hierarchically based method. These assume a more executive and cognitive position in training and supervision than an affective stance.

Hess (1980) stated that "Supervision which focuses on the trainee's skill development--rather than attempting to change the trainee's personality--is a supervision with a chance of succeeding" (p. 23).

## Terminology

Kutzik (1977) stated that definitions of supervision and consultation have different meanings and functions in the helping, mental health and medical professions. For Hess (1980) supervision is "quintessential interpersonal interaction with a general goal that one person, the supervisor, meets with another, the supervisee, in an effort to make the latter more effective" (p.25).

Kaslow (1977) could find no consensus in the definition of terms used in the training and supervision arena. Haley (1985), for example, objects to the use of the term "training" for family therapists and would prefer to see the word "preparation" used instead. Kaslow (1977) attempts to define some terms. She defines a supervisor as one who has

authority to hold a trainee accountable; a consultant is one who makes suggestions. Group supervision exists when the focus is on how trainees are conducting therapy, and staff training is concerned with didactic content. Kingston & Smith (1983) define a supervisor as one who has expertise and power to monitor and evaluate a therapist's work, while a consultant has expertise but no power to exercise it without the invitation of the therapist.

## Selection of Supervisors

At this stage of development of the field there is very little literature on how to train people to become family therapy supervisors. Two articles address this subject: Liddle, Breunlin, Schwartz & Constantine (1984) and Piercy & Sprenkle (1984). Otherwise those who train therapists to become supervisors must rely upon their own experience and personal contacts with other supervisors to develop their methods and approaches (Heath & Storm, 1984).

If clinicians are good therapists or group workers, it is frequently assumed that they will make good supervisors, but this assumption needs to be challenged (Liddle, et al., 1984). Kaslow (1977) stated that someone who was not a good therapist but was well organized, efficient and intellectually knowledgeable was often made a supervisor. Appointment to a supervisor's role did not require specific training in supervision, staff development or consultation.

She states that what is needed in the profession is sound training in all aspects of supervision and a stressing of professional accountability to the field. Hess (1980) holds that more attention should be paid to the definition, training and possible credentialing of supervisors who are currently defined largely by the training institute, academic department, or clinic. Developments in the field will make the need for definition of the supervisory processes more urgent. Liddle (1982) holds that the stage of development in family therapy training has been reached when the clinical and personal competence of trainers/supervisors needs to be examined. Certain questions should be asked, such as, what level of functioning should the supervisor be at and who should assess and guarantee this level. Goin & Klein (1978) consider a good supervisor for psychiatric residents to be one who teaches specific definable behaviors, encourages the resident to seek new ways, demands clear definition of the problem, and remains in touch with the problem throughout therapy.

Some Demographics of Approved Supervisors

In a survey of supervisors approved by the American Association for Marriage and Family Therapy, Everett (1980b) found the mean age to be 49.5 years with males forming 78.5% of the respondents and females 21.5%. Two-thirds had doctoral degrees and one-third masters degrees. Their professional identity was psychology (26.6%), social work

(22%) and only 12.4% had obtained their highest degree in marriage and family therapy. Theoretical orientations represented were: 42.9% identified themselves as eclectic, 27.7% as psychodynamic, and 10.7% as systemic. Private practice formed the most frequent work setting (40%), with community agencies next (29%) and academia in third place (26%). The number of students supervised weekly was 4.2% (mean) with 42% supervising less than three, with 27.8% supervising between six and eight, and 13.6% supervising over eight students.

## Techniques of Live Supervision

Live supervision, first used by Montalvo in 1973 (Liddle, 1978 and Everett, 1980b) is still in its infancy and according to Heath (1983) requires a solid theoretical base and empirical data to confirm its efficacy. Liddle (1978) sees the techniques employed by supervisors as reflective of their own theoretical and therapeutic orientations.

Haley (1985) held that live supervision is the most effective way to train therapists and also a very expensive one. Markowski & Cain (1983) stated that it was the most beneficial format. It is seen by Montalvo (1973) as only one more way of directing the therapeutic process. Its strong point is its capacity to get closer to the actual interactions in a session than self-report ever could.

Rickert & Turner (1978) see live supervision as having the following advantages: less time for collusion against the family and distortion of self-report sessions, opportunity to observe trainee's effect on the family system, and on the spot correction of any therapy mistake made by the trainee. Minuchin & Fishman (1981) hold that live supervision encourages the students to start doing therapy before they feel ready, with the supervisor's help, while Liddle & Schwartz (1983) see it as allowing the supervisor's support and skills to be used at the moment that they are most required during the course of a session.

Telephone

Liddle & Schwartz (1983) describe this technique as consisting of the supervisor phoning in to the session a suggestion to the supervisee about some strategy. The call is usually one-directional. The supervisee may ask for clarification or reiteration from the supervisor, and the whole exchange lasts twenty to sixty seconds. Haley (1976) states that the exchange should be limited to one or two suggestions, and Montalvo (1973) says that no dialogue should take place. Coppersmith (1980) sees the use of the telephone as having advantages with extremely rigid systems. In a family that seeks authority and may tend to reject the trainee, the use of the authority and the expertise of the supervisor over the phone may move the system. Planned use of the telephone can help to interrupt repetitive interac-

tional sequences involving the family. Clark (1982) wrote that created differences between trainee and team can be used as a strategic ploy to probe, test and unbalance the family system.

Bug in Ear

Byng-Hall (1982) held that this is the best tool for the supervision process, while Liddle & Schwartz (1983) write that they have not found it to be of any significant value. The advantages of this technique as seen by Byng-Hall (1982) are that it allows the flow of interaction between the therapist and the family to go uninterrupted and the supervisor's interventions appear as those of the therapist. McGoldrick (1982) finds the earphone to be especially beneficial to beginning therapists who may become stuck and need a way out of an impasse. It can also help therapists to pull back from mistakes and enable them to focus on the process and maintain a systems perspective and not get lost in content.

Byng-Hall (1982) and McGoldrick (1982) focus on similar disadvantages: it can draw the supervisor into over-functioning and almost becoming the therapist, it is echo therapy, and finally the therapist cannot reply or request clarification of the supervisor's interventions. Loewenstein & Reder (1982) found the bug-in-ear to be the most intrusive device of all, both cognitively and emotionally, as well as preventing the trainee from taking the initia-

tive. Russell (1976) feels that a supervisee should not be forced to listen exclusively to signals from a "bug" in the ear instead of to the family, and states that the use of dubious means cannot be justified. Liddle & Schwartz (1983) fail to see it as an intervention of significant value that may also lead to excessive intrusions into the sessions by the supervisor.

Supervisor's Walk into Session

The nature of the supervisory relationship and the supervisor's and supervisee's contract must be clarified and well defined prior to using this technique according to Liddle & Schwartz (1983). Its main advantage is that when it is used it puts the family's issues before those of the supervisee and its main disadvantage is that it usurps the therapeutic responsibility and authority of the supervisee in the presence of the family. It is not used in the Milan approach (Tomm, 1984b). Rickert & Turner (1978) observed that the nature of the supervisor's behavior in the room and his ability to extricate himself quickly, prevented the family from becoming dependent on him, and allowed the trainee to be immediately reestablished as the primary therapist.

Trainee Walk-Out

This method according to Loewenstein & Reder (1982) allows the trainee's autonomy, dignity, and therapeutic authority to be preserved. Liddle & Schwartz (1983) see this

as occurring at either the trainee's or supervisor's initiative and it allows a more mutual and beneficial exchange than in other methods.

## Techniques of Delayed Supervision

### Videotape

Perlmutter, Loeb, O'Hara & Higbie (1967), O'Hare, Heinrich, Kirschner, Oberstone & Ritz (1975) and Whiffen (1982) write that videotaping of sessions as part of training and supervision provides three unique opportunities: it enables all parts of the interview to be played and replayed, it allows the therapist to see himself as part of the whole interaction, and the effect of an intervention can be evaluated. Other benefits are that it can save time in the training/supervision process, especially when the therapist concentrates on sequences he wants help with, and it helps with skills development when the therapist focuses on these skills which he wants the supervisor and the team to review. Minuchin & Fishman (1981) state that the focus of this kind of supervision moves from the family to the trainee. The style of the trainee is the central issue and the supervisor can prescribe ways to expand the trainees' skills in the next live session. In this session the trainee is evaluated on the changes proposed and can even be reminded to implement them during the session. Whiffen (1982) sees the function of videotape supervision primarily as understanding

the interactions of the family with the focus on the problem, and secondarily on developing the skills of the therapist.

Much positive reinforcement is necessary in the initial stages of therapists' supervision when they are unused to video and are feeling undefended. But according to Stier & Goldenberg (1975) videotapes shown in groups allow the supervisees to see that their colleagues have weaknesses and strengths similar to their own. Whitaker (1978) sees the advantage of this method of supervision as protecting the trainee from the family who may politely exclude him, or who in another situation may render him ineffective by their warmth. Liddle (1980) sees that advantages of this technique come from a different kind of learning than in live supervision. Trainees are less pressured, more reflective and slower paced, supervisory anxiety is decreased and all of these allow for a more sophisticated integration of the particular theoretical orientation and the therapeutic skills that are identified with it. A major disadvantage of videotape (and also audiotape) is that it does not permit changes in the sessions when they go off course and does not correct therapist's errors at the point at which they occurred (Liddle & Schwartz, 1983). A disadvantage of supervising the videotape of a session is that it will not transform a poor supervisor into a good one, according to Heilveil (1983),

unless he is willing to expose his clinical skills to the students to see if he practices what he preaches. The discomfort of this process will enable the supervisor to be more truly empathic to those in training.

Audiotaping has a longer record than videotaping. Initial resistance to it came from traditional therapists because, as reported by Ferber & Bodin (1969), they felt that rapport would be disrupted by the presence of a machine and questioned the confidentiality of the one-to-one disclosure. Family therapy of its nature entails self-disclosure in the presence of others, so the question of privacy has to be rethought. Markowski & Cain (1983) state that audiotaping is recommended only when either live supervision or videotaping are not possible.

Self-Report

Markowski and Cain (1983) consider self-report or case notes as the least useful method of supervision. The inherent weaknesses of this technique according to Rickert & Turner (1978) are: the fallibility of human memory, the tendency of the supervisees to avoid discussing unpleasant material or conversely focusing on a specific aspect of a session to please the supervisor, and inadvertently omitting crucial matter because they are unaware of its importance.

## Reactions to Supervisors

### Therapist-Supervisor Relationship

Scratton & Seman (1982) state that the supervisor accepts ultimate responsibility for the successful treatment of the family and the development of a competent therapist. Bowen (1978) sees the relationship between a supervisor and a supervisee as similar to that of a coach. Birchler (1977) states that live supervision has potential for interpersonal conflict between supervisor and supevisee. Montalvo (1973), Barnat (1973) and Liddle & Schwartz (1983), stress the formulation of a contract to meet the various situations that may arise in the course of supervision so that the process may develop in a structured and harmonious way.

### Trainee's Personal Life: Impact of Supervision

The literature on training and supervision in family therapy according to Tucker, Hart & Liddle (1976) neglects to deal with the impact that supervision has upon the life of the supervisee. They suggest that a year long program has a personal and professional impact upon supervisors and supervisees alike. A movement in their relationship is seen by Scratton & Seman (1982) which evolves from a hierarchical to a collegial one as the trainee gains in experience,

knowledge and skills. Johnson (1961) holds that the relationship evolves in a six stage developmental process from the trainee's view of the supervisor as a judge-evaluator initially, to that of a teacher-helper in the final stage. Ard (1973) sees the evolutionary nature of the relationship from the point of view of a supervisor assessing the supervisee over time as occurring in five stages. Minuchin (1974) holds that when the hierarchical nature of the relationship is consistently violated the efficacy of both supervisor and supervisee is diminished. Haley (1976) states that it is error to deny or minimize the directive aspect of therapy and the hierarchical nature of the supervisor/supervisee relationship. Rather, he prefers to define, organize and develop the relationship around the task at hand, that is, assisting the therapist to help the family.

Tucker & Liddle (1978) found an evolutionary process took place in a group which they supervised. As knowledge of families and family therapy grew, the trainees' competitiveness, vulnerability and self-consciousness decreased. With a gain of self-confidence they expressed their ideas about cases and addressed each other more directly. At this stage, the role of the supervisors in the supervisory process became less central.

A successful relationship between supervisor and supervisee requires certain elements according to Liddle &

Schwartz (1983). First, mutual acceptance of the definition of the relationship must be obtained. Second, the supervisor must convey respect for the supervisee. Third, clarity is essential in the ground rules. Birchler (1977) stated that the supervisor must be continually alert and sensitive to the situation.

Tucker & Liddle (1978) found at the beginning of supervision high levels of anxiety, caution and competitiveness and strong reactions to the one-way mirror and inability to accept suggestions when a supervisor's comments were perceived as criticism. Neill & Kniskern (1982) state that the training experience is only useful if it entails a certain amount of anxiety as the trainee takes a chance with his personal involvement with each client. The more difficult the family problem the less critical the trainees were of each other. Ferber & Mendelsohn (1969) and Stier & Goldenberg (1975) stated that trainees have some initial reservation in group supervision of appearing inept before their peers, which dissipates gradually so that they eventually become less defensive in the group setting than in the one-to-one supervisory setting. They state that group supervision facilitates the development of a personal competency as a family therapist.

Supervisees, according to Gershenson & Cohen (1978), explain their reactions to supervision stating that they experienced "stage-fright," evaluation concerns, and an

anxious learning situation. They describe three stages. The first involved having persecution fantasies, anger and resistance to discuss family work with peers. In the second stage there was reduced vertical relationship with the supervisor and more contact with the family. In the final stage supervisees initiated their own strategies and took more responsibility for the therapy. Other supervisees described themselves in the initial stage of supervision as having "paranoid fantasies" (Loewenstein & Reder, 1982).

Supervisors tend to forget what it was like for them to start with their first families according to Tucker & Liddle (1978). Supervisees often have unusually high expectations of themselves and need to be reminded that progress is slow and discontinuous, while supervisors should remember that trainees have personal as well as technical difficulties in their development as family therapists. Trainees, O'Hare, Heinrich, Kirschner, Oberstone & Ritz (1975), describe their feeling of impotence when their therapeutic interventions met with frustration as a family resisted their initial efforts, and their sense of power when a small therapeutic intervention had an impact on the family system.

## Family's Reaction to Equipment

Andolfi (1979) informs the family about the equipment and procedures during the first session. He found that the family had no problem in accepting them despite their intrusive nature, and tended to forget that they were being heard, observed and perhaps even filmed. Rickert & Turner (1978) found that few families have any significant reaction to the supervisory interruptions once the therapists treats them as normal practice.

## Supervision in Training Programs

### Supervision in Training Institutes

Beavers (1986) holds that training in institutes allows for innovations and experimentation in clinical techniques and practitioners often experiment with the development of theory. Supervision can be rich and intense and trainees obtain a sense of being at the cutting edge of the field. The disadvantage in many institutes is that one particular approach is promoted, and integration which occurs in academic settings doesn't generally occur.

### Supervision in the Universities

Teaching supervision in a university setting is very rare because universities are less interested in producing skilled supervisors than in having their graduates become well-rounded professionals who are invested in therapy, teaching, research, theory development and supervision. Heath & Storm (1985) describe a university program with ambitious objectives for training family therapy supervisors. They aim to encourage their students to adapt and use their therapy theories as supervision theories, to develop their live supervision skills, to gain expertise by supervi-

sing other students doing therapy with a variety of theoretical orientations, and to provide both with close and consistent supervision.

Beavers (1986) sees distinct advantages in having supervision in an academic setting. First, supervisors are less hurried, quite conscientious and grounded in the latest systemic orientations. Second, they are likely to teach a variety of orientations and are more open to theoretical integration than indoctrination. Third, they give more time to the supervisees, and have better facilities than average for training.

The disadvantages are that supervisors in such settings have limited clinical experience and the clinical population may be narrow. These settings lack the variety of clients available in other agencies. Berg (1978) states that simulation can overcome this lack somewhat in the training process. Beavers (1986) writes that alert academic professionals overcome this weakness by seeking a wide variety of clinical facilities in different contexts so that their students may be prepared to deal with all situations after graduation.

## Supervision in Public Service Agencies

Family therapy concepts are generally not welcome in traditional public mental health facilities because the traditional concepts prevail and professional roles are

firmly established. Resistance to the theoretical approach of family therapy has resulted in only a few family therapists being employed so that little supervision exists at present.

## Theoretical Orientations in Training/Supervision

Beal (1976) made a comparison of fifteen family therapy programs in nine United States cities and classified his findings on a scale that reflected their theoretical orientations. He placed what he termed the experiential school which emphasizes the subjective experience of therapy and the subjective awareness and intuition of the therapist to guide the therapy at the A end of the spectrum. Whitaker is named as the most noted proponent of this approach, and the Family Institute of Chicago as one of the programs that operate within this theoretical orientation. At the Z end which he terms the structural orientation he places Bowen and Minuchin as the main proponents, and Georgetown and the Philadephia Child Guidance Clinic where trainees are coached in this approach. His final division is a combination of A and Z orientations which he calls M. In this category he names no proponents but specifies the Ackerman Institute as one location where this approach is taught.

Because there was no mention of training facilities in the GAP report (1970) it is not possible to gain any nationwide concept of theoretical orientations in training programs in the late 1960's. However, the report does furnish information on the status of family therapy among

mental health professionals. When asked to state their most frequently used modality of treatment twenty-two percent of psychiatrists replied that they used family therapy to ten percent of psychologists, and to forty percent of social workers.

Sugarman's (1981) survey found that psychiatry residency programs were moving to family therapy orientations and that the family therapy programs embedded in them were 34% theory oriented, while 66% described themselves as practice oriented. The most dominant label was eclectic, with structure in second place, and psychoanalytic the next common orientation. Together the eclectic and structural approaches formed 91% of all responses, and the directors of these programs reported that their focus was on changing the structure of the communications and relationship systems in the family. Direct expression of affect in the family was the prime focus of the remaining 9% of the programs. Sugarman (1984) stated that the resident is taught primarily an eclectic approach with the structural and strategic the most prominent orientations.

Programs in Sugarman's (1981) survey had been able to integrate family and individual therapy at a conceptual level. One-third of the residents had no paradigm conflict, and the remainder had varying degrees of difficulties, but none were found unable to cope. Flomenhaft (1980) describes the transition for a trainee from an individual orientation

to a systems one as a "quantum leap." Ehrlich (1980) holds that the trainee must be willing to accept the stress involved in balancing two contending points of view and priorities within his program. This may be fragmenting initially but it can act as a stimulus in the search for a philosophy and orientation which best fit the person of the trainee. Combrinck-Graham (1980) holds the opposite point of view when he states that one cannot teach good family therapy and theory in a training program whose primary orientation is psychoanalytic.

Sugarman (1984) holds that at this stage of development of both family therapy and psychiatry there could be a compromise between those parts of the theory and practice of family therapy that can be readily blended with current psychiatric practice, and the teaching of family therapy as a different and unique perspective. He states that significantly more family therapy training occurs in general psychiatry in 1984 than did in 1976, and that questions about family therapy are now being introduced on the psychiatry board examinations.

## Introducing Family Therapy into Non-Systemic Settings

To introduce family therapy into the traditional psychiatric institution challenges its functioning and according to Lieberman & Cooklin (1982) unsettles the hierarchy and may even destabilize the organization. Haley (1981) notes that it is unreasonable to expect a mental health institution to adopt family therapy because to do so would necessitate profound changes. It would require the acceptance of a new theoretical orientation and the abandoning of the theoretical orientation on which the institution was founded and in which all the professionals were trained. Other necessary changes would involve dropping its traditional diagnostic system, its theory of change, and instituting training for its staff as well as the blurring of the professional hierarchy. Lieberman & Cooklin (1982) stress that those changes would involve three non-traditional assumptions: the family approach implies that the root of many problems resides in relationships, not within the individual; real people are considered more important in psychiatric illness than intrapsychic fantasy or biology; and a family therapist views himself as part of the family system rather than an objective outsider. Haley and others

hold that to mix the models of individual and family orientation provides conflicts about those issues from the outset. Within the first decade of family therapy's existence, Ackerman (1967) advocated that a person not be removed from the context in which his problem developed but that he be treated in his natural habitat.

## General Psychiatry Residency Programs

There is little in the literature about the specific difficulties in integrating family therapy training into psychiatric settings. Martin & Lief (1973) commented that the strong emphasis placed on tradition in psychiatry training would be an inhibiting factor to the introduction of new approaches such as family therapy. Beal (1976) wrote that introducing family therapy training into psychiatric centers which are organized along traditional lines "creates disequilibrium and dysfunction." Ehrlich (1973) and Sugarman (1981) stated that conflict existed about family therapy's place within psychiatry because an impression lingers that the further a therapy is from psychoanalysis the more dilute it becomes and hence is an inferior form of therapy. Fisch (1977) wrote that the main obstacle to the introduction of family therapy in general psychiatry was the priority given to psychoanalytic concepts in training and practice.

Miyoshi & Liebman (1969), Harbin (1980) and Sugarman (1981) hold that part of the resistance to teaching family therapy in residency programs has been because most of the trained faculty/staff are not psychiatrists. Sugarman (1981) states that the inclusion of family therapy training into psychiatry training has the hallmark of a chaotic and uneven process similar to the introduction of other modalities. Garfield (1979) sees family therapy treading developmental paths within GPRP which were followed by group therapy and brief psychotherapy. Goodrich (1980) suggests eliminating or decreasing any adversarial elements that may arise from introducing family therapy training into a psychiatry training program by a partial introduction of family therapy into psychiatry training with the objective of a complete introduction at a later date. The former is administratively easier and psychologically less stressful to faculty, while the latter is theoretically more satisfying.

Family therapy is a new and complex way to explain human behavior and when it is introduced into a general psychiatry residency program it poses a problem for the teaching staff. To survive it must evolve within this confusing and competitive intellectual environment (Harbin, 1980). Resistance to an additional theoretical model by faculty and students may be another explanation of its slow acceptance.

Sugarman (1981) writes that integrating family therapy into general psychiatry training poses a problem, because it is not just another therapy, but a whole new view of human behavior which is incompatible with the treatment models that came before it. Miyoshi & Liebman (1969) named two major problems, the theoretical one, and the problem of supervision which is more intense and is done with a co-therapist who might be a social worker and not a psychiatrist. Harbin (1980) terms this last point a question of status alone, and feels that the faculty and students need to be flexible and tolerant to accept the integration of an additional model, but he fails to suggest how this integration might take place. As early as 1970 the GAP report predicted something which is coming about in the 1980's: "It is conceivable that the psychiatry of the future will be radically altered by a shift from the individual to relational psychology as its theoretical understructure." (p.571)

Sugarman (1981) holds that the core curriculum in family therapy training programs for psychiatrists depends on one's theoretical orientation. If one considers family therapy as a technique one can then talk about specific content issues, but if one considers it a conceptual viewpoint, the content of the core curriculum becomes complex. In this latter situation the focus would be on

changing and expanding the trainee's orientation, while specific techniques would be a secondary consideration.

It is considered possible in the GAP report (1970) that such a shift could take place, and the GAP report (1985) states that this shift has taken place: "Psychiatrists have learned to see families as systems---as a group of people whose interactions affect each other---rather than collections of separate individuals whose behavior is determined mostly by their past" (p. 70). The evidence in the literature presented here and in general would not fully support this optimistic statement. If this vast change could come about Sugarman (1981) believes it must take place at the metalevel of changing program structure as opposed to the level of learning new techniques.

Several factors are suggested by Sugarman (1984) which may be critical for determining the status of family therapy in any one particular residency program. First, a small tightly knit faculty is less likely to foster family therapy training than a large faculty which is accustomed to be open to more varied and contending viewpoints. Second, departments which are experiencing financial restrictions, suffer from lack of space, have small faculties or have limited cases, are less likely to spend time and energy on innovations, such as introducing family therapy. Third, there may only be a few family therapy advocates who are in positions of influence to channel the limited resources into family

therapy development. The position which a champion or champions of family therapy hold in a faculty will have a direct bearing on the growth and development of family therapy in that department.

## Child Psychiatry

Malone (1980) writes that in the past and even in the present dynamically oriented child psychiatrists have opposed or resisted family therapy on the grounds that it interferes with transference and needed confidentiality in child psychiatry and that it needlessly exposes children to the dangers in their family life. On the other hand family therapists have opposed dynamic child psychiatry because it separated the treatment of children from the source of their troubles in disturbed family patterns, in marriages in conflict, and in the parent's own problems. Many child psychiatrists have been able to move beyond the former polarization and have found common ground in viewing the child's or adolescent's problems in the context of the family, the school, peers and the neighborhood (Malone 1974).

Gottlieb (1980) found that child psychiatry departments had difficulties in establishing themselves, as they were predominantly located in university affiliated programs which were usually headed by an adult psychiatrist. Child psychiatry was treated like a stepchild housed in adult

psychiatric training programs (Malone 1974) and had to prove its worth. Liddle (1978) states that family therapy too will be accepted ultimately when it shows clearly its effectiveness.

Child psychiatry once paralleled the debate in general psychiatry on whether to introduce family therapy training into its curriculum (Langsley 1976). Now the discussion is on how to integrate it into the child psychiatry program (Barker, 1982). In 1974 McDermott wrote that for a long time text books in child psychiatry did not seem to list family therapy as a treatment modality while child's journals did not review books in the family field. Gottlieb (1980) stated that child psychiatrists now saw that an essential element in basic child psychiatry is expertise in interviewing, understanding and formulating issues and interventions from a family perspective. This is evidence that maturation is occurring in the field.

## Inpatient Settings

Implementation of a family therapy orientation runs into particular problems in the inpatient setting (Lieberman & Cooklin 1982; Todd 1984) and most problems seem to stem from the incompatibility of the two orientations. Todd (1984) states that most family therapists believe that inpatient hospitalization should be avoided at all costs. Such thinking results in unfavorable reaction and causes

resistance, which comes from the shift in the role required of the inpatient and other professional staff, the challenging of the "patienthood" of the individual, and the role of the relatives as to whether they are staff aides, patients themselves or the culprits (Lieberman & Cooklin 1982). A family therapist who works in a traditional inpatient psychiatric setting and whose aim is to work with the client's family and have the client returned as quickly as possible will be in conflict with the administration whose philosophy is quite different if not the opposite (Berger & Jurkovic 1984; Lieberman & Cooklin 1982). Underlying this situation is the difference in theoretical orientation between the psychodynamic and systems approach to problems. Haley (1981) and Framo (1976) hold that therapists with these two different orientations cannot reach agreement about a case, and any attempt to combine these two viewpoints leads to continual confusion.

## Hospitals

In a survey of family therapists working in hospitals across the United States in which sixty-two percent were clinical members of the American Association of Marriage and Family Therapy, McCall & Storm (1985) found that the therapists reported a high acceptance of their work by the administrators, and a supportive environment from the other personnel. The authors see this climate of acceptance as

offering unique opportunities for family therapists to get involved in teaching, community education programs, supervision and research.

A more hopeful picture emerges from at least one study of the status of family therapy in hospitals. Soman & Soman (1983) report on a voluntary family therapy training program in a family practice residency. Despite its limitation of being just one voluntary program and of having close researcher involvement, it had positive effects upon its participants in their social, cultural and psychological environment. While the residents who participated did not develop expertise as family therapists, they were judged to be better able to make informed, constructive referrals and to be sensitive to family issues.

## Universities

Liddle (1978) states that the prospect of change in universities is threatening the status quo of the system, and from his experience he describes the effects of his planning and implementing a family therapy training sequence in a counseling psychology department. When a family therapy trainer is introduced into an institution of intrapsychic thinkers a struggle for definition ensues. In Liddle's situation the hierarchical structure kept the family therapy training introduced by a junior faculty member in a position of lower regard. Live observation of

families which created openness about one's work became a source of concern for some faculty members. In the doctoral comprehensives responses to cases were to be from an individual or group perspective and not from a family one. Students' experiences of family therapy came only from elective courses which were discounted in the integration of their knowledge and experience in the final examination. Underlying these obstacles lay the fundamental difference of viewing family therapy as another treatment method and not as a unique way of viewing human behavior. Overall, Liddle stated that family therapy training was at best tolerated, and that continuation of the program depended upon administrative and select colleague support.

In universities where family therapy training programs are on a co-equal basis with the parent profession, Fenell & Hovestadt (1986) state that such an arrangement is usually difficult especially for family therapy which is seen as a new and maturing profession. Piercy & Hovestadt (1980) suggest that family therapy educators make themselves part of the parent discipline through publications, participation in convention representations and serve in positions in parent professional associations, while maintaining simultaneously similar status with the American Association of Marriage and Family Therapy. This alone will not overcome difficulties but should enable family therapy to have greater visibility and probable acceptance within the parent

discipline. Students receiving family therapy training in academic psychology departments have to deal with learning Rorschach and family therapy simultaneously (Haley, 1985).

## Community Mental Health Centers

Community Mental Health Centers (CMHC) are limited by ill-defined conceptual foundations according to Framo (1976). He states that people get caught up in organizational structures with their rules and guidelines, and that these systems develop a life of their own, with their own regulatory powers. His conclusion after nearly five years of attempting to introduce family therapy into a CMHC was that when the implication of a family therapy training orientation became apparent in terms of its effect upon diagnostic and treatment procedures, admissions policies, and status it was found to be too threatening. Carl (1984) sees changing the treatment model in public mental health to be a monumental task, but states that good systems therapists know that to introduce a series of small changes can lead to a major change. In this approach there exists the hope of change.

Auerswald (1983) stated that innovation is acceptable only as long as nothing significant is changed. He described an experiment in ecosystemic community health care delivery and found that its decline was due to gradual and persistent pressure to conform to the traditional health

care delivery structure. This can also be applied to family therapy. An individual effort to overcome agency resistance was reported by Viaro (1980) who, instead of waiting for the ideal conditions, overcame hindrances to doing family therapy by smuggling it into the setting without the knowledge of the sponsoring agency.

For Berger & Jurkovic (1984) the therapeutic system involves not only the therapist and the family, but also the larger social context in which the treatment takes place. When one views these three as part of a mutual process one then moves to integrate them into a workable system, which does not mean that the service agencies readily accept the systemic approach (Auerswald, 1983; Framo, 1976; Haley, 1981). According to Coppersmith (1983) family therapy is on the way to becoming an accepted clinical approach in settings which previously denied that family members should be seen conjointly in therapy. In those settings in which it is recognized it is seen and too often practiced as another modality rather than as a theoretical orientation which requires many fundamental changes in traditional practice.

## Tactics of Change

There are indications in the literature of partial, if not total, success in introducing family therapy into traditional psychiatric care facilities. Dirk (1982)

reports a project of introducing family therapy into a day care hospital whose tradition was to treat only individual clients. In training the staff there was a high level of agreement on the theoretical orientation which was eclectic, family systems and structural, but difficulties arose during training over the actual work with families themselves in the admission and treatment phases. Carpenter (1984) stated that if family therapy is to become more relevant to mental health professionals and agencies, a sharper focus by trainers on agency context is essential. In a postgraduate yearlong training program, the trainees' practice-organizer was consulted as a representative of the agency and supervision sessions were open to her. She was responsible for the management and timing of appropriate referrals to the trainees, providing technical resources and seeing that the students' work load allowed time for family therapy training. The director was expected to attend a contract-making meeting with the students and their advisors. By these methods the relevance of family therapy to the agency was established.

While there remains an uncertain acceptance of family therapy in many settings, Liddle (1978, 1986) found few training programs which prepared trainees for the less than enthusiastic reception some of them would receive. Training programs must provide trainees with strategies to cope with the professional resistances to an interpersonal definition

of human problems. An effective family therapy training program according to Haley (1976) will introduce trainees to a wide variety of clients and presenting problems. Berger & Jurkovic (1984) state that training should teach students to identify when they need support and how to act in non-systemic settings. Carl (1984) gives a working definition of resistance which helps to see it as an interaction artifact: "There is no such thing as a resistant system, only systems impervious to inopportune interventions" (p. 108).

One thing which trainees need to learn is to assess the system in which they work, find opportunities and come up with the kind of creative interventions which they use to help families change. Berger & Jurkovic (1984) state that therapists will have to actively create a functional therapeutic system rather than to expect one to come into being without their efforts. Haley (1976) holds that there are always sufficient degrees of freedom within the system to accomplish certain tasks. Todd (1984) believes that therapists will have to learn to make compromises, and Hobbs (1984) writes that this may mean working cooperatively at times as a traditional therapist, at other times as a social broker, or as a liaison.

Before attempting to do family therapy in a particular setting the therapist should learn how to obtain higher administrative support and to take administrative functions

seriously according to Jurkovic & Berger (1984). Bishop, Byles & Horn (1984) found involving both administrators and other professionals in the planning of a family therapy training program within an agency helps to motivate participants and minimizes negative institutional reactions. Therapists are reminded by Todd (1984) not to define the administration of a non-systemic setting as an enemy, as this could not only create further resistance but may bring about dismissal. There are rare occasions when therapists have to risk their positions in agencies by protecting the client from the actions of the agency.

Another way of facilitating the acceptance of family therapy is to cooperate with other agencies and programs that may be involved with a client. As long as the therapist avoids appearing militant, the other agencies are often surprisingly cooperative, according to Todd (1984). When the need to spend long hours in case coordination becomes obvious, other mental health practitioners, at least those who work in agency settings, are quite willing to transfer the case to the family therapist. This joining can also take place within the agency by the therapist with the agency staff and other professionals, in the same way they join with family members in order to see the world from their perspective, to speak their language, and to share their concerns (Berger & Jurkovic 1984). Success in family therapy, according to Haley (1980), can be determined as

much by what happens among professional colleagues as by what happens within the family, and the therapist must be as patient and ingenious in dealing with his colleagues as he is in dealing with difficult families. Coppersmith (1983) holds that the therapist must carefully avoid unplanned alliances and splits and demonstrate a willingness to work in a strategic way with larger systems.

Held (1983) suggests three strategic interventions for effective functioning within a non-systemic system. First, take a one-down position (Fisch, Weakland & Segal 1982) that is, seek the help and advice of staff members, and acknowledge the clinical expertise of others in one's own weak areas. Second, employ positive connotation and reframing, that is, validate the system's health, resources, strengths, and reframe any resistance to one and one's ideas in positive terms. Third, prescribe the symptom, that is, if the system is resistant, suggest it has every reason not to trust an untested newcomer and to ask them to test one's expertise.

## The Future

### The Politics of Family Therapy

One of the main issues facing family therapy in the 1980's is the question of licensure and credentialing because of third-party insurance payments when freedom of choice legislation usually only provides for reimbursement of licensed practitioners (Hess 1980). As more diverse programs are granting degrees in one or another area of mental health services, some ongoing credentialing procedures must develop which will result in quality control in the area of training. Hess (1980) thinks that more attention should be given to the definition of training and the possible credentialing of supervisors. According to Kolevzon & Green (1985) there are strong unifying forces within the family therapy profession for credentialing of curricula in graduate level programs and the licensing of family therapists.

Another important task for family therapy is to strengthen its identity with the rising culture according to Walrond-Skinner (1979). She sees that the field of family therapy not only has vital things to say to policy makers, politicians and health planners, but also can make vital contributions in the area of solutions to social problems,

community living and international relations. An outsider, Jordan (1981), sees family therapy's failure to date as the lack of a coherent social and political philosophy which could influence government social policies, and this he believes is because it might divide the movement. The consequences of the failure of family therapy to influence the social systems, especially with its unique approach to human problems, could see it replaced by older, more punitive methods even if these have already been shown to be ineffective.

Liddle (1986) asked how do family therapists define the limits or boundaries of their role, and whether they have any obligation to society to advance the systems philosophy. The question remains with the potential applicability of the systems view. If it is seen as limited only to the family then it would be inappropriate to universalize its benefits, but if it is seen as transferable to a wide variety of contexts then its application to a macro system would probably be accepted.

What Aponte (1983) writes about need assessment can be applied equally to the future of family therapy. He states that the focus will have to shift away from those already impaired towards those who may be at psychological risk, and interventions designed and planned for these high risk individuals will have potentially greater impact on the community and society than programs solely designed to treat

existing social, physical and psychological problems. Family therapy, according to Stanton & Todd (1982), has the greatest potential for prevention because: more individuals are involved, parents are involved who may have engendered the problem in others, when effective it may prevent similar effects in other offspring, and the client through successful treatment will probably become a better parent. prevention has not achieved widespread attention, according to Liddle (1986), nor has it been adopted by most therapists. He holds that family therapists who are interested in preventative work are often regarded as second class.

## Standardization

One overriding issue that needs to be addressed is that of family therapy as a distinct mental health specialty (Kaslow 1982). Bloch & Weiss (1981), Olson, Russell & Sprenkle (1983), Fenell & Hovestadt (1986) and Sutton (1986) hold that there already exists a new profession of family therapy with its own entry point and academic pathway. A fundamental question underlying this issue is whether family therapy ought to become a profession in its own right. Piercy & Sprenkle (1984) are concerned that the excitement which accompanied the start of family therapy may be eroded by the evolving move towards standardization - as they aptly state that one generation's dynamic radicalism may become the next generation's orthodoxy. Pilalis (1983) sees this

process of professionalization as having inherent dangers, such as the limiting of future creative developments and a narrowing of the dissemination and use of family therapy knowledge in all the helping professions. Kolevzon & Green (1985) likewise see the danger of any move toward standardization as a possible diminution in the richness created through diversity which tends to dissolve under the pressure of developing a unifying theme.

Haley (1984) feels that the age of transition has come to an end and that family therapy on the issue of clinical organization has matured to the point of setting standards for training and supervision. But as to its being an independent profession, he holds that the field has yet to reach a consensus on what a therapist should know and so come of age. His suggested solution to the problem is to create a new profession called "therapist" with specialization in different areas. Instead of dismembering the mental health field by adding new categories, the direction for the future should be in unifying the clinical professions.

## Epistemology

While the debate continues in the 1980's on the intellectual level about epistemology and paradox, Kaslow (1982) believes that these ideas will be absorbed rapidly into most theoretical approaches, while on the practical level families will remain concerned that the therapist be

skilled in reducing conflict and pain, and help the family cope and feel better and happier.

## Integrated Theory

In the attempt to develop a generic theory there exist the risks of producing a model of practice that may be internally inconsistent, difficult to put into operation and consequently therapeutically ineffective. (Kolevzon & Green, 1985) In the GAP Report (1970) there was an indication of a need for an integration of psychodynamic theory and family therapy.

## Training

Although it takes less time to reach competence in family therapy models of addiction than is required in individual models, the orientation, content and length of future training curricula need careful consideration (Stanton & Todd 1982). In a nationwide survey of counselor education departments, Meadows & Hetrick (1982) found a high level of commitment to marriage and family counseling preparation, with an indication of increased involvement. A greater number were offering graduate training in marriage and family counseling than had been previously indicated in the literature.

## Research

Pinsof (1981) feels that the field of family therapy process research has hardly been explored and that a clear and consistent body of knowledge has yet to emerge. Process researchers must build upon the research already done and develop this area of the field. Kolevzon & Green (1985) see the confusion about outcome studies as a result of the imbalance between process and outcome research. Future research, they state, must not be carried out between either process or outcome but that the two forms of investigation must complement, mutually reinforce and provide corrective feedback to one another. Gurman & Kniskern (1981) state that the time has come to integrate empirical study of the training process with empirical study of the outcome of family therapies themselves. If this integration were to occur the next generation of family therapists would benefit greatly and would avoid repeating blindly the present clinical and training methods and possible errors.

Jacobson (1985) sees the interest in outcome research among the participants of the family therapy field as an encouraging sign which will put the claims for effectiveness of family therapy on more solid foundations. He and Haley (1976) hold that the main criterion for successful therapy is whether the family obtained from the therapy what they wanted, while Kniskern (1985) holds the primary measure for

evaluating success in family therapy to be a change in family patterns of interaction.

## Supervision

As the expenditures for mental health continue to rise, the cost effectiveness of family treatment is becoming more evident. Agency administrators are having their trainees receive the supervision from currently employed professionals because it is cheaper. Beavers (1986) sees family therapy supervision in such settings becoming little more than discussions of administrative problems. Another change has been observed by Beavers in the increased numbers of professionals employed in public agencies who are seeking special training in marital and family therapy often with financial support of their employers.

## Focus on Therapist

Bloch (1980) states that the self of therapists has not been adequately studied and is not included as a significant conceptual issue. Both the Milan approach and the Ackerman Institute consider the personal characteristics of the therapist to be of major importance. In the future the issue might be what is the best match between the family of the therapist and the family in treatment.

## Psychiatry

Bloch (1981b) holds that training in family therapy at a sophisticated level is now to be a regular part of the future training of psychiatrists and psychiatric nurses as well as that of psychologists and social workers. Light (1980) is not optimistic about psychiatry's ability to cooperate with other mental health professionals, and sees it as being confused about its role relative to physicians, social scientists, non-medical therapists and paraprofessionals, and thinks that the enlightened cooperation that is required will not be forthcoming.

Flomenhaft (1980) states that the time has come for child psychiatry to consider seriously the significance and implication of family theory and therapy. To do so will necessitate a major shift in thinking which will be painful because it requires a re-examination of the assumptions and perspectives that have directed child psychiatry thinking over the years.

Issues touched upon in the literature describe the growing pains which family therapy experienced and is experiencing in the United States. In the various stages of growth and development certain challenges were met and still new ones lie ahead for the full and complete acceptance of family therapy as an independent discipline with its own

theoretical orientation, training standards and research. Reviewing the stages which the discipline has experienced in the United States should enable practitioners and educators in Ireland who are experiencing similar growing pains should provide a map which will enable them to steer their own course.

# CHAPTER III

## DESIGN

This is a descriptive study which strives to delineate the broad issues in family therapy training and supervision, before an examination of specific hypotheses can be beneficially undertaken. Because family therapy is in its initial stages in Ireland such a broad review of training and supervision should make a practical and conceptual contribution to the field. This examination is being carried out by self-report, (Babbie 1973) and the quality of the data will depend upon the accuracy and thoroughness of the individual responses to the inquiry (Goldman 1976; Clarkin 1980). Since no such examination has yet taken place, the theoretical underpinnings of training and practice have yet to emerge, as well as the structure and extent of the training programs themselves.

This study reflects Goldman's (1976) contention that counseling psychology needs to be broader in scope and possess more external validity than the present norms of experimental studies allow. After this self-report study has been completed the areas in need of further investigation should become clearer. Just as the GAP Report (1970) was recognized as being helpful in clarifying models of

family therapy, discovering their popularity, defining therapists' primary treatment goals, and examining shifts in theoretical orientations (Guerin 1976; Foley 1986; Gurman & Kniskern 1978a), so does this study aim to achieve similar goals but on a much more modest scale. The best definition of the field that can be obtained at this stage will be supplied by those who are currently active in it (Bloch & Weiss 1981).

## Respondents

When subjects for this study were being sought, it seemed to the author that the most representative organization of family therapists would be the members of the Family Therapy Network of Ireland. Later it was discovered that its membership was relatively small, and alone would not reflect the widest possible picture of the field that is being sought. To obtain a more comprehensive view it was necessary to contact the other organizations working in the mental health field and locate their members who might be working in some way with families. Two of the three organizations surveyed, the Family Therapy Network of Ireland, and the Psychological Society of Ireland have members who live in the Republic and in Northern Ireland. Only those members who live and work in the Republic were included in the study. Since Northern Ireland has a different health service structure from that of the Repub-

lic, to include both would have created a different, and perhaps a more interesting study, but the author's primary purpose was to obtain information on family therapy in the Republic.

Questionnaire I is the largest, containing 115 questions. It was mailed to "all who do family therapy in the Republic of Ireland, from the trained therapist to the individual who helps families in their interpersonal relationships in a voluntary organization" (See Appendix B). The associations and organizations whose members were invited to respond to Questionnaire I were:

(i) The Family Therapy Network of Ireland. No classification of its members' professions was given in its mailing list, but it is known as a multi-disciplinary body (McCarthy 1980). All its members were surveyed (n=65).

(ii) The Psychological Society of Ireland. In its 1982 Directory its membership was given at 405, and it also is a multi-disciplinary organization with its members working in mental health and non-mental health settings. The span of its professions was from university professorships and lecturers, child psychologists to teachers and administrators. Only those members who were named as clinical psychologists, and those who worked in child guidance clinics, were included in the study (n=54).

(iii) The Alumni of the Child Guidance Clinic at the Mater Hospital. These were teachers, nurses, social

workers, child care workers, psychologists and psychiatrists who attended at least the introductory seminars or the clinical training program. All alumni were surveyed (n=77).

(iv) The Irish Association of Social Workers has a policy of not releasing its members' names and addresses even for research purposes, consequently it was formally excluded from this study. However social workers are included as members of the Network and as alumni of the Mater's program, while still others were surveyed as "Individuals." Social work in Ireland is divided into thirty-one "Areas" for administrative purposes. In each of these there is one Senior Social Worker. To circumvent the exclusion of the members of the Association a tactic was used to include individuals who were known to be social workers. Before mailing the questionnaire the author wrote to the Senior Social Worker of each area advising him or her of the coming study, and requesting that when the questionnaire arrived to pass it on to the social worker in that particular area who was most involved with families or who had received some training in family therapy. Another request was made to send the author that social worker's name so that the author could communicate directly with him or her about it (n=31).

(vi) Having surveyed the main organizations, professional and lay, there remained certain individuals known to the author and to others, who were not members of any of

these organizations, yet who were involved in family or marital therapy. For convenience these were grouped together and titled, "Individuals" (n=30).

The subjects of the three remaining questionnaires were training programs in various types of institutes. Questionnaire II was addressed to the two known training programs and surveyed every aspect of their training and supervision (n=2) (See Appendix C). Questionnaire III was addressed to the social work and clinical psychology departments of the universities (n=8) (See Appendix D). Questionnaire IV was addressed to the individual consultants in specialty psychiatry (n=7) and general psychiatry (n=14) who are responsible for training the residents (known in Ireland as registrars) assigned to them (See Appendix E).

The following procedures were used to insure confidentiality of the participants' responses to Questionnaire I. Subjects were assigned code numbers for use on all questionnaires and no names were used. Names of training centers, clinical psychology and social work departments as well as psychiatric residency training programs were asked for by the author.

## Instrumentation

The questionnaires used in this study were constructed by the author from a review of the literature and their initial forms were modified by input from therapists in

three different training facilities, the Child Guidance Clinic, Dublin, the Family Institute of Chicago, and the Mental Research Institute, Palo Alto. Four questionnaires were designed to address the areas of any possible activity in the field of family therapy, but the greater proportion of questions in all questionnaires were directed to training and supervision.

The assistance obtained from the literature for the different questionnaires was as follows: Questionnaire I: Saba (1984) and the GAP Report (1970). Questionnaire II: the GAP Report (1970); and Bloch & Weiss (1981). Questionnaires III and IV: Bloch & Weiss (1981). A pilot study would have been the ideal and most helpful way of critically evaluating these instruments but this was not feasible in the Irish context. In this early stage of the development of family therapy the number of known therapists is so small, that such a pilot study would have decreased their number for the purposes of the main study.

In the endeavor to develop instruments as effective and efficient as possible under these conditions another approach was utilized. Initial forms of the different questionnaires were mailed to various people in Ireland, the United States and New Zealand who had experience and expertise in the relevant areas covered by the questionnaires. These individuals were asked not to respond to the questionnaires, but to evaluate the content, the construc-

tion and the clarity of the questions, and to estimate the time that would be required to answer them. They were also asked to add relevant areas of practice not covered in these initial forms. Respondents' suggestions were incorporated into the questionnaires where they were pertinent to the purpose of the study.

Questionnaire I was mailed to 21 individuals: 10 in Ireland with 8 responding, 10 in the United States with 9 responding and to 1 in New Zealand who responded. The particular feedback from people in Ireland indicated that the questionnaire was so comprehensive that it would highlight the sparseness of the field in Ireland, which some felt would have an overall positive effect. Others suggested removing the Americanisms which surfaced in the questionnaire despite the author's best effort to avoid their use, so that it would display an "apparent familiarity" with the Irish scene. Still others wrote that it was too long and would receive few responses, and that certain questions needed clarification. The most serious and valuable criticism received was that it contained far too many follow-up questions, e.g. "describe briefly" or "state briefly." These were removed wherever possible and were replaced by closed questions.

Questionnaire II was mailed to three individuals in Ireland and five in the United States and all responded. Questionnaire III was mailed to one in Ireland and five in

the United States and all responded. Questionnaire IV was mailed to five in the United States and all responded. The feedback on these questionnaires was that only minor modifications were required. Taken together, the response rate was ninety-two percent to the author's request for a critical review of the initial forms of the four questionnaires.

The construction, modification and final arrangements took about ten months from September 1983 to July 1984. In late November 1983 the initial forms of the questionnaires were mailed and by February 1984 the feedback had been incorporated into the second drafts, which were continually receiving minor modifications until the final drafts were approved by the author's committee in July 1984.

## Procedure

The total number of questionnaires in this study came to 299 which were prepared for mailing in August 1984, and were sent by air-cargo to Dublin. There, friends of the author affixed Irish stamps to the self-addressed envelopes and mailed all the questionnaires simultaneously in mid-September. The return envelope was addressed to the author at a Dublin address. Each questionnaire and the corresponding envelope had a given code number which was publicly displayed on each but whose key remained with the author in the United States to provide the confidentiality promised the

respondents. Those who responded to Questionnaire I were not asked to supply their names on their responses, and the question of a respondent signing his or her name on the other questionnaires was left optional, because there was little or no personal information sought in them. Every week from October onward the author received a telephone call from Dublin informing him of the number of questionnaires returned and their codes.

By mid-October the response rate had reached 22%. After that a general follow-up letter was mailed to all subjects who had not yet responded. By the first week of November the response rate had reached 38%. During the remainder of that month the author wrote letters to members of the various organizations tailored to the nature of each. By December 21 the overall response rate had reached 58%.

At the end of January 1985 the author was able to spend four days in Ireland and tried to contact as many non-respondents as time and telephone facilities would allow. Forty-three were selected randomly. Of these 27 were unable to be contacted for the following reasons: 14 names could not be found in the telephone directory, 7 were phoned twice or more but no personal contact was made (circumstances did not allow the author to leave a return phone number), 3 were phoned twice or more and their lines were busy, which in Ireland could mean that their phones

were out of order, 2 were out of the country at the time and 1 had changed address without leaving a new phone number. Those personally contacted totalled 15, 8 of whom responded later by forwarding answered questionnaires. Four others promised to do so but their questionnaires never arrived. Three of these individuals expressed hostility stating that they felt the questionnaire was an intrusion on their confidentiality. Two of these were psychiatrists. Of those whom the author contacted 44% responded by forwarding answered questionnaires.

After February 1985 no further attempt was made to collect data. The overall response rate for all questionnaires was 65.9%, which included answered questionnaires, returned questionnaires with accompanying letters stating why they could not be answered, or simply letters stating reasons for inability to complete them. The useable questionnaires totalled 50.6% of all that had been mailed. By July the data had been coded and made ready for the computer.

## Statistical Analysis

All the raw data for Questionnaire I data were number coded and entered into a computer database at Loyola University of Chicago. A master list of respondents' names and code numbers was kept in a private file by the author to allow for individual feedback of the results. Raw data from

the other questionnaires were manually coded by the author because the number of questionnaires was so small and material too diffuse. The Statistical Package for the Social Sciences (SPSSX) was used to analyze the data.

Missing data was excluded on an analysis by analysis basis. Frequencies were used to derive means, standard deviations and percentages. Because this was a survey research project the data was translated into categorical data for the purpose of statistical analysis.

# Chapter IV

## RESULTS

The data presented in this chapter was obtained through four separate questionnaires. Questionnaire I focused on the demographics of the first generation of family therapy practitioners and especially on the effects which this training had on their professional and personal lives. Questionnaire II sought to obtain, in the greatest possible detail, the various elements in family therapy training at the two known centers in Dublin. Questionnaire III attempted to determine the didactic and practical elements of family therapy training available to students in the social work and clinical psychology departments in the universities. Questionnaire IV sought to pinpoint the elements of family therapy that may have permeated general and specialty psychiatry in the residency training programs.

The three objectives of the study were: to survey the current practitioners, trainers and supervisors on the effects that their training and supervision had on them (Objective I); to survey the training programs and other settings where family therapy is taught and supervised (Objective II); and to gather opinions from all respondents

on the content and direction of future training programs (Objective III).

These objectives were met in different ways. Objective I was met by the respondents to the first questionnaire and Objective II by the respondents to the remaining three, which were directed to educational institutes. Objective III, however, was different. In all four questionnaires certain questions concerning future training were placed and these were extracted to form the third objective.

## Characteristics of Respondents

### Demographics

The greater majority of respondents to this study were females, 61.2% (n=79), while males formed 38.8% (n=50). Of the 127 who reported their ages, out of a possible total of 130, the vast majority, 72.4% (n=92) were 40 years of age or younger with the mode 26-30 years (n=30) (see Table 2).

Table 3 shows that 53.1% (n=68) were married, 29.7% (n=38) were single, and 11.7% (n=15) were priests or religious men and women. Of those who were married 82.4% reported having children, with a range of 1 (n=16) to 14 (n=1).

The expression of religious belief found in Table 4 shows that the majority, 76% (n=98) were Catholic, other christian denominations accounted for 8.6% (n=11) with the

remainder expressing other religious beliefs, 2.3% (n=3) or none, 12.4% (n=16).

Table 2

Sex and Age

| Sex | Frequency (n=129) | Percentage |
|---|---|---|
| Male | 50 | 38.8 |
| Female | 79 | 61.2 |
| **Age** | **Frequency (n=127)** | **Percentage** |
| 20-25 | 7 | 5.5 |
| 26-30 | 30 | 23.6 |
| 31-35 | 27 | 21.3 |
| 36-40 | 28 | 22.0 |
| 41-45 | 15 | 11.8 |
| 46-50 | 4 | 3.1 |
| 51-55 | 7 | 5.5 |
| Over 55 | 9 | 7.1 |

Table 3

Marital Status and Family Size

| Marital Status | Frequency (n=128) | Percentage |
|---|---|---|
| Married | 68 | 53.1 |
| Single | 38 | 29.7 |
| Religious | 9 | 7.0 |
| Priest | 6 | 4.7 |
| Divorced | 2 | 1.6 |
| Separated | 2 | 1.6 |
| Widowed | 1 | 0.8 |
| Other | 2 | 1.6 |

Family Size

| Number in Family | Frequency (n=56) | Percentage |
|---|---|---|
| 1 | 16 | 28.6 |
| 2 | 13 | 23.2 |
| 3 | 13 | 23.2 |
| 4 | 9 | 16.1 |
| 5 | 2 | 3.6 |
| 6 | 1 | 1.8 |
| 7 | 1 | 1.8 |
| 14 | 1 | 1.8 |

Table 4

Religious Belief

| Religion | Frequency (n=129) | Percentage |
|---|---|---|
| Catholic | 98 | 76.0 |
| Church of Ireland | 5 | 3.9 |
| Methodist | 1 | 0.8 |
| Other Christian | 5 | 3.9 |
| Society of Friends | 1 | 0.8 |
| Other | 3 | 2.3 |
| None | 16 | 12.4 |

All who responded to the questionnaire were not citizens of Ireland as 10.8% (n=14) held citizenship of other countries, with the United Kingdom having 6.2% (n=8) of the total. The largest proportion of the respondents, as shown in Table 5, work in Leinster, which includes Dublin city, 74.5% (n=86) as compared with 10.9% (n=14) for the provinces of Connaught and Munster, and 1.6% (n=2) for the three counties of Ulster.

Membership in a professional family therapy organization is shown in Table 6. Of the sixty who responded, 78.3% (n=47) stated that they were current members of associations primarily concerned with family therapy.

Those respondents who reported spending six months or more outside Ireland for study or work came to 69.3% (n=88). Of the 74 who named the country, 44 (59.5%) spent that time in the United Kingdom and 18 (24.3%) in the United States (see Table 7). Most, 53.5% (n=39) spent from two to five years outside Ireland, and Table 8 shows that of the seventy-three who reported the places of training, 58.9% (n=43) spent their time in a university context.

Table 5

Country of Citizenship and Current Work Location

| Citizenship | Frequency (n=130) | Percentage |
|---|---|---|
| Ireland | 116 | 89.2 |
| United States | 3 | 2.3 |
| Netherlands | 1 | 0.8 |
| United Kingdom | 8 | 6.2 |
| Australia | 1 | 0.8 |
| West Germany | 1 | 0.8 |

| Work Location | Frequency (n=129) | Percentage |
|---|---|---|
| Dublin City | 78 | 60.5 |
| Leinster | 18 | 14.0 |
| Connaught | 14 | 10.9 |
| Munster | 14 | 10.9 |
| Ulster | 2 | 1.6 |
| Other | 3 | 2.3 |

Table 6

Membership in a Professional Family Therapy Organization

| Organization | Frequency (n=60) | Percentage |
|---|---|---|
| Family Therapy Network of Ireland | 43 | 71.7 |
| American Association of Marriage and Family Therapy | 2 | 3.3 |
| American Family Therapy Association | 2 | 3.3 |
| Catholic Marriage Advisory Council | 2 | 3.3 |
| Psychological Society of Ireland | 2 | 3.3 |
| Irish Association of Social Workers | 3 | 5.0 |
| Other | 6 | 10.0 |

Table 7

Time Spent Outside Ireland (Six Months or More) For Study or Work Purposes and the Countries Where This Time Was Spent

| Purpose | Frequency (n=127) | Percentage |
|---|---|---|
| Study | 54 | 42.5 |
| Work | 34 | 26.8 |
| For neither | 39 | 30.7 |
| **Country** | **Frequency (n=74)** | **Percentage** |
| United Kingdom | 44 | 59.5 |
| United States | 18 | 24.3 |
| Europe | 9 | 12.2 |
| Africa | 2 | 2.7 |
| Canada | 1 | 1.4 |

Table 8

The Years and the Locations That Respondents Spent Outside Ireland for Study or Work

| Duration (in Years) | Frequency (n=73) | Percentage |
|---|---|---|
| Six months to one year | 17 | 23.3 |
| Two | 19 | 26.0 |
| Three | 8 | 11.0 |
| Four | 5 | 6.8 |
| Five | 7 | 9.6 |
| Six | 3 | 4.1 |
| Seven | 6 | 8.2 |
| Eight | 2 | 2.7 |
| Nine | 6 | 8.2 |

| Location | Frequency (n=12) | Percentage |
|---|---|---|
| University | 39 | 53.4 |
| Social service | 9 | 12.3 |
| Hospital | 7 | 9.6 |
| University Hospital | 4 | 5.5 |
| Family therapy training program | 2 | 2.7 |
| Other | 12 | 16.5 |

## Primary Work Setting

Community Care was reported as the dominant work setting, 31.9% (n=51), by the respondents. The seven remaining settings are shown in Table 9 and "other" settings were stated to be: priest, 3.9% (n=5), addiction centers, universities, pediatrics and prison system.

When the general question of satisfaction in their current work setting was asked, Table 10 shows that 86.7% (n=110) replied that they were satisfied to completely satisfied, and this contrasted with 13.3% (n=17) who stated that they were moderately to completely dissatisfied. In the attempt to define the elements that contributed to satisfaction in the primary work setting, of the 110 responding in Table 11, 41.8% (n=46) stated that "cooperative staff relationships" was their first choice among the various elements. In Table 12 dissatisfaction in their primary work setting was related to the element, "conflictive staff relationships" by 28.6% (n=14). Of the elements in both tables which were stated to lead to satisfaction or dissatisfaction, "financial remuneration" was in third place, 8.2% (n=9), and 10.2% (n=5) respectively. The total numbers reporting satisfaction were appreciably greater than those reporting dissatisfaction.

Table 9

Primary Work Settings

| Work Setting | Frequency (n=129) | Percentage |
|---|---|---|
| Community care | 51 | 39.5 |
| Child and family psychiatry | 22 | 17.1 |
| Counseling | 10 | 7.8 |
| Child guidance clinic | 8 | 6.2 |
| Psychiatric hospital | 7 | 5.4 |
| Adult psychiatry | 6 | 4.7 |
| Catholic Marriage Advisory Council | 2 | 1.5 |
| Other | 23 | 17.8 |

Table 10

Levels of Satisfaction With Primary Work Setting

| Levels | | Frequency (n=127) | Percentage |
|---|---|---|---|
| 1 | Completely satisfied | 11 | 8.7 |
| 2 | Moderately satisfied | 57 | 44.9 |
| 3 | Satisfied | 42 | 33.1 |
| 4 | Moderately dissatisfied | 12 | 9.4 |
| 5 | Completely dissatisfied | 5 | 3.9 |

Table 11

Elements Contributing to Job Satisfaction in Primary Work Setting

| Contributing Elements | Rankings First (n=110) | Second (n=102) | Third (n=98) |
|---|---|---|---|
| Cooperative staff relationships | | | |
| Frequency | 46 | 28 | 13 |
| Percentage | 41.8 | 27.5 | 13.3 |
| Challenging intellectual environment | | | |
| Frequency | 33 | 37 | 16 |
| Percentage | 30.0 | 36.3 | 16.3 |
| Adequate remuneration | | | |
| Frequency | 9 | 14 | 23 |
| Percentage | 8.2 | 13.7 | 22.5 |
| Good physical facilities | | | |
| Frequency | 5 | 9 | 24 |
| Percentage | 4.5 | 8.8 | 24.5 |
| Satisfactory secretarial staff | | | |
| Frequency | 1 | 8 | 16 |
| Percentage | 0.9 | 7.8 | 16.3 |
| Other elements | | | |
| Frequency | 16 | 6 | 6 |
| Percentage | 14.5 | 5.9 | 6.1 |

Table 12

Elements Contributing to Dissatisfaction in Primary Work Setting

| Contributing Elements | Rankings | | |
|---|---|---|---|
| | First (n=49) | Second (n=32) | Third (n=22) |
| Conflictual staff relationships | | | |
| Frequency | 14 | 6 | 2 |
| Percentage | 28.6 | 18.8 | 9.1 |
| Overmuch paper work | | | |
| Frequency | 7 | 6 | 5 |
| Percentage | 14.3 | 18.8 | 22.7 |
| Inadequate remuneration | | | |
| Frequency | 5 | 4 | 1 |
| Percentage | 10.2 | 12.5 | 4.5 |
| Boring routine | | | |
| Frequency | 4 | 3 | 5 |
| Percentage | 8.2 | 9.4 | 22.7 |
| Inadequate physical facility | | | |
| Frequency | 3 | 9 | 5 |
| Percentage | 6.1 | 28.1 | 22.7 |
| Other elements | | | |
| Frequency | 16 | 4 | 4 |
| Percentage | 32.7 | 12.5 | 18.2 |

To the question whether their training in family therapy might have led to a change in their primary work setting, 56.6% (n=34) replied that it had had little or no influence in such a decision, while 11.8% (n=7) indicated that it had had some or had been the main influence (See Table 13). However, Table 14 demonstrates a trend to increased participation in family therapy activities by the respondents who reported that 2.3% (n=3) formerly had had a private practice and that 13.1% (n=17) were now engaged in that activity but not as their primary work. Again the number who formerly taught family therapy at a university or non-university setting as a parttime activity had risen from 4.6% (n=6) to 13.1% (n=17). While family therapy training may not have been instrumental in many people changing their primary work settings, there are indications that their training influenced their parttime activities.

Table 15 shows that income obtained from primary work settings ranges from under 5,000 Irish pounds (n=6) to over 16,000 (n=14) with the modal income ranging from 12,000 to 13,999 (n=37). The Irish pound at the time of this study averaged 1.25 U.S. dollars.

Table 13

Levels of Influence of Training On Change of Work Setting

| Degree of Influence | | Frequency (n=60) | Percentage |
|---|---|---|---|
| 1 | No influence | 26 | 43.3 |
| 2 | Slight influence | 8 | 13.3 |
| 3 | Not a consideration | 7 | 11.7 |
| 4 | Strong influence | 4 | 6.7 |
| 5 | Main influence | 3 | 5.0 |
| | Not applicable | 12 | 20.0 |

Table 14

Current and Former Work Settings

| | Current | | | Former | | |
|---|---|---|---|---|---|---|
| Work Setting | f | % | n | f | % | n |
| School counselor | 3 | 2.3 | 129 | 14 | 10.8 | 130 |
| General hospital | 12 | 9.3 | 129 | 22 | 17.1 | 129 |
| Child and family psychiatry | 43 | 33.3 | 129 | 32 | 24.8 | 129 |
| Adult psychiatry: in-patient | 15 | 11.6 | 129 | 31 | 24.0 | 129 |
| Adult psychiatry: out-patient | 20 | 15.5 | 129 | 29 | 22.4 | 129 |
| Private practice in family therapy | 17 | 13.3 | 128 | 3 | 2.3 | 129 |
| Mentally handicapped | 17 | 13.3 | 128 | 24 | 18.6 | 129 |
| Teach family therapy (university) | 7 | 5.5 | 128 | 4 | 3.1 | 129 |
| Teach family therapy (non-university) | 10 | 7.8 | 128 | 2 | 1.6 | 129 |
| Church: voluntary organization | 12 | 9.4 | 128 | 10 | 7.7 | 129 |
| Non-church: voluntary organization | 5 | 3.9 | 128 | 7 | 5.4 | 129 |
| General medical practice | 6 | 4.6 | 128 | 2 | 1.6 | 129 |
| Drug program | 9 | 7.0 | 128 | 2 | 1.6 | 129 |
| Alcohol program | 16 | 12.5 | 128 | 8 | 6.2 | 129 |
| Community care | 35 | 27.1 | 129 | 27 | 20.9 | 129 |
| Court system | 9 | 7.0 | 128 | 10 | 7.7 | 129 |
| Counseling center | 14 | 10.9 | 128 | 5 | 3.9 | 129 |
| Psychiatric dept. (general hospital) | 7 | 5.4 | 129 | 10 | 7.7 | 129 |
| Counseling students (university) | 5 | 3.8 | 129 | 7 | 5.4 | 129 |
| Other | 27 | 20.8 | 130 | 12 | 9.3 | 129 |

Table 15

Income From Primary Work Setting

| Income in Irish Poundsa | Frequency (n=119) | Percentage |
|---|---|---|
| Under 5,000 | 6 | 5.0 |
| 5,000 - 8,999 | 15 | 12.6 |
| 9,000 - 11,999 | 31 | 26.1 |
| 12,000 - 13,999 | 37 | 31.1 |
| 14,000 - 15,999 | 16 | 13.4 |
| Over 16,000 | 14 | 11.8 |

[a]The Irish pound at the time of study was valued at $1.25 (U.S.)

## Influences in Becoming a Family Therapist

Table 16 shows that 28.2% (n=29) first heard of family therapy outside of Ireland while 71.8% (n=74) heard of it at home, and the prime setting was a university context, 24.8% (n=25), followed by the context of a workshop, 20.8% (n=21). There is a noticeable increase in the numbers who heard of family therapy from 1976 to 1984 from those in the previous decade: 70.3% (n=71) compared to 29.7% (n=30).

The number of respondents who reported that a family member was a mental health professional is found in Table 17. Those who reported that a member of their family of origin is a therapist of some description formed 12.7% (n=14), and of these parents form 1.8% (n=2) and the remaining 10.9% (n=12) were siblings. In the extended family spouses were the members who most often were reported as being mental health professionals, 13.6% (n=15).

The influences that prompted respondents to become family therapists are presented in Table 18. Their colleagues' persuasive power on the benefits of family therapy was the major influence that led them to training, 27.4% (n=29), while a more professional reason was chosen as second influence, "to learn additional techniques," 21.7% (n=33). The third motive was their "frustration with other approaches," 12.3% (n=13).

Table 16

Geographical Area - Setting, Occasion and Year Respondents First Heard of Family Therapy

| Geographical Area | Frequency (n=103) | Percentage |
|---|---|---|
| Ireland | 74 | 71.8 |
| United Kingdom | 22 | 21.4 |
| United States | 4 | 3.9 |
| Canada | 2 | 1.9 |
| Australia | 1 | 1.0 |

| Setting/Occasion | Frequency (n=101) | Percentage |
|---|---|---|
| University | 25 | 24.8 |
| Workshop | 21 | 20.8 |
| Workplace | 16 | 15.8 |
| Hospital | 9 | 8.9 |
| Family Therapy Center | 9 | 8.9 |
| Colleagues | 7 | 6.9 |
| Training | 6 | 5.9 |
| Personal Reading | 4 | 4.0 |
| Other | 4 | 4.0 |

| Year | Frequency (n=101) | Percentage |
|---|---|---|
| 1966-1975 | 30 | 29.7 |
| 1976-1984 | 71 | 70.3 |

Table 17

Family Members Who Are Therapists

| Family Member | Frequency (n=110) | Percentage |
|---|---|---|
| Spouse | 15 | 13.6 |
| Sibling | 12 | 10.9 |
| Aunt, Uncle, Cousin | 7 | 6.4 |
| Father | 1 | 0.9 |
| Mother | 1 | 0.9 |
| No member | 74 | 67.2 |

Table 18

The Three Most Significant Influences That Prompted Respondents To Become Family Therapists

| Influence | 1st Choice (n=106) | 2nd Choice (n=105) | 3rd Choice (n=108) |
|---|---|---|---|
| Professional colleagues | | | |
| Frequency | 29 | 15 | 9 |
| Percentage | 27.4 | 14.3 | 8.3 |
| To learn additional techniques | | | |
| Frequency | 23 | 30 | 18 |
| Percentage | 21.7 | 28.3 | 16.7 |
| Frustration with other approaches | | | |
| Frequency | 13 | 7 | 9 |
| Percentage | 12.3 | 6.7 | 8.3 |
| To meet job requirement | | | |
| Frequency | 11 | 11 | 10 |
| Percentage | 10.4 | 10.5 | 9.3 |
| Observing family therapist at work | | | |
| Frequency | 9 | 7 | 18 |
| Percentage | 8.5 | 6.7 | 16.7 |
| Reading, lectures | | | |
| Frequency | 7 | 14 | 11 |
| Percentage | 6.6 | 13.3 | 10.2 |
| Previous work with groups | | | |
| Frequency | 2 | 10 | 12 |
| Percentage | 1.9 | 9.5 | 11.1 |
| A felt need to change career | | | |
| Frequency | 2 | 3 | 3 |
| Percentage | 1.9 | 2.9 | 2.8 |
| Problems in one's family of origin | | | |
| Frequency | 2 | 2 | 4 |
| Percentage | 1.9 | 1.9 | 3.7 |
| To help friends with family problems | | | |
| Frequency | 1 | 1 | 2 |
| Percentage | 0.9 | 0.9 | 1.9 |
| To solve one's nuclear family problems | | | |
| Frequency | 1 | 1 | 2 |
| Percentage | 0.9 | 0.9 | 1.9 |
| A family member is a therapist | | | |
| Frequency | 1 | 1 | 3 |
| Percentage | 0.9 | 0.9 | 2.8 |
| To solve family problems in Ireland | | | |
| Frequency | 4 | 2 | 5 |
| Percentage | 3.8 | 1.9 | 4.6 |
| Other | | | |
| Frequency | 1 | 1 | 2 |
| Percentage | 0.9 | 0.9 | 1.9 |

## Professions and Qualifications

Many of the respondents had come to family therapy from a wide variety of backgrounds as can be seen in Table 19. However, the vast majority have come from the helping professions. Of those holding the B.A. degree, 44.7% (n=55) hold it in the arts, sciences, social science and engineering. Those who hold an M.A. or M.Sc. degree, 26.8% (n=33), have obtained them in the arts, sciences, psychiatric science and in social work. The number holding a medical degree forms 10.6% (n=13), while the Ph.D. is held by 4.1% (n=5) of the total. Other degrees reported were in home economics, theology, law and philosophy.

The respondents' professions were constructed by the author from a combination of their highest academic qualifications and their current work setting. Social workers formed the most frequent single profession, 43.1% (n=56), with psychologists, 28.5% (n=37) and counselors 7.7% (n=10) forming the next most frequent professions respectively. A qualification whose primary focus was on family therapy was obtained by 16 respondents, and as Table 20 shows, 81.2% (n=13) of these were obtained at a training center, while the remainder were obtained in a university context. Qualifications in which family therapy formed a part were obtained by 55 respondents and 83.6% (n=46) of these were obtained from a university either in Ireland, 36.4% (n=20) or abroad, 47.3% (n=26) (See Table 21).

Table 19

Degrees and Professions

| Degree | Frequency (n=123) | Percentage |
|---|---|---|
| B.A. | 23 | 18.7 |
| M.A. | 15 | 12.2 |
| B.Sc. | 3 | 2.4 |
| M.Sc. | 6 | 4.9 |
| B.Soc.Sc. | 28 | 22.8 |
| B.Eng. | 1 | 0.8 |
| Ph.D. | 5 | 4.1 |
| M.B.B.Ch. [M.D.] | 13 | 10.6 |
| M.Psych.Sc. | 6 | 4.9 |
| M.S.W. | 6 | 4.9 |
| Other | 17 | 13.8 |

| Profession | Frequency (n=130) | Percentage |
|---|---|---|
| Social Worker | 56 | 43.1 |
| Psychologist | 37 | 28.5 |
| Psychiatrist | 9 | 6.9 |
| Counsellor | 10 | 7.7 |
| Teacher | 2 | 1.5 |
| Doctor | 2 | 1.5 |
| Family Therapist | 3 | 2.3 |
| Other | 11 | 8.5 |

Table 20

Qualifications Whose Primary Focus Was Family Therapy and the Granting Institute

| Qualification | Frequency (n=16) | Percentage |
|---|---|---|
| Certificate | 11 | 68.8 |
| Degree | 3 | 18.7 |
| Diploma | 2 | 12.5 |
| **Granting Institute** | **Frequency (n=16)** | **Percentage** |
| Training center | 13 | 81.2 |
| University | 2 | 12.5 |
| University medical school | 1 | 6.3 |

Table 21

Qualifications in Which Courses in Family Therapy Were Offered and the Granting Institutes

| Qualification | Frequency (n=55) | Percentage |
|---|---|---|
| Certificate | 9 | 16.4 |
| Diploma | 27 | 49.1 |
| Degree | 19 | 34.5 |

| Granting Institute | Frequency (n=55) | Percentage |
|---|---|---|
| Irish University | 20 | 36.4 |
| University (U.K.) | 20 | 36.4 |
| University (U.S.) | 6 | 10.9 |
| Third Level (Ireland) | 3 | 5.4 |
| Third Level (U.K.) | 1 | 1.8 |
| Training Center(Ireland) | 4 | 7.3 |
| Training Center (U.K.) | 1 | 1.8 |

Of all the 123 qualifications reported a large number, 40.7% (n=50), were obtained outside Ireland. Two features are of note: first, the three degrees in family therapy and secondly, the four out of the five Ph.D.'s reported were obtained outside the country. Table 22 provides the complete breakdown of their numbers and percentages.

## Modalities and Methods of Supervision

This section of the study reports the descriptive statistics of the training and supervisory activities which the respondents undertook in the very recent past.

Live supervision was the first choice of modalities, 47.0% (n=32), and delayed ranked second, 20.5% (n=14), as Table 23 shows. Of the 75 who responded to the question of what was the predominant form of supervision that they had received in their training, 62.0% (n=49) reported receiving it in group and 38.0% (n=30) receiving it individually.

Those who received live supervision in group or individually reported in Tables 24 and 25 that the telephone was the prime method of supervision, with 62.5% (n=25) receiving it in group and with 42.9% (n=9) receiving it individually.

Table 22

Qualification Received Outside Ireland

| Qualification | Received by all respondents | Received outside Ireland | Percentage outside Ireland |
|---|---|---|---|
| Masters | 33 | 13 | 39.4 |
| Ph.D. | 5 | 4 | 80.0 |
| M.A. (Family Therapy) | 3 | 3 | 100.0 |
| Psychiatric Residency | 9 | 5 | 55.6 |

Table 23

Supervisory Modalities in Training

| Modalities | Rankings First (n=68) | Second (n=63) | Third (n=46) |
|---|---|---|---|
| Live supervision | | | |
| Frequency | 32 | 10 | 10 |
| Percentage | 47.0 | 15.9 | 21.7 |
| Delayed | | | |
| Frequency | 14 | 11 | 12 |
| Percentage | 20.5 | 17.5 | 26.1 |
| Pre/post session | | | |
| Frequency | 11 | 26 | 14 |
| Percentage | 16.2 | 41.3 | 30.4 |
| Co-Therapy | | | |
| Frequency | 6 | 14 | 8 |
| Percentage | 8.8 | 22.2 | 17.4 |
| Other | | | |
| Frequency | 5 | 2 | 2 |
| Percentage | 7.4 | 3.2 | 4.3 |

Table 24

Methods of Live Supervision Received in Group

| Methods | Rankings First (n=40) | Second (n=25) | Third (n=16) |
|---|---|---|---|
| Telephone | | | |
| Frequency | 25 | 2 | - |
| Percentage | 62.5 | 8.0 | - |
| Therapist walk-out | | | |
| Frequency | 5 | 17 | 3 |
| Percentage | 12.5 | 68.0 | 18.8 |
| Supervisor walk-in | | | |
| Frequency | 5 | 2 | 11 |
| Percentage | 12.5 | 8.0 | 69.0 |
| Bug-in-ear | | | |
| Frequency | 2 | - | 1 |
| Percentage | 5.0 | - | 6.3 |
| Group member walk-in | | | |
| Frequency | 2 | 4 | 1 |
| Percentage | 5.0 | 16.0 | 6.3 |
| Other | | | |
| Frequency | 1 | - | - |
| Percentage | 2.5 | - | - |

Table 25

Methods of Live Supervision Received Individually

| Methods | Rankings First (n=21) | Second (n=7) | Third (n=3) |
|---|---|---|---|
| Telephone | | | |
| Frequency | 9 | 1 | - |
| Percentage | 42.9 | 14.2 | - |
| Therapist walk-out | | | |
| Frequency | 3 | 4 | - |
| Percentage | 14.3 | 57.1 | - |
| Supervisor walk-in | | | |
| Frequency | 3 | 2 | 1 |
| Percentage | 14.3 | 28.6 | 33.3 |
| Bug-in-ear | | | |
| Frequency | 2 | - | 1 |
| Percentage | 9.5 | - | 33.3 |
| Group member walk-in | | | |
| Frequency | 1 | - | 1 |
| Percentage | 4.8 | - | 33.3 |
| Other | | | |
| Frequency | 3 | - | - |
| Percentage | 14.3 | - | - |

In delayed supervision, those who received it in group reported that the prime supervisory method was videotape, 62.9% (n=22), and for those who received delayed supervision individually, self-report was the prime method used, 66.7% (n=18) (See Tables 26 and 27).

The hours of supervision received by the respondents are reported in Table 28. Those who received over 50 hours of family therapy supervision formed 40.0% (n=20) of the group reporting, while the highest number of hours, 100 plus, was received by 27.4% (n=14). The proportion of those who report receiving family therapy supervision, 33.3% (n=11), received all of theirs outside Ireland, while 66.7% (n=22) received all of theirs at home (See Table 29).

The elements in their training which most helped the respondents professionally are presented in Table 30. Live supervision was selected as the first choice by 22.6% (n=24) while the second and third choices were certain qualities of the supervisor which where: "conceptual clarity," 20.8% (n=22), and "interpersonal skills," 17.0% (n=18). When the respondents chose the elements that were personally helpful to them, the first choice was "interaction with the supervisor," 22.9% (n=22), and the other two elements are reported in Table 31.

Table 26

Methods of Delayed Supervision in Group

| Methods | Rankings First (n=35) | Second (n=22) | Third (n=9) |
|---|---|---|---|
| Videotape | | | |
| Frequency | 22 | 6 | 2 |
| Percentage | 62.9 | 27.3 | 22.2 |
| Self-report | | | |
| Frequency | 11 | 9 | 1 |
| Percentage | 31.4 | 40.9 | 11.1 |
| Audiotape | | | |
| Frequency | - | 3 | - |
| Percentage | - | 13.6 | - |
| Personal issues | | | |
| Frequency | - | 4 | 5 |
| Percentage | - | 18.2 | 55.6 |
| Other | | | |
| Frequency | 2 | - | 1 |
| Percentage | 5.7 | - | 11.1 |

Table 27

Methods of Delayed Supervision Received Individually

| Methods | Rankings First (n=27) | Second (n=18) | Third (n=13) |
|---|---|---|---|
| Self-report | | | |
| Frequency | 18 | 3 | 1 |
| Percentage | 66.7 | 16.7 | 7.7 |
| Videotape | | | |
| Frequency | 5 | 7 | - |
| Percentage | 18.5 | 38.9 | - |
| Audiotape | | | |
| Frequency | 2 | 3 | 3 |
| Percentage | 7.4 | 16.7 | 23.1 |
| Personal issues | | | |
| Frequency | 1 | 5 | 9 |
| Percentage | 3.7 | 27.8 | 69.2 |
| Other | | | |
| Frequency | 1 | - | - |
| Percentage | 3.7 | - | - |

Table 28

The Hours of Supervision During Training

| Hours Received | Frequency (n=51) | Percentage |
|---|---|---|
| 1 - 9 | 9 | 17.6 |
| 10 - 19 | 6 | 11.8 |
| 20 - 29 | 6 | 11.8 |
| 30 - 39 | 4 | 7.8 |
| 40 - 49 | 6 | 11.8 |
| 50 - 79 | 3 | 5.9 |
| 80 - 99 | 3 | 5.9 |
| 100 and over | 14 | 27.4 |

Table 29

Countries Where Respondents Received All Their Supervision

| Country | Frequency (n=33) | Percentage |
|---|---|---|
| Ireland | 22 | 66.7 |
| United Kingdom | 5 | 15.1 |
| United States | 6 | 18.2 |

Table 30

Ranking of Elements That Were Professionally Helpful in the Training Process

| Elements | | Rankings First (n=106) | Second (n=101) | Third (n=98) |
|---|---|---|---|---|
| Live supervision | | | | |
| | Frequency | 24 | 12 | 6 |
| | Percentage | 22.6 | 11.9 | 6.1 |
| Conceptual clarity of supervisor | | | | |
| | Frequency | 22 | 14 | 14 |
| | Percentage | 20.8 | 13.9 | 14.3 |
| Interpersonal skills of supervisor | | | | |
| | Frequency | 18 | 14 | 18 |
| | Percentage | 17.0 | 13.9 | 18.4 |
| Interaction with supervisor | | | | |
| | Frequency | 12 | 7 | 6 |
| | Percentage | 11.3 | 6.9 | 6.1 |
| Videotape playback | | | | |
| | Frequency | 7 | 7 | 11 |
| | Percentage | 6.6 | 6.9 | 11.2 |
| Theoretical dimensions | | | | |
| | Frequency | 7 | 19 | 12 |
| | Percentage | 6.6 | 18.8 | 12.2 |
| Supervisor feedback on work | | | | |
| | Frequency | 6 | 9 | 6 |
| | Percentage | 5.7 | 8.9 | 6.1 |
| Cooperation with peers | | | | |
| | Frequency | 4 | 10 | 15 |
| | Percentage | 3.8 | 9.9 | 15.3 |
| Feedback from peers | | | | |
| | Frequency | 4 | 7 | 10 |
| | Percentage | 3.8 | 6.9 | 10.2 |
| Audiotape playback | | | | |
| | Frequency | - | 2 | - |
| | Percentage | - | 2.0 | - |
| Other | | | | |
| | Frequency | 2 | - | - |
| | Percentage | 1.9 | - | - |

Table 31

Ranking of Elements That Were Personally Helpful in the Training Process

| Elements | | Rankings First (n=96) | Second (n=97) | Third (n=93) |
|---|---|---|---|---|
| Interaction with supervisor | | | | |
| | Frequency | 22 | 8 | 6 |
| | Percentage | 22.9 | 8.2 | 6.5 |
| Interpersonal skills of supervisor | | | | |
| | Frequency | 14 | 18 | 11 |
| | Percentage | 14.6 | 18.6 | 11.8 |
| Conceptual clarity of supervisor | | | | |
| | Frequency | 12 | 9 | 13 |
| | Percentage | 12.5 | 9.3 | 14.0 |
| Live supervision | | | | |
| | Frequency | 11 | 7 | 10 |
| | Percentage | 11.4 | 7.2 | 10.8 |
| Cooperation with peers | | | | |
| | Frequency | 11 | 16 | 13 |
| | Percentage | 11.4 | 16.5 | 14.0 |
| Theoretical dimensions | | | | |
| | Frequency | 9 | 10 | 11 |
| | Percentage | 9.4 | 10.3 | 11.8 |
| Feedback from peers | | | | |
| | Frequency | 7 | 10 | 13 |
| | Percentage | 7.3 | 10.3 | 14.0 |
| Videotape playback | | | | |
| | Frequency | 6 | 3 | 5 |
| | Percentage | 6.3 | 3.1 | 5.4 |
| Supervisor feedback on work | | | | |
| | Frequency | 2 | 16 | 11 |
| | Percentage | 2.1 | 16.5 | 11.8 |
| Audiotape playback | | | | |
| | Frequency | - | - | - |
| | Percentage | - | - | - |
| Other | | | | |
| | Frequency | 2 | - | - |
| | Percentage | 2.1 | - | - |

Those elements which hindered the respondents in their training professionally and personally are presented in Tables 32 and 33. There was a variety of elements that hindered their professional development, with "previous inadequate skills training," 22.3% (n=21), given as the prime element, with "lack of finance," 14.9% (n=14), and "discomfort with theoretical framework," 12.8% (n=12), in second and third places respectively. Two of the elements that hindered personal growth are quite similar: "feeling inadequate," 27.7% (n=23), as first choice, and "need to maintain image of competency," 13.3% (n=11), as third choice. The second element was stated to be "inadequate skills training," and this formed 14.5% (n=12) of their responses.

## Theoretical Orientations

This section attempts to record the most influential theories which underpin the work of this first generation of family therapy practitioners. Their basic philosophy of therapy and what they considered the most influential factor in their learning of family therapy are recorded.

The theories which the respondents recorded as influencing their work are presented in Table 34. Their first three choices were the Communication Approach of Satir, 24.7% (n=22), the Milan School, 22.5% (n=20), and the

Structural Approach, 14.7% (n=13). However, the first three theories in their second choices paint a very different picture where the Structural Approach is chosen first while the Milan and the Strategic form a joint second.

In the expression of their basic philosophy of family therapy, 52.9% (n=54) held it to be a theoretical approach to solving problems, while the remaining 47.1% (n=48) saw it merely as a skills approach which when incorporated with individual therapy is useful in solving problems (See Table 35).

The picture that emerges from what they considered the most influential factor in learning family therapy is a fragmented one indeed, and this is presented in Table 36. However, the most strongly expressed single factor, "gaining a conceptual understanding of systems," 40.4% (n=40), is supported twice as strongly as the next two factors: "acquiring a set of specific skills" and one's "own personal growth and development, " each of which was supported by 21.2% (n=21) of respondents.

Table 32

Elements in Training that Hindered Professional Development

| Elements | Rankings First (n=94) | Second (n=89) | Third (n=69) |
|---|---|---|---|
| Previous inadequate skills training | | | |
| Frequency | 21 | 12 | 3 |
| Percentage | 22.3 | 13.5 | 4.3 |
| Lack of finance | | | |
| Frequency | 14 | 8 | 6 |
| Percentage | 14.9 | 9.0 | 8.7 |
| Discomfort with theoretical framework | | | |
| Frequency | 12 | 10 | 8 |
| Percentage | 12.8 | 11.2 | 11.6 |
| Feeling inadequate | | | |
| Frequency | 12 | 12 | 20 |
| Percentage | 12.8 | 13.5 | 29.0 |
| Need to maintain image of competency | | | |
| Frequency | 12 | 15 | 11 |
| Percentage | 12.8 | 16.9 | 16.0 |
| Resistance to supervisor's input | | | |
| Frequency | 4 | 6 | 8 |
| Percentage | 4.3 | 6.7 | 11.6 |
| Family of origin issues | | | |
| Frequency | 4 | 7 | 4 |
| Percentage | 4.3 | 7.9 | 5.8 |
| Competition with other trainees | | | |
| Frequency | 3 | 3 | 2 |
| Percentage | 3.2 | 3.4 | 2.9 |
| Poor interaction with other trainees | | | |
| Frequency | 2 | 1 | 3 |
| Percentage | 2.1 | 1.1 | 4.3 |
| Poor relationship with supervisor | | | |
| Frequency | 2 | 3 | 2 |
| Percentage | 2.1 | 3.4 | 2.9 |
| Other | | | |
| Frequency | 8 | 8 | 2 |
| Percentage | 8.5 | 9.0 | 2.9 |

Table 33

Elements in Training that Hindered Personal Development

| Elements | Rankings First (n=83) | Second (n=76) | Third (n=60) |
|---|---|---|---|
| Feeling inadequate | | | |
| Frequency | 23 | 15 | 10 |
| Percentage | 27.7 | 19.7 | 16.7 |
| Previous inadequate skills training | | | |
| Frequency | 12 | 9 | 3 |
| Percentage | 14.5 | 11.8 | 5.0 |
| Need to maintain image of competency | | | |
| Frequency | 11 | 18 | 12 |
| Percentage | 13.3 | 23.7 | 20.0 |
| Family of origin issues | | | |
| Frequency | 10 | 6 | 9 |
| Percentage | 12.0 | 7.9 | 15.0 |
| Discomfort with theoretical framework | | | |
| Frequency | 8 | 6 | 4 |
| Percentage | 9.6 | 7.9 | 6.7 |
| Lack of finance | | | |
| Frequency | 5 | 3 | 8 |
| Percentage | 6.0 | 3.9 | 13.3 |
| Poor interaction with other trainees | | | |
| Frequency | 4 | 3 | 4 |
| Percentage | 4.8 | 3.9 | 6.7 |
| Resistance to supervisor's input | | | |
| Frequency | 3 | 4 | 5 |
| Percentage | 3.6 | 5.3 | 8.3 |
| Poor relationship with supervisor | | | |
| Frequency | 2 | 2 | 1 |
| Percentage | 2.4 | 2.6 | 1.7 |
| Competition with other trainees | | | |
| Frequency | 1 | 7 | 2 |
| Percentage | 1.2 | 9.2 | 3.3 |
| Other | | | |
| Frequency | 4 | 3 | 2 |
| Percentage | 4.8 | 3.9 | 3.3 |

Table 34

Most Influential Theories

| Theories | Rankings First (n=89) | Second (n=85) | Third (n=82) |
|---|---|---|---|
| Communication Approach | | | |
| Frequency | 22 | 9 | 4 |
| Percentage | 24.7 | 10.6 | 4.9 |
| Milan School | | | |
| Frequency | 20 | 10 | 8 |
| Percentage | 22.4 | 11.8 | 9.8 |
| Structural Approach | | | |
| Frequency | 13 | 25 | 16 |
| Percentage | 14.7 | 29.4 | 19.5 |
| Strategic Approach | | | |
| Frequency | 10 | 10 | 23 |
| Percentage | 11.2 | 11.8 | 28.0 |
| Psychodynamic | | | |
| Frequency | 7 | 4 | 7 |
| Percentage | 7.9 | 4.7 | 8.5 |
| Family Systems | | | |
| Frequency | 6 | 5 | 6 |
| Percentage | 6.7 | 5.9 | 7.3 |
| Interactional Approach | | | |
| Frequency | 2 | 6 | 4 |
| Percentage | 2.3 | 7.1 | 4.9 |
| Transactional Approach | | | |
| Frequency | 2 | 5 | - |
| Percentage | 2.3 | 5.9 | - |
| Behavioral | | | |
| Frequency | 2 | 4 | 3 |
| Percentage | 2.3 | 4.7 | 3.7 |
| Open Systems | | | |
| Frequency | 2 | 2 | 4 |
| Percentage | 2.3 | 2.4 | 4.9 |
| Problem Centered Approach | | | |
| Frequency | 2 | 1 | 5 |
| Percentage | 2.3 | 1.2 | 6.1 |
| Symbolic/Experiential | | | |
| Frequency | 1 | 2 | 2 |
| Percentage | 1.1 | 2.4 | 2.4 |
| Integrative Approach | | | |
| Frequency | - | 2 | - |
| Percentage | - | 2.4 | - |

Table 35

Respondents' Basic Philosophy of Family Therapy

| Philosophy | Frequency (n=102) | Percentage |
|---|---|---|
| Alone, it is useful in solving problems | 31 | 30.4 |
| Only represents useful skills | 26 | 25.5 |
| Method of choice over others | 23 | 22.5 |
| Method in combination with individual therapy | 22 | 21.6 |

Table 36

Most Influential Factor In Learning Family Therapy

| Factor | Frequency (n=99) | Percentage |
|---|---|---|
| Gaining a conceptual understanding of systems | 40 | 40.4 |
| Acquiring a set of specific skills | 21 | 21.2 |
| Own personal growth and development | 21 | 21.2 |
| Differentiation from family of origin | 5 | 5.1 |
| Enacting alternative patterns in sessions | 5 | 5.1 |
| Overcoming own problems in personal therapy | 4 | 4.0 |
| Other | 3 | 3.0 |

## Readings That Were Helpful

Of the family journals which respondents found helpful in their work, Family Process, from the United States, was the clear favorite: 71.4% (n=35). The British Journal of Family Therapy was their second choice: 12.2% (n=6). Other journals mentioned were: The Australian Journal of Family Therapy, Family Systems Medicine, and The International Journal of Family Therapy (See Table 37).

Journals were more readily available to respondents in their work settings than through personal subscription as is shown in Table 38. Of the specific family therapy journals received in both work settings and personally, Family Process is the one that is most frequently subscribed to, 28.4% (n=33), and 7.5% (n=9) respectively. The second choice at work settings was The Journal of Family Therapy, 21.6% (n=25), while the second choice personally was Family Therapy Networker, 6.7% (n=8).

The two books which were chosen as their joint first choice were Haley's Problem Solving Therapy and Hoffman's Foundations of Family Therapy, both at 19.2% (n=10), but Haley's was most often quoted across the board as being most helpful. Minuchin's Families and Family Therapy was ranked their third choice by 11.5% (n=6). Among others were Tactics of Change (Fisch, et al.), The Turning Point (Capra) and Strategic Family Therapy (Madanes) (See Table 39).

Table 37

Most Helpful Journals

| Journal | | 1st Choice (n=49) | 2nd Choice (n=31) | 3rd Choice (n=15) |
|---|---|---|---|---|
| Family Process | | | | |
| | Frequency | 35 | 3 | 1 |
| | Percentage | 71.4 | 9.7 | 6.9 |
| Journal of Family Therapy | | | | |
| | Frequency | 6 | 11 | 2 |
| | Percentage | 12.2 | 35.5 | 13.3 |
| Journal of Strategic and Systemic Therapies | | | | |
| | Frequency | - | 3 | 4 |
| | Percentage | - | 9.7 | 26.7 |
| The Family Therapy Networker | | | | |
| | Frequency | - | 2 | 2 |
| | Percentage | - | 6.5 | 13.3 |
| Journal of Marital and Family Therapy | | | | |
| | Frequency | - | 3 | 1 |
| | Percentage | - | 9.7 | 6.7 |
| Other | | | | |
| | Frequency | 8 | 9 | 5 |
| | Percentage | 16.3 | 29.0 | 33.3 |

Table 38

Journals Received At Primary Work Setting and Personally

| Journal | Work Setting Frequency | Work Setting Percentage (n=116) | Personally Frequency | Personally Percentage (n=120) |
|---|---|---|---|---|
| Irish Social Worker | 44 | 37.9 | 12 | 10.0 |
| Family Process | 33 | 28.4 | 9 | 7.5 |
| Journal of Family Therapy | 25 | 21.6 | 3 | 2.3 |
| Orthopsychiatry | 19 | 16.4 | 1 | 0.8 |
| Family Therapy Networker | 11 | 9.5 | 8 | 6.7 |
| International Journal of Family Therapy | 8 | 6.9 | 2 | 1.7 |
| Journal of Strategic and Systemic Therapies | 4 | 3.4 | 2 | 1.7 |
| Australian Journal of Family Therapy | 3 | 2.6 | 2 | 1.7 |
| Family Studies Abstracts | 2 | 1.7 | - | - |
| Journal of Family Issues | 2 | 1.7 | - | - |
| Other | 15 | 13.5 | 3 | 2.5 |

Table 39

Most Helpful Books

| Book | 1st Choice (n=52) | 2nd Choice (n=39) | 3rd Choice (n=29) |
|---|---|---|---|
| Problem Solving Therapy (J. Haley) | | | |
| Frequency | 10 | 5 | 6 |
| Percentage | 19.2 | 12.8 | 20.7 |
| Foundations of Family Therapy (L. Hoffman) | | | |
| Frequency | 10 | 1 | 6 |
| Percentage | 19.2 | 2.6 | 20.7 |
| Families and Family Therapy (S. Minuchin) | | | |
| Frequency | 6 | 3 | 1 |
| Percentage | 11.5 | 7.7 | 3.4 |
| Paradox and Counterparadox (M. Pallazzoli) | | | |
| Frequency | 5 | 4 | 1 |
| Percentage | 9.3 | 10.3 | 3.4 |
| Peoplemaking (V. Satir) | | | |
| Frequency | 1 | 4 | - |
| Percentage | 1.9 | 10.3 | - |
| Family Therapy Techniques (Minuchin & Fishman) | | | |
| Frequency | 2 | - | 1 |
| Percentage | 3.8 | - | 3.4 |
| Tactics of Change (R. Fisch, et al.) | | | |
| Frequency | 2 | - | 2 |
| Percentage | 3.8 | - | 6.9 |
| Other | | | |
| Frequency | 16 | 22 | 12 |
| Percentage | 30.8 | 56.4 | 41.4 |

Since family therapy is a relatively new theoretical approach to problems to availability of books in university and work place libraries is very limited as is shown in Table 40. The two main sources were family therapists who obtained them at their own expense, 63.1% (n=60) and their peers from whom the books were borrowed, 21.1% (n=20).

## Personal Issues After Training

When asked if their family therapy training had any beneficial results in their own family lives, 75.7% (n=81) replied in the affirmative, while 24.3% (n=26) stated that it had had non-beneficial results.

The four main beneficial effects are presented in Table 41, of which the most frequent one reported was "understanding the family system," 43.5% (n=30) of the respondents. When asked what difficulty or difficulties they may have experienced as a result of their training, 87 (79.8%) replied that no difficulty had followed. However, in Table 42, those who expressed having difficulties, 20.2% (n=22), stated that the main problem came from the frustration which followed the collapse of the high expectations raised by their training.

Table 40

Sources of Books on Family Therapy

| Source | Rankings First (n=95) | Second (n=70) | Third (n=47) |
|---|---|---|---|
| Purchase at own expense | | | |
| Frequency | 60 | 10 | 4 |
| Percentage | 63.1 | 14.3 | 8.5 |
| Borrow from peers | | | |
| Frequency | 20 | 17 | 7 |
| Percentage | 21.1 | 24.3 | 14.9 |
| Borrow from work setting | | | |
| Frequency | 7 | 29 | 21 |
| Percentage | 7.4 | 41.4 | 44.7 |
| Borrow from university library | | | |
| Frequency | 5 | 7 | 10 |
| Percentage | 5.3 | 10.0 | 21.3 |
| Borrow from public library | | | |
| Frequency | 1 | 6 | 4 |
| Percentage | 1.1 | 8.6 | 8.5 |
| Other | | | |
| Frequency | 2 | 1 | 1 |
| Percentage | 2.1 | 1.4 | 2.1 |

Table 41

Beneficial Effects of Family Therapy Training On Respondents' Family Life and How It Was Beneficial

| | Frequency (n=107) | Percentage |
|---|---|---|
| Beneficial | 81 | 75.7 |
| Non-beneficial | 26 | 24.3 |

| Beneficial effects | Frequency (n=69) | Percentage |
|---|---|---|
| Understanding of family system | 30 | 43.5 |
| Communication of feelings | 17 | 24.6 |
| Awareness of family interactions | 10 | 14.5 |
| Tolerance of conflicting opinions | 6 | 8.7 |
| Other | 6 | 8.7 |

Table 42

Difficulties of Integrating Family Therapy Training With Respondents' Family Life

| | Frequency (n=109) | Percentage |
|---|---|---|
| Experienced difficulties | 22 | 20.2 |
| Experienced no difficulties | 87 | 79.8 |

| Difficulties experienced | Frequency (n=22) | % |
|---|---|---|
| Frustration as expectations had been raised | 7 | 31.8 |
| Tendency to treat own family as a client | 6 | 27.3 |
| Increased difficulties in marriage | 3 | 13.6 |
| Own family expected easier life at home | 2 | 9.1 |
| Other | 4 | 18.2 |

The respondents' personal commitment to continue their training may be gauged by their efforts to seek out peer consultation. Of the 92 who responded, 59.8% (n=55) stated that they consult with their peers and Table 43 presents the structure of this consultation. The weekly meeting is held by 45.3% (n=24) and the most prevalent numbers at meetings are 2 and 3 people, 43.1% (n=22). Meetings last 1 and 2 hours, 87.8% (n=43) of the time, while the most popular form is the open forum type, 53.7% (n=36). Other formats such as "one person presents" and "paper read followed by discussion" are equally used, 24.6% (n=16).

Table 43

Peer Consultation, Numbers That Meet, Frequency, Duration and Structure of Meetings

| | Frequency | Percentage |
|---|---|---|
| Consult with peers | 55 | 59.8 |
| Do not consult with peers | 37 | 40.2 |
| **Number of persons who meet** | | |
| Two | 12 | 23.5 |
| Three | 10 | 19.6 |
| Four | 8 | 15.7 |
| Five | 7 | 13.7 |
| Six | 2 | 3.9 |
| Seven | 3 | 5.9 |
| Eight | 3 | 5.9 |
| Ten | 5 | 9.8 |
| Sixteen | 1 | 2.0 |
| **Occurrence of consultation** | | |
| Weekly | 24 | 45.3 |
| Fortnightly | 15 | 28.3 |
| Monthly | 4 | 7.5 |
| Other | 10 | 18.9 |
| **Number of hours in consultation** | | |
| One | 22 | 49.9 |
| Two | 21 | 42.9 |
| Three | 3 | 6.1 |
| Four | 1 | 2.0 |
| Five | 2 | 4.1 |
| **Structure of consultation** | | |
| One person presents | 16 | 24.6 |
| Open forum | 36 | 53.7 |
| Paper read followed by discussion | 16 | 24.6 |

## Institutional Issues After Training

This section will describe statistically the reactions to family therapy training and supervision in the professional and personal lives of the respondents and their efforts to promote family therapy.

With 114 respondents reporting their colleagues' attitudes to family therapy since the beginning of the 1980 decade, 69.3% (n=79) stated that it had found increased acceptance, while 27.2% (n=31) said that they had noticed no change (See Table 44). Their training prompted them to increase the acceptance of family therapy in institutions where it had never before been introduced. Table 45 shows that 78.4% (n=69) attempted to increase its acceptance, and of this number 38 specified the factors which they thought facilitated this acceptance. The main factors that they found were: "staff trained and enthusiastic," 44.7% (n=17), and the "institute open to new ideas," 26.3% (n=10).

When reporting on their efforts to introduce family therapy 43.3% (n=29) stated that they experienced resistance beyond the normal, while the majority, 56.7% (n=38), felt that whatever resistance they met was not beyond the normal for new ideas within an institutional context. The ways in which this resistance was shown are presented in Table 46.

Table 44

Attitude of Respondents' Colleagues Towards Family Therapy Since 1980

| Attitude | Frequency (n=114) | Percentage |
|---|---|---|
| Increasing acceptance | 79 | 69.3 |
| Increasing resistance | 4 | 3.5 |
| No change | 31 | 27.2 |

Table 45

Attempts to Increase Acceptance of Family Therapy In Institutional Settings, and Factors Accounting for Acceptance

| | Frequency (n=88) | Percentage |
|---|---|---|
| Attempts to increase acceptance | 69 | 78.4 |
| No attempts to increase acceptance | 19 | 21.6 |

| Factors accounting for acceptance | Frequency (n=38) | Percentage |
|---|---|---|
| Staff trained and enthusiastic | 17 | 44.7 |
| Institute open to new ideas | 10 | 26.3 |
| Director's initiative or indifference | 8 | 21.1 |
| Respondent only suggests family therapy | 2 | 5.3 |
| Other | 1 | 2.6 |

Table 46

Resistance to Family Therapy in Institutional Settings, Ways This Resistance Was Shown and Respondents' Reactions

| | Frequency (n=67) | Percentage |
|---|---|---|
| Resistance Beyond the Normal | 29 | 43.3 |
| Resistance Not Beyond the Normal | 38 | 56.7 |
| **Ways resistance was shown** | **(n=25)** | |
| Ignore existence of family therapy | 10 | 40.0 |
| Dismiss concept of family therapy | 5 | 20.0 |
| Opposition for director and staff | 3 | 12.0 |
| Opposition to a new theory and practice | 3 | 12.0 |
| Isolate family therapy advocate | 2 | 8.0 |
| Director shows no interest | 1 | 4.0 |
| Doubts cast about its practicality | 1 | 4.0 |
| **Reactions** | **(n=20)** | |
| Did therapy quietly within system | 10 | 50.0 |
| Respondent became angry and frustrated | 4 | 20.0 |
| Sought colleague support | 2 | 10.0 |
| Took the "one down" position | 2 | 10.0 |
| Indicated greater cost of current methods | 1 | 5.0 |
| Stated that if it works it should not be dismissed | 1 | 5.0 |

The main methods of resistance were to "ignore the existence of" and "dismiss the concept of family therapy." Respondents' main response to these and other ways of resistance was to do therapy "quietly within the system," 50.0% (n=10). As many persons experienced no difficulty in integrating family therapy within their work settings as those who did have such difficulty. Table 47 reported that the main difficulty was the conflict between the agency's model and family therapy's model of dealing with problems, 28.6% (n=16). A wide variety of stratagems were used to circumvent the difficulties faced among which the chief one was to "introduce family therapy slowly," 34.2% (n=13). Table 48 presents the remaining ones.

Further commitment is shown in Table 49 where the numbers who have written on and taught family therapy form 12% (n=12) and 20% (n=20) respectively. Table 50 presents the limited data on research in the new field of family therapy where it remains the cinderella of this new discipline. In the years 1980-1984 some forms of research were carried out by 7.9% (n=8) of the respondents.

Table 47

Difficulties Integrating Family Therapy in Work Settings

| | Frequency (n=104) | Percentage |
|---|---|---|
| Had difficulty | 58 | 50.9 |
| Had no difficulty | 56 | 49.1 |
| Reported difficultiesa | (n=56) | |
| Model conflicts with agency model | 16 | 28.6 |
| Work setting unsuitable for family therapy | 11 | 19.7 |
| Non-acceptance of family therapy by agency | 8 | 14.3 |
| Respondent had inadequate training | 7 | 12.7 |
| Agency not interested in family therapy | 6 | 10.7 |
| No facility to do family therapy in agency | 3 | 5.4 |
| Time constraints | 2 | 3.6 |
| Other | 3 | 5.4 |

[a]A discrepancy exists between the number reporting difficulties and those reporting the specific difficulty.

Table 48

How Respondents Handled Difficulty of Integrating Family Therapy With Work or Discipline

| How Difficulty Was Handled | Frequency (n=38) | Percentage |
|---|---|---|
| Introduced family therapy slowly | 13 | 34.2 |
| Used family therapy skills | 5 | 13.1 |
| Worked with like-minded professionals | 4 | 10.5 |
| Did not use family therapy in practice | 4 | 10.5 |
| Thought systemically | 3 | 7.9 |
| Avoided discussion of family therapy | 3 | 7.9 |
| Voiced dissatisfaction without success | 2 | 5.3 |
| Other | 4 | 10.5 |

Table 49

Have Taught and Written on Family Therapy

| | Frequency (n=100) | Percentage |
|---|---|---|
| Have taught | 20 | 20.0 |
| Have not taught | 80 | 80.0 |
| Have written | 12 | 12.0 |
| Have not written | 88 | 88.0 |

Table 50

Research on Family Therapy and a Classification of the Topics Researched

| Respondents | Frequency (n=101) | Percentage |
|---|---|---|
| Have carried out research | 8 | 7.9 |
| Have not carried out research | 93 | 92.1 |

| Topic of Research Families | Year | Method |
|---|---|---|
| Incest | 1982 | - |
| Team Process | 1983 | Team Discussion |
| Schizophrenia and Family Therapy | - | With co-therapist |
| Stability, Change and Co-Evolution | 1980-82 | Conceptual |
| Outcome Evaluation | 1984 | Analysis of outcome |
| Reviewing Agency Cases | 1984 | - |

## Family Therapy Training Centers

Four years before this survey was carried out there did not exist one family therapy training center in Dublin. At the time it was initiated there were two in full operation. The first one started in September 1980 and is known officially as the Family Therapy Training Program at the Mater Hospital, Dublin Department of Child and Family Psychiatry (DCFP), but for the sake of brevity it will be referred to in this study as the CGC. (Child Guidance Clinic). The second one came into existence in 1982 and is known as the Marriage and Family Institute (MFI). The Institute began its first structured training in September 1984.

The CGC program has had Dr. Don Bloch as consultant and Nollaig Byrne, M.B.,B.Ch.,F.R.C.P. (c) as its coordinator since its foundation. Edward McHale, Ph.D. Candidate and Philip Kearney, M.A. were founders of the MFI which now has six other mental health professionals on its board of directors. While the CGC is hospital affiliated, with the Mater responsible for its policy, the MFI is free-standing with its board of directors responsible for its affairs.

## Programs Offered By Centers

A summary of the two programs is given in Table 51. In the CGC two levels of programs are offered. The first one is a year-long introductory course which consists of 14 seminars, and requires a professional qualification, and in 1983-84 had 30 students. The second is a two-year clinical training program, which requires a post graduate qualification and a specified work experience and had 18 students in 1983-84.

The MFI offers a slightly different program. In September 1984 it began in its initial year of training and in the description of this program, it had no specific entry requirements and had 26 students. After its initial year of training the Institute plans to have two extra years of training which will continue from the first year. A unique service is offered by the Institute to family therapists who wish to receive supervision, which is given weekly for two hours throughout the year. Four family therapists availed themselves of this program in 1983-84.

Table 51

Outline of Programs Offered By The Training Centers

---

Child Guidance Clinic

1. One year introductory program.
   Professional qualification required.
   Fourteen seminars.
   Students, 30 (1983-84)

2. Two year clinical program.
   Professional qualification required.
   Students, 18 (1983-84)

Marital and Family Institute

1. Program initiated in September 1984.
   First year: no specific entry requirement.
   Students, 26 (1984-85)

2. Post-graduate supervision.
   Two hours weekly for one year.
   Students, 4 (1983-84)

## Theoretical Orientation

The Child Guidance Clinic claims to follow the Milan model of therapy and training with second and third preferences for the Mental Research Institute and Psychodynamic (Ackerman) approaches. The three theoretical models preferred by the Marriage and Family Institute in Table 52 follow no order of preference, but express an eclectic orientation which could be broadly termed "strategic." In recommending texts to their students both centers selected as their first and second choices, Foundations of Family Therapy (L. Hoffman) and Paradox and Counterparadox (M. Palazzoli) respectively. The major article recommended by both centers was "Hypothesizing-Circularity - Neutrality," Family Process, 21, 3.

Table 52

Theoretical Orientations of Family Therapy Training Centers

| Theoretical Orientation | Child Guidance Clinic | Marriage and Family Institute |
|---|---|---|
| 1st Choice: | Milan | Milan |
| 2nd Choice: | Interactional (MRI) | Interactional |
| 3rd Choice: | Psychodynamic (Ackerman) | Strategic |

A review of the texts which each Center recommends to their trainees in order of importance shows a concurrence in the first two texts selected. Their first choice was "Foundations of Family Therapy" by Lynn Hoffman, and their second choice was "Paradox and Counter-Paradox" by Palazzoli. On their third choice there was a difference, with the CGC selecting "Mind and Nature" by Gregory Bateson, and the MFI selecting "The Tactics of Change" by Richard Fisch, et al. Once again the MFI had an addendum stating that their choice was not in order of importance and that their "approach in an integrated one rather than ascribing priority to any one school of therapy."

Three journal articles which the programs require their trainees to read continue to demonstrate the difference of theoretical orientation in the two programs. The Milan Approach is clearly the one which the CGC wishes their trainees to learn in their training. These journal articles are recommended in the first year of their two year clinical program: "Hypothesizing - Circularity - Neutrality. Three Guidelines for the Conductor of a Session" Maria Palazzoli Selvini et al. in Family Process, Vol. 19, No.1.; "Circular Questioning" by Peggy Penn, in Family Process, Vol. 21, No.3; and "One Perspective on the Milan Systemic Approach" by Karl Tomm in Journal of Marital and Family Therapy, Vol. 10, Nos. 2 and 3.

On the other hand, the texts selected by the MFI show a varied orientation in keeping with their stated policy of striving for an integrated model of family therapy. These texts were: "Hypothesizing - Circularity - Neutrality. Three Guidelines for the Conductor of a Session" Maria Palazzoli Selvini et al. in Family Process, Vol. 19, No.1.; their second choice was "Contrasting Strategic and Milan Approaches" by Laurie MacKinnon in Family Process, Vol. 22, No.4 and thirdly, "The Greek Chorus and Other Techniques of Family Therapy" by Peggy Papp in Family Process, Vol. 19 No.1. It can be assumed that these articles are not in order of importance as was stated about theorists and texts suggested to the trainees at the MFI.

From the weight of evidence presented it is evident that the two centers present the trainees with a different perspective on family therapy. The CGC can be considered to be clearly committed to teaching the Milan School to its trainees and the MFI are attempting to teach an eclectic or integrated model and even possibly develop its own.

## Integrating New Approaches With the Old

In a society where the family therapy approach to solving problems is a relatively new discipline both programs are sensitive to the trainee's position in learning a radical viewpoint and how they will not only integrate them in their thinking, but also use and incorporate them in

their work. This awareness of the trainees' possible internal confusion and external conflict is dealt with in rather similar ways. The CGC facilitates the trainees by having "discussion in groups" about these problems, while the MFI method parallels the CGC by "case discussion, including systems issues within the trainee's work setting."

## Facilities

Both training centers possess libraries for the benefit of their respective trainees. The CGC has 50 volumes on family therapy available which are provided by the trainers/supervisors personally and the MFI states that 90% of its volumes in its trainee library are books dealing directly with family therapy. These libraries receive a generous supply of journals on family and marital therapy with the CGC receiving six and the MFI receiving five. Videotaping equipment is available at both centers for training purposes. Each center is equipped with at least one room with a one-way screen for the supervising of training sessions.

The facilities available to family therapy trainees seem to measure up to the best available or equal to what may be found in most training centers in the United States and are adequate to train the numbers seeking that training.

## Training

For individuals who wish to attend these family therapy training centers there are as yet no scholarships available so that all or most of the financing must come from the trainees' own resources. Those attending the CGC generally pay 100% out of their pockets but those attending the MFI pay 90% of the cost themselves with their agencies paying the remaining ten percent.

The professional backgrounds of those attending the CGC are quite varied, as they range from social workers, schools counselors, clinical psychologists, general medical practitioners, psychiatrists, priests/ministers, women religious, men religious, and nurses to family therapists. All the above have attended the MFI with the exception of the following: general medical practitioners, medical students, priests/ministers, psychoanalysts, women religious, male religious, and lay helpers in voluntary organizations. The professions which have not yet attended the CGC are as follows: medical students, solicitors, psychoanalysts, lay helpers in voluntary organizations and the police.

Family therapy has yet to become part of a medical student's training in mental health. Lay helpers in voluntary organizations are absent from family therapy

training because generally they lack professional qualifications, so that they are generally not accepted.

## Assessing Skills of Potential Trainees

Prior to acceptance, both programs have structures in existence to evaluate the potential skills of a candidate, but the assessment process varies in each program. At the CGC the assessment is carried out primarily through personal interview and secondarily through the written recommendation of others. In the MFI program, which extends over three years, the trainee must complete the first year and then there are three stages in assessment before acceptance into the two final years of the program. The first stage is an assessment made by the first-year teachers of the candidate, the second is a personal interview and the third is the recommendation of others, or a job reference.

## Goals for Trainees

Goals are mutually determined in an arrangement between the organizers and the trainee in both programs.

## Assessing Progress in Training

In both programs there exists a structure for evaluating the trainee's progress. Trainee's progress is reviewed according to the established goals which were mutually determined at the outset, and also by observation of work

sample. The third element in reviewing the trainee's progress varies in each program. In the CGC the evaluation is made by comparing the trainee's status at the time of evaluation with the initial assessment. This feedback is given to the trainee at the end of the training and is given through written report and verbally. In the MFI the assessment is through peer evaluation and is given verbally each week as an "integral part of the applied supervision."

## Division of Trainee's Time During Training

Each program stresses certain elements in its training, based upon how it views the nature of training, and perhaps upon the needs and wants of its particular trainees. As Table 53 demonstrates, live and delayed supervision form 75% of the CGC's program to 50% to live in the MFI program. The latter gives 50% of its training over to other elements of training at least in its first year.

## Supervision

While live supervision forms 50% of both programs it is the main modality of supervision in the CGC program. It will become the prime modality in the MFI in their second and third years of training with co-therapy and pre/post session as other modalities.

Table 53

Division of Time In Training in the Training Centers

| | C.G.C. | M.F.I. |
|---|---|---|
| Supervision | | |
| Live | 50% | 50% |
| Pre/post | 25% | - |
| Selective reading program | 20% | - |
| Consultation on trainees' problems | 5% | - |
| Didactic input | - | 30% |
| Discussion and experiential work | - | 15% |
| Group problems | - | 5% |

Only the CGC has delayed supervision and this is with the supervisor and the group. Delayed supervision is primarily carried out by audio tape playback, with videotape playback and therapist self-report in second and third places respectively.

Live supervision in both programs is conducted in group and with a supervisor, with the supervisor intervening by phoning in to the trainee-therapist. In the CGC the second way of intervening is by the therapist walk-out, then group member walks in, and lastly by having supervisor walk into the session. In the MFI program there is only one other way of intervention and that is by having the therapist walk out to consult with the group behind the one-way screen (see Table 54).

Table 54

Order of Importance of Methods of Intervention in Supervision in Training Centers

| Center | Live | Delayed |
|---|---|---|
| C.G.C. | Telephone | Audiotape |
| | Therapist walk-out | Videotape |
| | Group member walk-in | Self-report |
| M.F.I. | Therapist walk-out | None |

## Formal Recognition of Supervisors

Since family therapy is at an early stage of development in Ireland, it is too early to have an organization which accredits family therapy supervisors, so that the status a supervisor possesses is that conferred by the program itself. The CGC reported having an M.S.W., a family therapist and a psychiatrist as their supervisors each of which does five hours of supervision each week. At the MFI there are two supervisors, one who is a Ph.D. Candidate and the other is a family therapist, who also acts as supervisor at the CGC, both of these do three hours of supervision each week. From these two programs there is a total of five recognized family therapy supervisors in Ireland.

## Ongoing Education of Family Therapists

The vision of the people running these family therapy programs stretches far beyond the mere training of family therapists in their own programs, and out to other professionals and to the public at large. Over the few short years of their existence they have, apart from getting their own programs under way, attempted to educate people on the value of family therapy in helping to solve problems prevalent in the Irish population at present.

In 1980 the Family Therapy Network of Ireland, in conjunction with the CGC organized a workshop conducted by Salvador Minuchin and had 200 people attending. Two years later another workshop conducted by Boszormenyi-Nagy had 60 attending. In 1984 Don Block of the Ackerman Institute conducted a workshop with 40 attending. The largest conference organized by the CGC and by Monica McGoldrick and Rutgers University was an international one on alcoholism that attracted 160 professionals.

While the MFI is a more recently founded organization, it too has contributed to the widening of the horizons of family therapists. In 1983 it organized its first major conference titled "Systemic Family Therapy - the Milan Approach" with Boscolo and Cecchin as the main speakers and had 40 in attendance. This was followed up in 1984 with "Family Therapy of Couples and Adolescents" conducted by Peggy Papp and Olga Silverstein with 50 in attendance.

The exposure of the professional community to world renowned figures in the field of family therapy may well have had a distinct influence on the growth of family therapy. All conferences were held in the Dublin area and had an average attendance of ninety.

## Ongoing Education of Other Professionals

Other professionals have been reached by both programs in workshops organized on different topics. In 1983 a

seminar on "Incest" was organized by the staff of the CGC and given to a multidisciplinary group of 50, and in the following year another seminar on the same topic was given to a group of 30 marriage counselors. The staff of the MFI gave two seminars to Occupational Therapists in 1982 with 122 attending the first, and 8 the second.

## Ongoing Education of the General Public

The effort to reach out to a wider audience is recorded in the programs' addressing the public on family issues. In 1982 the CGC offered a series of seminars on "Understanding the Family" to an audience of 40. Family issues were also involved in the title of a talk given the MFI in 1983 on "Parenting" and this had an audience of 24. In 1984 other talks were given, "Family Dynamics" with 25 attending, and 12 parents of handicapped children attended another on how to cope within the family.

## Summary

The two Family Therapy Training Programs possess the most up-to-date facilities available anywhere to trainees in family therapy. An added innovation is that the two centers implement training and supervision in two different contexts, one which is a public institution and the other which is a private one.

More importantly, both programs have highly qualified and experienced professionals who were trained in the United States and Canada, training and supervising future family therapists. The very fact that they possess different theoretical orientations and different approaches to supervision should lead to a healthy competitive spirit which will benefit not only the trainees to view problems and their possible solutions from different perspectives, but also offer a wider choice of facilities to families who seek help to deal with their problems. Variety is said to be the spice of life, so may it be the spice of family therapy life in Ireland for many years to come!

## Universities

### Clinical Psychology

Four out of the five Irish universities were surveyed for this particular study. The fifth, Maynooth College, was excluded because it does not possess a Clinical Psychology Department. Those that were surveyed were University College, Dublin (U.C.D.), University College, Galway, (U.C.G.), University College, Cork, (U.C.C.), and the University of Dublin, better known as Trinity College, or T.C.D. Only one of these four, Trinity College, replied that family and marital therapy does not form any part of their program, and that there are no plans to introduce it in the coming two years, because there were "no funds for such ventures." The data available on the position of family and marital therapy in the various degree/diploma programs offered by the remaining three will appear very fragmentary, but there are indications of efforts to introduce their students to its theory or theories and its practice.

### Additional Responses

University College Dublin gave a description of its Master's in Psychological Science degree which may help clarify some of the information which will follow. "The

M.Psych.Sc. is a 24-month intensive professional training in clinical psychology. Students are required to cover a broad yet in-depth academic knowledge, must carry out supervised placements in a range of clinical settings and must complete a piece of clinical research. They all study the major therapies, including the Family Therapies. The actual experience in Family and Marital Therapy varies according to the placement.

This year one student studied at the Family Therapy Training Program at the Mater. Another student has just completed a placement in a centre which specializes in marital problems. A number of students will gain experience in these areas as part of a wider placement, e.g., in Adult Psychology, in Child and Adolescent Services, in services for the mentally handicapped, and in a centre for the treatment of addiction."

University College Galway wrote a note on its view of the importance of family therapy, and a caveat about training students who are too young to benefit from such training. "We are well aware of the need for training in marital and family therapy, but with only four full-time staff in this Department, and many other commitments we cannot even contemplate providing post-graduate training in that area in the foreseeable future, and we do not consider it a suitable subject for practical training at undergrad-

uate level since most of our students are still in their teens and unmarried."

Degrees/Diplomas Offered

The degrees and diplomas offered by the psychology departments are presented in Table 55. All offer bachelors degrees, and masters of various descriptions while Dublin and Cork offer diplomas, and all have Ph.D. programs in clinical psychology.

Didactic Elements

None of the universities have lectures exclusively in family therapy. Two, Dublin and Galway, reported that the didactic parts of their programs are titled "Marital and Family Therapy" while Cork has lectures exclusively in "Marital Therapy" (See Table 56).

Table 55

Clinical Psychology Degrees and Diplomas Granted By Irish Universities

| Degree/Diploma | University College Dublin | Galway | Cork |
|---|---|---|---|
| B.A. | yes | yes | yes |
| B.A. in Psych. (Double Hons.) | - | - | yes |
| M.A. | yes | - | yes |
| M.Sc. | - | yes | - |
| M. Psych. Sc. | yes | - | - |
| M. Psych. Sc. (Specialties) | yes | - | - |
| Diploma in Psych. | yes | - | yes |
| Diploma in Career Guidance | yes | - | yes |
| Ph.D. | yes | yes | yes |

Table 56

Hours of Didactic Input in Family Therapy and Numbers of Students in Clinical Psychology Departments in 1983-84

| University College | Number of lectures | Duration of each lecture | Maximum no.of hours | Number of Students |
|---|---|---|---|---|
| Dublin | 14 | 1-1/2 to 3 | 21-42 | 24 |
| Galway | 4 | 1 | 4 | 28 |
| Cork | 1-4 | 1 | 1-4 | 59 |

Practice

Two universities, Dublin and Cork, have their students do their practical training in outside agencies. Dublin students are placed in various counseling centers around the city, while Cork students are placed in Cork and in Dublin. The amount of a student's time spent in actual practice depends largely upon the placement. In Dublin placements are for 3 to 4 days per week for 12 to 26 weeks, but no student would be permitted to spend all his/her time in the exclusive practice of family therapy. In Cork a student spends 6 hours each week in practice of marital therapy and the number of weeks varies. No specific number was cited. As reported above, Galway finds it inappropriate to have young students placed in agencies to do marital and/or family therapy.

Supervision

Like the practice of family and marital therapy, the practice of supervision takes place outside the direct control of the universities. Students who attend Dublin receive 3 hours supervision at their placement for a period extending from 12 to 26 weeks. This supervision is not exclusively supervision of family and marital cases. The university does exercise control over the status of the supervisors who supervise its students. These "must be a at least Senior Psychologist status." Occasionally the

university will appoint a non-psychologist, such as...a consultant psychiatrist will be asked to provide supervision in a specialist area such as family therapy. This is an exception. In Cork the students receive 5 hours of clinical supervision each week, for an unspecified number of weeks, and 100 hours of supervision in the acquisition of counseling skills.

Research

Galway had one student who just completed Ph.D research on the topic "Gender Identity and Gender Constancy in Young Children." The status of research in Dublin and Cork remains in the reports at the proposal stage. Only Dublin gave the title of its proposal "Sex Role and Marital Difficulties."

Theoretical Orientation

The philosophical view of family therapy ranges between "a useful method of solving problems" (Dublin) to "the method of choice but only in conjunction with individual therapy" (Galway).

In selecting theorists that influence their family therapy work Galway selected Behavioral Family Therapy as their choice. Cork selected as its first choice the Structural Approach and secondly the Communication Approach. Dublin did not select an orientation for its faculty, but its students are expected to be conversant with the major theorists.

In the provision of family and marital journals Dublin leads the way with eight, Cork receives three and Galway discontinued its only subscription to one "due to lack of funds" (see Table 57).

Table 57

Theoretical Orientation in, and Number of Family Therapy Journals Received By, The Clinical Psychology Departments

| University College | Theoretical Orientation First Choice | Second Choice |
|---|---|---|
| Cork | Structural | Communication |
| Galway | Behavioral | - |
| Dublin[a] | | |

| | Number of Family Therapy Journals Received |
|---|---|
| Cork | 3 |
| Galway | none |
| Dublin | 8 |

[a]U.C. Dublin does not focus on any one or specific theory but requires its students to be conversant with all the major ones.

## Social Work

Four universities were surveyed, three responded, two by answering the questionnaire and one by submitting a description of its courses. This description came from the Social Studies Department at Trinity College and it allows the reader to grasp some concept of how family therapy theory and practice are interwoven into the pattern of their various courses. In doing so it will help the reader to understand how the other universities incorporate family therapy ideas into their similar social work degree and diploma programs.

### Trinity College Response

Social studies courses are generic courses in which a number of skills are taught on the assumption that they can be generalized across a range of professional client-worker settings. Trinity tends not to teach family or marital therapy in isolated modules, but teaches concepts and techniques through many courses. Thus, family and marital therapy concepts and skills are used by several different teachers and in different formats so that it is difficult to quantify the hours precisely. The courses also change from year to year as do student numbers, and thus some parts of the course are in transition each year.

Trinity College's Bachelor of Social Studies Degree and Certified Qualification in Social Work (C.Q.S.W.)

Students spend the last two years of their four year undergraduate honors degree course in the Department of Social Studies. In these two years, students take courses in Sociology, Psychology, and Social Administration. Field work practice represents 50% of total teaching time over the two years. Thus, skills teaching and most supervised practice occurs on placement. Since agencies vary so much, some students practice marital and family therapy, whereas others have little practical exposure to these methods. There is a maximum of 20 students in each of the two years and an average of 18 to 19 students per course. There are no optional courses, and all students in theory receive the same number of courses.

Third year.

(1) Theory and methods course introduces systems theory.

(2) Skills workshop (experiential using role play and video) focuses mainly on basic one-to-one counseling skills, but also includes some dyadic work.

(3) Family studies course (28 hours) includes two hours on family therapy principles with a focus on communication and structural problems, one hour on marital therapy, and 1 to 3 hour workshop on sexual problems.

Theoretical input includes pervasive reference to concepts relevant to structural, strategic and communication

orientations to family therapy, e.g. family as system; life cycle transitions; sex and generation boundary settings; communication styles and the power of paradox. This is difficult to quantify but occupies probably part of another 10 hours.

Fourth year.

(1) Mental health course - 36 hours

(a) Teaching on schizophrenia (6 hours), affective disorders (2 hours), and how family therapy may be used as one of the range of intervention options available to the students in drug and alcohol dependence (4 hours).

(b) Six hours teaching specifically on family therapy theory including experiential exercises (structural/strategic orientation).

(2) 1 x 3 hour workshop on sexual problems

(3) Skills workshop (44 hours) includes a minimum of 6 hours specifically on working with marital and parent-child dyads but the nature of the course involves many occasions when couple or family group work are practiced and discussed.

On placement some students have opportunities to practice family therapy, especially in Child and Family Centres and in alcohol treatment centers, and in some community care teams. Others have no such opportunity.

Addiction Studies Diploma Course

This includes 16 weeks academic work, a ten-week placement and project work. This is a multi-disciplinary course with no formal requirements regarding professional or academic qualification but specifies a requirement that students have been working in the field of alcohol/drug dependence. Eight students were enrolled last year and 12 students this year.

(1) Skills workshops (90 hours) include pervasive family therapy focus for work with drug and alcohol abusers and their families. Approximately one-third (30 hours) is devoted to the presentation of family therapy theory and role play. The theoretical orientation is mainly structural and strategic in which the writings of Stanton, Bowen, Haley and Minuchin are used.

(2) Family Studies Module (8 hours) uses life cycle and structural concepts throughout to explore the impact of addiction and other social problems on family functioning.

On placement, some students are able to practice family therapy -- others not.

No students are referred specifically to extramural training in marital or family therapy, but are encouraged to attend conferences or training workshops as these arise.

## Degrees/Diplomas Offered

The qualifications offered by the universities that responded are recorded in Table 58. Family and marital therapy form components in their degree and diploma courses. All these courses are required in the three universities. In the academic year 1983-84 Trinity College Dublin and University College Dublin had 20 students in each year. University College Cork had twelve.

## Didactic Elements

As in the Clinical Psychology Departments so also in the Social Work, family therapy is not taught exclusively in lectures but is combined with marital therapy. In Trinity College Dublin and in University College Dublin family and marital therapy are taught in degree and diploma courses, and in University College Cork in diploma and certificate courses. The number of hours students receive in classroom instruction is 28 hours in Trinity College Dublin's Social Studies degree and 8 hours in their Addiction Diploma course. In University College Cork students receive a total of 8 hours. No report on hours was received from University College Dublin (See Table 59).

Table 58

Social Work Degrees and Diplomas Granted By Irish Universities

| Degree/Diploma | U.C. Dublin | U.C. Cork | T.C.D. |
|---|---|---|---|
| Bachelor of Social Science | yes | yes | - |
| Bachelor of Social Studies and C.Q.S.W.a | - | - | yes |
| Master of Social Science | yes | yes | - |
| Diploma in Social Work | - | yes | - |
| Diploma in Applied Social Studies | yes | - | - |
| Diploma in Social Administration | yes | - | - |
| C.Q.S.W.a | yes | yes | - |
| Ph.D. | yes | - | - |
| Diploma in Addiction Studies | - | - | yes |

[a]Certified Qualification in Social Work

Table 59

Theoretical Orientation and Hours of Didactic Input in the Social Work Departments of Irish Universities

| University | Theoretical Orientation | | |
|---|---|---|---|
| | First Choice | Second Choice | Third Choice |
| U.C. Cork | Structural | Strategic | Milan |
| T.C.D. | Structural | - | - |
| U.C. Dublin[a] | | | |
| **Didactic Input in Number of Hours** | | | |
| U.C. Cork | | | 8 |
| T.C.D. | | | |
| | Social Studies Degree | | 28 |
| | Addiction Studies | | 8 |
| U.C. Dublin[b] | | | |

[a]U.C. Dublin does not focus on any one or specific theory but requires its students to be conversant with all the major ones.

[b]No report received.

Practice

The practice of family and marital therapy depends largely upon the placement site, and what any particular placement allows the student to do. In Trinity College Dublin's placement only a limited number of students have the opportunity to practice, and this seems to hold for their degree and diploma programs. University College Cork had its students in various placements in Ireland and abroad, and it may be reasonably assumed that student opportunities for practicing family therapy depend upon the particular agency. No report was had from University College Dublin.

Supervision

The same pattern unfolds for supervision as did for practice in the reports received from Trinity College Dublin and University College Cork. University College Dublin reported that its supervision placements are in "Family Agencies where marital and family are practiced, and where supervision is qualified and experienced."

Research

The quantity and nature of the research carried out in the different Faculties is uncertain from the answers received. University College Cork reported one research topic "Family Therapy and Critical Theory" and University College Dublin "several areas and many people."

## Theoretical Orientation

In University College Dublin Faculty the philosophical view of family therapy is given as "different staff and different perspectives -- no agreed one," and from University College Cork the view on family therapy is that it "only represents useful skills and techniques."

In selecting theorists that influence the direction of their work, University College Dublin's comment was consistent with its philosophy when it reported "different people employ different frameworks." University College Cork's choices in order of influence on its work were, first the Structural Approach, secondly the Strategic Approach, and in third place the Milan School. From the information already supplied, it could be concluded that Trinity and University College Cork have a Structural/Strategic approach to family therapy.

## Psychiatric Residency Training

### Specialty Psychiatry

Seven psychiatric consultants in specialty education of future Irish psychiatrists were surveyed. Four responded by letter and written submission, and two responded by answering the questionnaire in as far as it was possible for them to do so. From these sources we are able to grasp the extent that family therapy pervades their psychiatry training programs.

### Additional Responses

From the following accounts which attempt to state the place of family therapy in the overall training of psychiatrists we obtain one perspective, and another from the two answered questionnaires. It is hoped that through these two methods a picture will emerge of family therapy training in the context of specialty psychiatry.

Response I (from a post graduate tutor): "The program is a post graduate training in psychiatry which is up to the standard of the Royal College of Psychiatrists and allows its trainees to sit for their membership. It is a four-year program offering a comprehensive training in basic general psychiatry, with usually one year spent in the sub-specialties. There has not always been a great emphasis on formal

training in psychotherapy in the U.K. and Ireland. This position is gradually changing and the Royal College of Psychiatrists has now laid down minimum requirements with regard to training in individual and group psychotherapy. In one program, training in psychotherapy, in the first few years, is confined to weekly seminars on individual and group psychotherapy and the practice and supervision of the same. At this level of training, registrars would receive one lecture on family therapy and two on marital therapy.

"Ninety percent of registrars take a six to twelve month elective in Child and Adolescent Psychiatry and during that time gain experience in family therapy.

"The most comprehensive experience in family therapy would be for registrars who opt for a career in Child Psychiatry to continue their training at Senior Registrar level. Any registrar who expresses a particular wish to gain experience in either marital or family therapy, special arrangements can be made."

Response II (from a consultant working in a Mentally Handicapped facility): "Our service is one for the Mentally Handicapped. While we provide informal family counseling regarding mentally handicapped members, we are not involved in any formal arrangements for family therapy as indicated by your questionnaire, so our registrars and senior registrars do not have any formal experience or training in this field while attached to our services."

Response III (from a Consultant Psychiatrist): I would however like to state that our in-service training at ---hospital and about which I can speak with ...confidence as I am also the specialty tutor in psychotherapy, includes with the whole spectrum of psychiatric treatments a family psychiatry component and indeed the whole ethos of our community-oriented psychiatric service recognizes this." Response IV (from a Clinical Director): "All Eastern Health Board Clinics are Child Psychiatry Departments rather than Family Therapy Clinics. All patient care is free. Our work has always involved seeing as many members of family together as possible, and usually embarking on some form of therapy which frequently involved the whole family being together during therapy sessions."

The consultant then goes on to describe part of his day's work and gives us a personal insight into his work with families. "This afternoon I am heading to a Special Delinquent School . . . wherein I will spend an hour and a half with a youngster and his family, but I will neither regard it as high powered adolescent psychiatry or family psychiatry. I will of course be trying to zero in on attitudes, how they handle one another, what they all see as the ultimate objective, how they can involve themselves in programs, etc. I find it hard to really call this family therapy."

He goes on to describe another part of his work in a paediatric hospital. "From our clinic we also work many other agencies, e.g., two long sessions per week in a paediatric hospital ... where we see children with severe psychosomatic disorders. We always see them in the presence of their families initially, and at that point decisions are made as to what form of therapeutic approach would be most appropriate. They all involve the family to some extent and in some way, but only something like 5% would actually become involved in classical family therapy.

"Our therapy varies from Minuchin to Milan to Ackerman."

These responses will help us understand the following attempts to define the training of psychiatric registrars, and that in turn will clarify our understanding of the above responses.

Responses to Questionnaire

The information obtained in this part of the study is quite fragmentary, but the effort is the first to gather concrete facts of the status of family therapy in the realm of psychiatry training in Ireland. As family therapy education at any level only began in 1980 it is understandable that family therapy would take time to find its place in the long established mental health training programs. An outline of the two specialty programs that responded to the questionnaire is given in Table 60.

Table 60

Structure of Specialty Psychiatry Training Programsa

| Characteristics of programs | Program A | Program B |
|---|---|---|
| Description | Post graduate program in child psychiatry | Higher psychiatric training program. |
| Qualifications granted | None | Makes trainee eligible for consultancy |
| Duration | 3 years | 3-4 years |
| Number of studies (1983-84) | 2 | 2 |

[a]No similar information was available about general psychiatry.

Both training facilities include family therapy in their programs, possess video equipment for the purposes of delayed supervision, and have rooms with one-way screens. While family therapy training occupies a part in their program it appears that this is a small one. Table 61 shows the best picture that can be created of the time given to supervision and didactic input in their programs. Neither program teaches their residents how to carry out research in family or marital therapy.

Theoretical Orientation

When asked about their philosophy of family therapy both programs had the same basic viewpoint. They saw family therapy to be an independent theory or an approach to family problems, which alone they considered a "useful method of solving problems." They were also in agreement that their goal in training their residents was to have them at the end of their training possess "a balance between theoretical and therapeutic components." Only Program A responded to the question of what was considered the most influential experience that a resident can have in the training process and this was for him/her to gain a "conceptual understanding of systems."

Table 61

Division of Time in Family Therapy Training In Psychiatry Residency Programs

| Specialty Psychiatry | Division of Time: Live Supervision | Delayed | Didactic |
|---|---|---|---|
| Program A | 50% | 40% | 10% |
| Program B | None recorded | | |
| General Psychiatry | - | 50% | 50%[a] |

| Specialty Psychiatry | Hours of Supervision |
|---|---|
| Program A | 0 - 1 hour per week, for 46 weeks (Number of years not recorded) |
| Program B | Hours dependent on Consultant |
| General Psychiatry | (Only data available is as recorded under delayed supervision above.) |

[a]Didactic input consists of a total of three hours of lectures in family therapy, and one and one-half hours in marital therapy during the whole training program. Both subjects are optional.

When the question of which three theories most influenced their training/supervision was asked, a difference appeared in their orientations. Table 62 shows that program A chose an older school of therapists than Program B.

In their choices of articles which each program recommends to their residents, a slight difference can be detected. While both lists are committed to a systemic orientation, Consultant I is more eclectic in his recommendations than Consultant II, who seems completely committed to the Milan Approach. Table 63 names the articles. The journals which they found most helpful in their training are reported in Table 64, with Family Process being the first choice of both consultants.

Supervision

Supervision in both programs is on an individual basis. In Tables 65 and 66 are recorded the modalities and methods of supervision carried out. The modalities used, either as first or second choices, in both programs are delayed supervision and pre/post sessions. When it comes to the prime method of delayed supervision both select self-report. Program A is the only one to report live supervision, and here the chief method of supervision intervention is by telephone.

Table 62

Theoretical Orientations in the Family Therapy Training of Psychiatrists

| Training | First Choice | Second Choice | Third Choice |
|---|---|---|---|
| Specialty psychiatry | | | |
| Program A | Psychodynamic (Ackerman) | Systems (Bowen) | Behavioral (Patterson) |
| Program B | Milan (Selvini) | Interactional (MRI) | Psychodynamic (Ackerman) |
| General Psychiatry | | | |
| | Communication (Satir) | Structural (Minuchin) | Open systems (Skynner) |

Table 63

Recommended Readings for Psychiatric Residents

Specialty Psychiatry

Consultant I

1st Choice: Hypothesizing-Circularity-Neutrality
Selvini, Family Process

2nd Choice: Study of the Family
Don Jackson, Family Process

3rd Choice: Coalitions and Binding Interactions
Peggy Penn, Family Systems Medicine

Consultant II

1st Choice: Hypthesizing (as above)

2nd Choice: Circular Questioning
Peggy Penn, Family Process, 22, 4.

3rd Choice: One Perspective on the Milan Approach
Tomm, Journal of Marital and Family Therapy, 10, 2 + 3.

General Psychiatry

No articles recorded.

Table 64

Consultants' Choice of Journals Which Are Helpful In Their Training

| Training | First Choice | Second Choice | Third Choice |
|---|---|---|---|
| Specialty Psychiatry | | | |
| Program A | Family Process | Journal of Family Therapy | Orthopsychiatry |
| Program B | Family Process | Journal of Marital and Family Therapy | Journal of Strategic and Systemic Therapies |
| General Psychiatry | | | |
| | No journals recorded. | | |

Table 65

Modalities of Supervision in Specialty and General Psychiatry

| Training Program | 1st Choice | 2nd Choice | 3rd Choice |
|---|---|---|---|
| **Specialty Psychiatry** | | | |
| Program A | Pre/post session | Delayed | Live |
| Program B | Delayed | Pre/post session | - |
| **General Psychiatry** | | | |
| | Delayed | Co-therapy | Pre/post session |

Table 66

Methods of Delayed and Live Supervision in the Family Therapy Training of Psychiatrists

| Training Program | 1st Choice | 2nd Choice | 3rd Choice |
|---|---|---|---|
| **Delayed supervision** | | | |
| Specialty Psychiatry | | | |
| Program A | Self-report | Personal issues | Videotape |
| Program B | Self-report | Videotape | Audiotape |
| General Psychiatry | | | |
| | Self-report | Pre/post session | - |
| **Live Supervision** | | | |
| Specialty Psychiatry | | | |
| | Telephone | Trainee walk-out | Consultant walk-in |

## General Psychiatry

An even more fragmentary pattern of the state of the art of family therapy emerges from the training program for general psychiatry than did from the specialty section. Overall, the responses given focus some light for the first time on the status of family therapy in general psychiatry. Fourteen questionnaires were mailed altogether with some going to consultants in the Southern and Western Regions. Four questionnaires were returned, one of which was completely answered, three were initially or partially answered. Two letters explaining difficulties in replying were received, and phone contact gave the author reasons for two further non-responses. There was nearly a 60% response rate from returned questionnaires, letters and phone contacts. The non-responses in the light of the contacts made and information obtained, all indicate that family therapy concepts and techniques are still lingering on the periphery of general psychiatry training.

### Additional Responses

From a consultant psychiatrist:

"In Ireland in general the practice of marital and family therapy is not highly developed, limited to 'schools' or 'theories', or taught in a systematic way in other than a few centres.....While our trainees are encouraged in adult

psychiatry, to take a family or marital perspective in the management of mental disorder, the main family contact is often the Community Nurse or Psychiatric Social Worker. Many instances of neurosis and personality disorder with consequent marital difficulties are referred to lay counsellors (e.g., C.M.A.C) or to private psychologists specializing in the field."

Titles of Programs

Although family therapy training was not part of the programs, the four returned questionnaires affixed a title to each program. These are as follows: "St.John of God Psychiatric Services", "Post Graduate Training - one-half day release, weekly", "Group Therapy Seminar, (weekly) on behalf of Irish Psychiatric Training Committee - Eastern Region", and "Irish Post Graduate Training Programme". The first mentioned runs for four years and the majority of its trainees sit for membership of the Royal College of Psychiatrists, while the last program runs for three years and likewise prepares its trainees to sit for the same membership examination. Numbers of trainees were not given for any program. Two programs had video equipment for training purposes, but none recorded having a room with a one-way screen for supervision. Only one program reported having family therapy in its training.

The one program which responded reports minimal lectures on family therapy as is recorded in Table 61. The

supervision which is provided is given on an individual basis and its prime modality is delayed. As in Specialty psychiatry the prime method is through self-report.

The main theoretical orientation is based on the Communication Approach of Satir, but the overall orientation is clearly eclectic as can be seen in Table 62. This program views family therapy less as a clear theoretical approach to problems than as a set of useful skills. The evidence for this comment comes from the responses to two questions. First when asked what was the consultant's goal for training, the reply was that the resident would "possess a set of techniques and skills, and the response to the question of what constituted the most influential experience in training, the consultant state "acquiring a set of specific skills." Residents were not trained to carry out research in family therapy.

## The Future

In this section those who had recently become family therapists and those who practiced family therapy as part of their primary work expressed their current educational needs. They also expressed their opinions on what topics, theories and academic programs would most benefit future Irish family therapists. The institutes directly responsible for training therapists such as the two training centers and those institutes such as the universities and the psychiatric residencies' programs where some elements of family therapy are taught were surveyed as to their plans, if any, for the expansion of family therapy education in the immediate future.

### Need for Further Training

Those who expressed need for further education in family therapy formed a high percentage 78.5% (n=102) as presented in Table 67. Formal education, such as academic programs, seminars, and courses found favor with 56.2% (n=73) while an exactly equal number expressed a need for informal education such as supervision, and peer group consultation.

Formal Training

This need for formal training is expressed in Tables 68 and 69 where respondents selected "Techniques" 34.6% (n=36) and "Theories" 22.1% (n=23) as their first and second choices of topic for their own further training. Their first choice of preferred training 29.2% (n=26) was a three month course with a full day each week.

Table 67

Need For Further Training and Its Nature

| | Frequency | Percentage |
|---|---|---|
| Expressed need for further training | (n=130) | |
| Yes | 102 | 78.5 |
| No | 7 | 5.4 |
| No response | 21 | 16.2 |
| Formal training (seminars, courses) | (n=130) | |
| Yes | 73 | 56.2 |
| No | 24 | 18.5 |
| Not applicable | 1 | 0.8 |
| No response | 32 | 24.6 |
| Informal training (supervision, peer group) | (n=130) | |
| Yes | 73 | 56.2 |
| No | 17 | 13.1 |
| Not applicable | 1 | 0.8 |
| No response | 39 | 30.0 |

Table 68

Topics in Which Respondents Would Like to Receive Further Training

| Topic | Rankings First (n=104) | Second (n=95) | Third (n=92) |
|---|---|---|---|
| Techniques | | | |
| Frequency | 36 | 21 | 1 |
| Percentage | 34.6 | 22.1 | 1.1 |
| Theories | | | |
| Frequency | 23 | 12 | 1 |
| Percentage | 22.1 | 12.6 | 1.1 |
| Alcoholism | | | |
| Frequency | 8 | 5 | 9 |
| Percentage | 7.7 | 5.2 | 9.8 |
| Life-Cycle Problems | | | |
| Frequency | 8 | 4 | 11 |
| Percentage | 7.7 | 4.2 | 11.9 |
| Child-Rearing Problems | | | |
| Frequency | 4 | 10 | 13 |
| Percentage | 3.8 | 10.5 | 14.1 |
| Drug Problems | | | |
| Frequency | - | 3 | 10 |
| Percentage | - | 3.1 | 10.9 |
| Schizophrenia | | | |
| Frequency | 2 | 3 | 1 |
| Percentage | 1.9 | 3.1 | 1.1 |
| Adolescent Problems | | | |
| Frequency | 2 | 8 | 6 |
| Percentage | 1.9 | 8.4 | 6.5 |
| Sexual Problems in Marriage | | | |
| Frequency | - | 2 | 7 |
| Percentage | - | 2.1 | 7.6 |

(Continued on next page)

Table 68 (Continued)

Topics in Which Respondents Would Like to Receive Further Training

| Topic | Rankings First (n=104) | Second (n=95) | Third (n=92) |
|---|---|---|---|
| Violence in Families | | | |
| Frequency | 4 | 9 | 3 |
| Percentage | 3.8 | 9.5 | 3.3 |
| Incest | | | |
| Frequency | 2 | 7 | 10 |
| Percentage | 1.9 | 7.3 | 10.9 |
| Desertion | | | |
| Frequency | - | - | 3 |
| Percentage | - | - | 3.3 |
| Separation/Divorce | | | |
| Frequency | - | 1 | 9 |
| Percentage | - | 1.1 | 9.9 |
| Aging | | | |
| Frequency | 1 | - | 1 |
| Percentage | 1.0 | - | 1.1 |
| Anorexia | | | |
| Frequency | 1 | 3 | 1 |
| Percentage | 1.0 | 3.1 | 1.1 |
| Bulemia | | | |
| Frequency | 1 | - | 1 |
| Percentage | 1.0 | - | 1.1 |
| Reconstituted Families | | | |
| Frequency | 1 | 1 | - |
| Percentage | 1.0 | 1.1 | - |
| Depression in Family Member | | | |
| Frequency | 1 | 6 | 5 |
| Percentage | 1.0 | 6.3 | 5.4 |

Table 69

Preferences For Further Training

| Preferred Training | Rankings First (n=89) | Second (n=68) | Third (n=57) |
|---|---|---|---|
| Three month course: full day weekly | | | |
| Frequency | 26 | 5 | 9 |
| Percentage | 29.2 | 7.4 | 15.8 |
| On-going peer group supervision/consultation | | | |
| Frequency | 17 | 17 | 8 |
| Percentage | 19.1 | 25.0 | 14.0 |
| Day release | | | |
| Frequency | 15 | 11 | 2 |
| Percentage | 16.9 | 16.2 | 3.5 |
| Workshop/seminar for two to three days | | | |
| Frequency | 10 | 7 | 16 |
| Percentage | 11.2 | 10.3 | 28.1 |
| Full-time course, five days weekly, for two to three weeks | | | |
| Frequency | 8 | 10 | 4 |
| Percentage | 9.0 | 14.7 | 7.0 |
| Weekly meeting in a group of trained supervisors | | | |
| Frequency | 8 | 14 | 18 |
| Percentage | 9.0 | 20.6 | 31.6 |
| Other | | | |
| Frequency | 5 | 4 | - |
| Percentage | 5.6 | 5.9 | - |

## Informal Training

The definition of informal training is a very wide one ranging from workshop/seminar over 2-3 days to day release. Table 69 presents the respondents' choices. The first of which is an on-going peer group supervision/consultation 19.1% (n=17) to weekly meetings in group with trained supervisors 9.0% (n=8). The topics which respondents wished to be touched upon in this informal training are indicated in Table 68. Perhaps the list of topics offered them was too long, but two topics were chosen equally as the prime 7.7% (n=8): "Alcoholism" and "Life-cycle problems," and both were also the most frequently requested.

Of the theories which they would like to learn more about, their first choice was the Milan School 37.5% (n=24) and their second choice was the Strategic Approach 17.2% (n=11) which was also the most frequently requested theory (see Table 68).

## Opinions on Future Training Programs

The people best suited to propose the future training programs are those who have been trained recently in family therapy and who are current practitioners of the art. This study has solicited their opinions as to the priorities they favor in future training.

## Academic Programs

Ireland was the country that the overwhelming majority of respondents stated should be the location where future Irish therapists should be trained, 97.1% (n=100). Table 70 places the United Kingdom second with 2.9% (n=3). Their preferred first choice of program was not a new university degree, but rather a greater emphasis on family therapy training in the existing social work and clinical psychology programs in the universities. This position was supported by 41.2% (n=42) of all respondents. A masters degree from a training center was doubly preferred to a similar degree from a university by 16.6% (n=17) to 7.8% (n=8). Advanced courses were favored by 25.5% (n=26) of respondents whether offered by training center or by university (see Table 71).

## Topics and Theories for Training

When asked what topics should be dealt with in future training the respondents favored the teaching of theories, 26.3% (n=24) as their first choice, followed by techniques as their second, 23.1% (n=21). Table 72 shows that the next preferred topic to be dealt with was alcoholism by 13.1% (n=12).

Table 70

Countries of Preference For Training

Future Irish Family Therapists

| Country | Rankings First (n=104) | Second (n=71) | Third (n=66) |
|---|---|---|---|
| Ireland | | | |
| Frequency | 100 | 1 | 5 |
| Percentage | 97.1 | 1.7 | 17.2 |
| United Kingdom | | | |
| Frequency | 3 | 50 | 13 |
| Percentage | 2.9 | 84.7 | 44.8 |
| United States | | | |
| Frequency | 1 | 12 | 37 |
| Percentage | 1.0 | 16.9 | 56.1 |
| Canada | | | |
| Frequency | - | 7 | 9 |
| Percentage | | 11.9 | 31.0 |
| Other | | | |
| Frequency | - | 1 | 2 |
| Percentage | - | 1.7 | 6.9 |

Table 71

Preferred Future Academic Training In Family Therapy

| Preferred Training | Rankings First (n=102) | Second (n=97) | Third (n=88) |
|---|---|---|---|
| Greater emphasis in social work and clinical psychology programs in the universities | | | |
| Frequency | 42 | 24 | 12 |
| Percentage | 41.2 | 24.7 | 13.6 |
| Advanced courses | | | |
| Frequency | 26 | 29 | 29 |
| Percentage | 25.5 | 29.9 | 33.0 |
| Masters degree from a family therapy training center | | | |
| Frequency | 17 | 18 | 16 |
| Percentage | 16.6 | 18.5 | 18.1 |
| Greater emphasis on family therapy in training psychiatrists | | | |
| Frequency | 9 | 16 | 19 |
| Percentage | 8.8 | 16.5 | 21.6 |
| Masters degree from the universities | | | |
| Frequency | 8 | 8 | 12 |
| Percentage | 7.8 | 8.2 | 13.6 |
| Other | | | |
| Frequency | - | 2 | - |
| Percentage | - | 2.1 | - |

Table 72

Topics Which Respondents Thought Should Be Dealt With In Future Training

| Topic | Rankings First (n=91) | Second (n=88) | Third (n=88) |
|---|---|---|---|
| Theories | | | |
| Frequency | 24 | 13 | 1 |
| Percentage | 26.3 | 16.0 | 1.1 |
| Techniques | | | |
| Frequency | 21 | 22 | 1 |
| Percentage | 23.1 | 25.0 | 1.1 |
| Alcoholism | | | |
| Frequency | 12 | 10 | 21 |
| Percentage | 13.1 | 11.4 | 23.9 |
| Separation/Divorce | | | |
| Frequency | 7 | 3 | 8 |
| Percentage | 7.7 | 3.4 | 9.1 |
| Life-Cycle Problems | | | |
| Frequency | 6 | 2 | 5 |
| Percentage | 6.6 | 2.3 | 5.7 |
| Incest | | | |
| Frequency | 5 | 3 | 3 |
| Percentage | 5.5 | 3.4 | 3.4 |
| Violence in Families | | | |
| Frequency | 4 | 6 | 9 |
| Percentage | 4.4 | 6.8 | 10.2 |
| Child-Rearing Problems | | | |
| Frequency | 3 | 6 | 6 |
| Percentage | 3.3 | 6.8 | 6.8 |
| Schizophrenia | | | |
| Frequency | 3 | 1 | 1 |
| Percentage | 3.3 | 1.1 | 1.1 |

(Continued on next page)

Table 72 (Continued)

Topics Which Respondents Thought Should Be Dealt With In Future Training

| Topic | Rankings First (n=91) | Second (n=88) | Third (n=88) |
|---|---|---|---|
| Sexual Problems in Marriage | | | |
| Frequency | 2 | 3 | 11 |
| Percentage | 2.2 | 3.4 | 23.9 |
| Desertion | | | |
| Frequency | 2 | 2 | 1 |
| Percentage | 2.2 | 2.3 | 1.1 |
| Drug Problems | | | |
| Frequency | 1 | 7 | 6 |
| Percentage | 1.1 | 8.0 | 6.8 |
| Adolescent Problems | | | |
| Frequency | 1 | 1 | 6 |
| Percentage | 1.1 | 1.1 | 6.8 |
| Aging | | | |
| Frequency | - | - | 2 |
| Percentage | - | - | 2.3 |
| Anorexia | | | |
| Frequency | - | 1 | - |
| Percentage | - | 1.1 | - |
| Bulemia | | | |
| Frequency | - | - | - |
| Percentage | - | - | - |
| Reconstituted Families | | | |
| Frequency | - | 1 | 1 |
| Percentage | - | 1.1 | 1.1 |
| Depression in Family Member | | | |
| Frequency | - | 7 | 6 |
| Percentage | - | 8.0 | 6.8 |

The three theories which they felt would be most helpful to people working in Ireland were the Milan School, 37.5% (n=24), the Strategic, 17.2% (n=11) and the Structural Approach, 12.5% (n=8) (See Table 73). Table 74 shows that the remaining theories received about equal support.

## Teaching Non-Mental Health Professionals

When the current practitioners were surveyed as to what other non-mental health professionals should receive some elementary training in or introduction to family therapy, three groups received a high degree of approval. All the results are presented in Table 75. The first chosen by the respondents were general practitioners, 33.3% (n=35) and the third place were school counselors with 21.9% (n=23). Their second choice was not necessarily a professional group but rather those people who volunteer their services to work with families. This felt need to train such people in basic knowledge of family systems met with approval by 26.6% (n=28) of the respondents.

Table 73

Theories Which Respondents Thought Would Be Helpful For Future Therapists In Ireland

| Theories | | 1st Choice (n=56) | 2nd Choice (n=53) | 3rd Choice (n=46) |
|---|---|---|---|---|
| Milan Approach | | | | |
| | Frequency | 14 | 8 | 6 |
| | Percentage | 25.0 | 15.1 | 13.0 |
| Structural | | | | |
| | Frequency | 10 | 12 | 14 |
| | Percentage | 17.9 | 22.6 | 30.4 |
| Communication | | | | |
| | Frequency | 8 | 3 | 3 |
| | Percentage | 14.3 | 5.7 | 6.5 |
| Strategic | | | | |
| | Frequency | 7 | 14 | 10 |
| | Percentage | 12.5 | 26.4 | 21.7 |
| Systems | | | | |
| | Frequency | 6 | 4 | 2 |
| | Percentage | 10.7 | 7.5 | 4.3 |
| Interactional (MRI) | | | | |
| | Frequency | - | 3 | 2 |
| | Percentage | - | 5.7 | 4.3 |
| Experiential-Symbolic | | | | |
| | Frequency | 1 | - | 2 |
| | Percentage | 1.8 | - | 4.3 |
| Other | | | | |
| | Frequency | 10 | 9 | 7 |
| | Percentage | 17.9 | 17.0 | 15.2 |

Table 74

Theories Respondents Would Like to Learn More About

| Theories | 1st Choice (n=64) | 2nd Choice (n=56) | 3rd Choice (n=56) |
|---|---|---|---|
| Milan Approach | | | |
| Frequency | 24 | 1 | 6 |
| Percentage | 37.5 | 1.8 | 10.7 |
| Strategic | | | |
| Frequency | 11 | 15 | 9 |
| Percentage | 17.2 | 26.8 | 16.1 |
| Structural | | | |
| Frequency | 8 | 11 | 12 |
| Percentage | 12.5 | 19.6 | 21.4 |
| Systems | | | |
| Frequency | 4 | 7 | 5 |
| Percentage | 6.3 | 12.5 | 8.9 |
| Interactional (MRI) | | | |
| Frequency | 4 | 4 | 4 |
| Percentage | 6.3 | 7.1 | 7.1 |
| Communication | | | |
| Frequency | 4 | 2 | 4 |
| Percentage | 6.3 | 3.6 | 7.1 |
| Experiential-Symbolic | | | |
| Frequency | 1 | 2 | 2 |
| Percentage | 1.6 | 3.6 | 3.6 |
| Other | | | |
| Frequency | 8 | 14 | 14 |
| Percentage | 12.5 | 25.0 | 25.0 |

Table 75

Preferred Future Training for Non-Mental Health Professionals

| Preferred Training | Rankings First (n=105) | Second (n=97) | Third (n=97) |
|---|---|---|---|
| Introductory courses for future general practitioners | | | |
| Frequency | 35 | 29 | 16 |
| Percentage | 33.3 | 29.9 | 16.5 |
| Basic training for those in voluntary organizations that work with families | | | |
| Frequency | 28 | 17 | 14 |
| Percentage | 26.6 | 17.5 | 14.4 |
| Inclusion of courses in secondary school counselor education | | | |
| Frequency | 23 | 15 | 20 |
| Percentage | 21.9 | 15.5 | 20.6 |
| Basic training in schools of theology for future priests and ministers | | | |
| Frequency | 7 | 18 | 26 |
| Percentage | 6.6 | 18.5 | 26.8 |
| Introductory courses for students in law schools | | | |
| Frequency | 6 | 8 | 12 |
| Percentage | 5.7 | 8.2 | 12.4 |
| Introductory courses in schools of nursing | | | |
| Frequency | 6 | 10 | 11 |
| Percentage | 5.7 | 10.3 | 11.3 |

## Family Therapy In Training Centers

At the time the survey was carried out, the CGC had no definite plans to develop its Family Therapy Training Program beyond its current status, nor was it considering possible development over 1985 or 1986.

Over the years 1985 and 1986 the MFI stated that they had definite plans to expand its program of training family therapists. These plans include increasing the number of its trainees, extending its training program to other parts of the country, offering more advanced courses, undertaking research on family therapy in Ireland, offering consultation to family therapists, and continuing to offer practical courses to the general public. Under serious consideration is the development of their library facilities and offering courses on family therapy to other professionals.

## Family Therapy In Clinical Psychology

When asked about the possibility of extending the family and marital programs in their departments, none had any plans for the immediate future.

## Family Therapy In Social Work Departments

There are encouraging signs for the growth of family therapy, as an approach to problems, within the different Faculties of Social Work. From Trinity "the Social Studies

Department has been aware of a steady interest in family and marital techniques and organizes workshops for practice teachers (field instructors) and social workers when appropriate workshop teachers are available. We have gradually expanded skills teaching for students in marital and family work and would like to develop them more within our generic context, but have no immediate plans to alter the amount of teaching that presently exists in these areas."

From University College Dublin comes the statement that its Faculty has plans to increase its current commitment to marital and family therapy within the immediate future. These plans are to increase the hours of teaching both marital and family therapy and to ally more closely with an external agency already involved in teaching marital and family therapy. University College Cork joins with University College Dublin in planning to undertake the supervision of its students' practice of marital and family therapy.

## Family Therapy In Residency Programs

No comments were received on any plans for the future development of family therapy training in general or specialty psychiatry.

The results presented above form the first comprehensive study of family therapy training in Ireland. They are

uneven and quite incomplete, but at this relatively early stage of development, they supply data which should prove helpful to trainers and supervisors as well as to those who are responsible for mental health education.

# CHAPTER V

## SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Family therapy was tentatively introduced into Ireland in 1975 and since that time has grown dramatically. Its development has not only been the adoption of theories in the academic arena, but the establishment of two centers where mental health professionals are trained and supervised to become family therapists, and others interested are introduced to it.

### Summary of Study

#### Purpose and Objectives

This study intends to provide the first comprehensive review of the state of family therapy training and supervision opportunities available to those people in Ireland who wish to become family therapy professionals and/or paraprofessionals. No literature exists on any similar research, so this general study becomes a starting point for further and more detailed research. The definition of training and supervision was provided by those who were trained in the very recent past, and who are now practicing. To the definition formulated by the current practitioners is added those of the two training centers, the

clinical psychology and social work departments of the five universities and some general and specialty consultants in psychiatry residency programs, all continuing to form a mosaic with many pieces missing.

Objective I

This objective was to provide a description of the training and supervision which the first generation of professionals in the field received. From this group have come the trainers and supervisors of the second generation of family therapists. The pertinent variables examined are the educational and professional backgrounds of the respondents, their training and their experiences in that training, their theoretical orientations, the effects of the training in their professional and personal lives, and their endeavors, after training, to promote family therapy in the work settings.

Objective II

The chief purpose in this objective was to survey, as minutely as possible, the centers which specifically provide family therapy training and supervision, so as to evaluate the standard of that training. The universities and the psychiatry residency training programs were surveyed in an effort to locate the elements of family therapy training and supervision that exist in these larger programs. Variables examined were the modalities and methods of supervision, the theoretical orientations, their recommended texts, and the proportion of time given to these elements.

Objective III

This objective assessed the needs of current practitioners for further training for themselves and to elicit the opinions of all individuals and institutes that responded on the direction or directions that they thought that future training and supervision should take and the nature of future programs.

## Methods and Procedures

This is a descriptive study which employed the survey research method. When this research was carried out there were a limited number of known family therapy practitioners, and to have included them in a pilot study would have drastically reduced their number or might have eliminated them altogether. Another stratagem was used. The instruments were scrutinized by psychologists, social workers, family therapists and psychiatrists both in Ireland and the United States, and their comments and corrections were utilized to shape the final versions. The four questionnaires were received by the subjects in early August 1984 and data collection was terminated in March 1985.

Once the data had been gathered it was coded by the author, and examined by a computer expert, prior to being analyzed. Objective I was realized through calculation of frequencies, percentages, means and standard deviations. Objective II was assessed by comparisons of the data supplied by the two training centers and it was coded by hand and results

displayed whenever possible in table form for easy and rapid review. The same procedure was utilized in analyzing Objective III.

## Conclusions: Objective I

Contrary to the findings of a similar study (Saba 1984), this current study reported having fewer males (38.8%) respond than females (61.2%). Those who were 40 years of age or younger formed 72.4% of the respondents contrasted with 44.4% who were 40 years or younger in the Group for the Advancement of Psychiatry (GAP) Report of 1970. While many religious faiths were represented the majority (76.0%) stated they were Catholic which reflects the professed faith of the majority of people of the Republic. Slightly over 10% reported that they were not citizens of the country. Seventy-five percent of the respondents work in Dublin and the eastern region of the country. A majority (69.3%) have spent six months or more outside the country for purposes of study or work.

### Primary Work Setting

By far the single most frequent work setting was stated to be Community Care, and a vast majority reported being satisfied and only 13.3% claimed to be dissatisfied in their primary work setting. This high level of satisfaction was attributed by them to be primarily the result of cooperative staff relationships, while the opposite was reported as the main factor in their dissatisfaction. Financial remuneration was not

a major element in either satisfaction or dissatisfaction. A change in their primary work setting, as a result of their family therapy training, was reported by only 11.7%, but this training led respondents to increase their teaching and private practice of family therapy as part-time activities.

## Influences in Becoming a Family Therapist

"Colleagues and a desire to possess additional techniques" were motives prompting respondents to becoming family therapists. Most respondents first heard of family therapy in a university context and only one was primarily influenced in becoming a family therapist because one or two parents were mental health professionals. In the extended family, one's spouse was the family member who was most often reported as being a mental health professional.

## Professions and Qualifications

In this study as in the GAP Report (1970) social work was the single most frequently reported profession. Although all respondents identified themselves as possessing terminal degrees in traditional subjects, only three have received their highest degree in family therapy. However 71 have received qualifications whose primary focus was family therapy or in which courses in family therapy were required, while the remainder attended introductory courses or were self-educated.

## Methods and Modalities of Supervision

The two modalities most frequently cited were live and delayed supervision with live supervision being the prime modality and being more than twice as frequently used as delayed. Of the methods of intervention used in live group supervision, the telephone was used five times more frequently than the next method which was therapist walk-out.

Results were mixed in delayed supervision. Where it was received in group settings, the videotape method was used twice as often as the next method which was self-report, and where it was received individually, self-report was cited over three times more frequently than the next method which was videotape.

Live supervision was considered the major factor in their training that facilitated their professional development, and previous inadequate skills training was the major element that obstructed their development. In training they were primarily helped by their interaction with the supervisor, and hindered by their feeling of inadequacy.

## Theoretical Orientations

While the Communication Approach was cited as being the most influential theory in the respondents' practices, the Milan School was very close in second position, with the Structural and Strategic approaches being next. These four approaches were clearly the dominant theories with the others having a much

lesser number of adherents. A slight majority saw family therapy as a theoretical orientation to problems and others saw it as providing additional skills not provided by individual theories. They considered "gaining a conceptual understanding of systems" as the major factor in their learning of family therapy.

## Readings That Were Helpful

Two foreign journals were chosen as those that were helpful in their practice. The first, Family Process, was cited nearly six times more frequently than the next, Journal of Family Therapy. This same priority existed in the reception of journals at their primary work setting and personally. Of the books that they reported, Haley's Problem Solving Therapy and Hoffman's Foundations of Family Therapy were both chosen as first choice, although Haley's text was more frequently cited. At this early stage of development, books are mostly obtained by the respondents themselves, or borrowed from peers.

## Personal Issues After Training

The majority (75.7%) stated that their training in family therapy had been beneficial in their own family life mainly in affording them a better understanding of the family system. Any difficulties coming from their training was traced to the high expectations that had been aroused. Nearly 60% have

continued to meet in peer consultation mainly on a weekly or fortnightly basis.

## Institutional Issues After Training

Over three quarters of those who received family therapy training attempted to promote it in their institutional settings. Their success was attributed to a well trained and enthusiastic staff, and failure was primarily due to the conflict between family therapy's model and that of the agency, and secondarily due the staff ignoring the existence of family therapy. Commitment to teaching and writing on family therapy was reasonably high, but stated commitment to research on their work was found to be insignificant.

## Conclusions: Objective II

Three different questionnaires to suit the particular circumstances were mailed to the family therapy training centers, the universities and the psychiatric residency training programs. Since the nature of the training centers differs so much from the other institutes no comparison is possible. Any parallels that may appear between the universities and the residency programs should be viewed most cautiously, nevertheless some tenuous comparisons will be made below.

## Family Therapy Training Centers

### Programs and Facilities

Both training programs were initiated in the decade of the 1980's, with the Child Guidance Clinic (CGC) being initiated

in 1980 and the Marriage and Family Institute (MFI) in 1984. The former requires a professional qualification for entry into its programs while the latter states it has no specific entry requirements. Two independent programs are offered by the CGC, one is a one-year introductory course, and the other is a two-year clinical program. The MFI has proposed a three-year clinical program with entry into the two last years dependent on performance in the initial year. For professionals, they offer a one-year supervision program. Both institutes possess libraries, videotaping equipment and at least a one-way screen.

Assessing Candidates

Assessment at the CGC is primarily through a personal interview and secondarily through the written recommendations of others, while the MFI assesses candidates after the initial year by a personal interview with their teachers and by written recommendations or a job reference.

Trainees' Professions

A wide range of professions has already attended the CGC, and understandably not so wide a range had applied to the MFI in its initial year of training.

Goals for Trainees

Each program determines the goal for training with the trainee by mutual agreement.

Assessing Progress in Training

Both programs use the same first two stages of measuring progress in training. First, by reviewing the goals mutually

set at the beginning and second, by observation of a work sample. The third stage varies. At the CGC this is carried out by comparing the trainees' current status with the first assessment, and at the MFI the third stage will be given by peer evaluation which is given verbally on a weekly basis.

Division of Time in Training

Supervision, live (50%) and delayed (25%), forms the greatest part of the CGC program with the remainder divided between didactic input and trainees' problems. In the MFI program live supervision will take up 50% of the time while the remainder will be spent in didactic input (30%) and other training activities.

Theoretical Orientations

The first clear choice of the CGC was the Milan school, with the Interactional (MRI) and the Psychodynamic (Ackerman) in second and third place respectively. In the MFI their orientations were the Milan school, the Interactional, and the Strategic approaches, but no order of preference was indicated.

Recommended Texts and Articles

There was accord in two texts chosen, Foundations of Family Therapy ( L. Hoffman, 1981) and Paradox and Counterparadox (M. Palazzoli-Selvini, 1978) with third choices varying. Mind and Nature (G. Bateson, 1979) was selected by the CGC and Tactics of Change (Fisch, et al., 1982) by the MFI. Journal articles varied but the first choice was similar, "Hypothesizing-

Circularity - Neutrality" by M. Palazzoli-Selvini, Family process, 21, 3.

Integrating Old and New Learning

Both programs realized the possible conflict that their trainees would probably face in returning to their primary work settings where the theoretical orientation of family therapy and that of the agency could cause professional and personal problems. Possible difficulties were discussed in groups so that trainees would be prepared to handle them when they occurred.

Modalities and Methods of Supervision

Live and delayed supervision were the two modalities in use at the CGC. Live supervision will become the sole modality when the program is initiated at the MFI. In the two programs supervision is carried out only in groups. At the CGC the telephone is the prime method of intervention in live supervision and videotape is the prime method in delayed supervision. Therapist walk-out is the only method of intervention proposed at the MFI.

Recognition of Supervisors

In both programs combined there are five recognized supervisors and that status is conferred by the institutes themselves.

Continuing Education

Probably due in part to its greater length of time in existence, the CGC has been responsible for sponsoring more workshops by leading American family therapists than the MFI.

However, the MFI has introduced Italian and American therapists to the professional community. Both institutes have organized seminars on family relationships and related topics for the general public.

## The Universities: Clinical Psychology

### Degrees Offered

All the universities offer bachelors, masters and doctoral degrees in clinical psychology. Dublin and Cork offer diplomas in both psychology and career guidance.

### Theoretical Orientations

The main choices expressed by Cork were Structural and Communication approaches, and Galway had one preference and that was Behavioral. Dublin has a policy of introducing its students to all of the main family therapy theories.

### Didactic Input

All courses in family therapy form part of the universities' degree programs. Dublin offers fourteen lectures on family and marital therapy, Galway four and Cork offers one.

### Supervision

Supervision is outside the control of the university and that which the student receives may or may not be in family therapy. The agencies where the students receive their practical

training control the type of therapy that they do as well as the amount of supervision they receive.

Practice

Outside agencies are the sites where students receive their training. The actual amount of time students spend in doing therapy depends on the agency where they are placed.

Research

The evidence for research in the area of family therapy is extremely vague and cannot be recorded with any accuracy.

Additional Responses

Dublin supplied a brief written description of its masters degree in psychiatry science. Galway wrote that it does not consider its students, while at the bachelor degree level, ready for family therapy training due to their youth and inexperience.

## The Universities: Social Work

Degrees Offered

Dublin reported the widest offering from a bachelors to the doctoral degree. A unique qualification in Addiction Studies is offered by Trinity College.

Theoretical Orientations

Cork's preferences were for the Structural, the Strategic and Milan schools, in that order. Trinity College

seemed to favor the Structural approach, while Dublin required a comprehensive understanding of the main theories.

Didactic Input

Didactic input is part of the larger program and the hours reported given to family therapy range from 28 hours in Trinity to a maximum of 8 hours in Cork.

Supervision

As in the clinical psychology programs the social work departments have no control over the amount or quality of family therapy supervision which their students receive.

Practice

Again, the practice of therapy, family or otherwise, is dependent upon the agency where the student is placed.

Research

Minimal amounts of family therapy research were reported.

Additional Responses

Trinity College submitted an extensive description of the degree in Social Studies, as well as an outline of its diploma course in Addiction Studies.

## Psychiatry: Specialty and General

Degrees Offered

No specific qualifications result from the training offered but such training makes the trainees eligible for consultancy appointments.

Theoretical Orientations

General psychiatry and Program A in specialty psychiatry report favoring an eclectic approach, while Program B can be said to use the Milan school as its main theoretical orientation. Despite the declared specific orientation, all programs show a strong preference in their recommended reading for the Milan approach.

Didactic Input

The didactic input varied from program in specialty granting it 10% of training time to 50% given by general psychiatry.

Supervision

The preponderance of supervision is individual and delayed with self-report as the prime method in all programs.

Research

No research is taught or carried out in family therapy in the process of the residents' training.

Additional Responses

Four consultants responded through written submission and therein described their approaches to and philosophy of family therapy.

## Conclusions: Objective III

### The Future

Over 75% of the respondents to Questionnaire I expressed a desire to have further training in family therapy.

Formal training needs were primarily stated to be in a three-month course with a full day each week, and their first choice of topics were techniques and theories. Their first preference in informal training was group supervision with trained supervisors.

Academic Programs for Future Family Therapists

The first choice was to see the current clinical psychology and social work degree programs expand their family therapy training and supervision components. Their next choice was to have a masters degree in family therapy from a training center, which was selected twice as frequently as the same degree from a university. In seminars and workshops they thought that future therapists should hear about theories first and techniques later. The respondents expressed their opinions that the Milan and Structural approaches would be the most beneficial to future therapists working in the Irish culture. General medical practitioners and other professionals in voluntary family associations were the two groups of non-mental health professionals whom respondents thought should receive introductory courses in family therapy.

Family Therapy Training Centers

No plans were in place for expanding the CGC's commitment to family therapy for the years 1985 or 1986, while the MFI had plans for expanding its program to other parts of the

country, offering advanced courses, consultation and courses to the general public.

Universities

No plans for extending family therapy content of their clinical psychology programs were reported for the academic years 1984-85 and 1985-86. However, Trinity College Dublin's (TCD) social work department hoped to continue expanding skills teaching for students in family and marital therapy. University College Dublin (UCD) hoped to increase the hours of teaching family therapy and to ally more closely with an external agency to supervise the students who practice. University College Cork (UCC), like UCD, hoped to be in a position to supervise its students' practice.

Specialty and General Psychiatry

No report was received on their plans for increasing family therapy content in their training.

Implications for Policy Makers and Educators

Ireland was chosen by the vast majority of respondents as the country where they felt future Irish family therapists should be trained. This offers an opportunity to all currently involved to any degree in family therapy training to review their positions in order to see where they can continue to promote and develop higher educational standards in the field. While two quality training centers exist in Dublin, similar training facilities need to be extended to the Provinces. The majority of those already initiated into family therapy practice have

expressed a need for further formal and informal education, and those who will seek training in the future should have the best possible trainers and supervisors available to them.

Respondents have strongly expressed their first academic preference in future training and this is to see the universities expand the family therapy component in their clinical psychology and social work degree programs. In the social work departments, there has been very concrete action taken to develop components of family therapy training such as to expand skills training, to increase didactic hours in family therapy, and to involve themselves in the training and supervision of their students in external agencies. Clinical psychology departments have fewer didactic hours given to family therapy, and have expressed no plans for developing or expanding their commitment. The universities have yet to play a major role in family therapy education and respondents have expressed a need that they become involved in such development.

There exists among family therapy practitioners a strongly expressed need for advanced courses which last over a three month period, taking up one day a week, and dealing with techniques and theories. While the centers provide year long courses, perhaps the needs for such advance courses should be considered by present educators.

When it came to the question of a masters degree in family therapy from a university or a family therapy institute respondents selected the institute twice as often as the

university. This may reflect the experiences of family therapy that they had in the universities, and may be an additional challenge to the academic community to increase its commitment to family therapy in its current programs. Family therapy training centers, as they currently stand are not equipped to offer masters degrees. Perhaps the universities and the training centers may seek to combine in order to offer a new type of qualification that combines the expertise of both institutions.

While the response from psychiatry was limited, nevertheless the consultants who responded viewed family therapy as a theoretical orientation and not as a mere set of skills. If this point of view were held by a large number of consultants the core curriculum in psychiatry would radically change. Although this is considered to have occurred in the United States, there is no reason to believe it has even begun in Ireland. The fact that some psychiatrists view family therapy as an orientation is an indication of change.

Extending family therapy concepts to non-mental health professionals was supported by high percentages of respondents. Future general practitioners were mentioned as the first significant group that should receive some introduction to family therapy in the course of their training. There is no indication that this takes place at present. As these professionals deal mostly in family medicine, some training in systems therapy would help them deal more effectively with family problems, medical or non-medical.

Individuals who work in voluntary organizations are mentioned by respondents as people who should be introduced to family therapy concepts. However a problem ensues. The CGC requires a specific qualification for entry and many in voluntary organizations may not have the necessary academic qualifications. One organization, the Catholic Marriage Advisory Council (CMAC), that deals mainly with marital problems on a national level, could be a beneficiary of an introduction to family therapy, but special courses would need to be set up to facilitate the nature of their work.

One professional organization, the secondary school counselors, were mentioned by the respondents as people who would benefit from receiving some introduction to family therapy in their training programs. These professionals stand in a unique position to be of help from the systemic point of view, between individual student, home, school, and possibly other agencies. If trained in basic systems concepts they could beneficially intervene in family difficulties before these developed into major problems, and they could be preventive agents within the family system.

Other groups of professionals could be preventive agents if trained in basic systems concepts and how to implement them. Respondents expressed opinions that priests and ministers, lawyers and nurses should receive this training so as to assist those with whom they come in contact in their work. Such training lies in the future.

In the elements that contributed to the respondents' professional and personal growth during the process of family therapy training three of the first four were supervisors' skills. Since the skills and person of the supervisor play such a central role in the learning process, careful scrutiny ought to be exercised in the selection of those who are to be assigned to supervise trainees.

Those elements that hindered professional and personal growth in the trainees were most often external to the supervisor, but if the supervisor was aware and sensitive to the trainee's personal situation, the trainee would be set more at ease and learning facilitated.

Implications for Therapy

Family therapy at present seems to be available mainly in public health facilities. No known research has yet been published on the kinds of clients or the general nature of the problems they present at these clinics. There are indications that more professionals are doing parttime private practice in family therapy. Also the MFI is situated away from a public health facility and may attract a different clientele with different problems. With the expansion of family therapy a wider option is being offered people who have problems in their

interpersonal relationships than was heretofore available to them.

## Summary

From being considered almost heretical nearly thirty years ago family therapy (Bowen 1978) has become the fastest growing discipline in the mental health field (Liddle & Halpin 1978; Skynner 1979; Bross 1983; Gurman & Kniskern 1981). The Group for the Advancement of Psychiatry in their Report 1985 No. 117 has recognized that the evidence for family therapy's success is such as to "mandate its addition to the traditional treatments." Kolevzon & Green (1985) examine the growth and development under four headings, first, the range of problems to which family therapy is applied, second, the growth of membership in professional organizations, third, the body of literature it has produced, fourth, the training and supervision that has been undertaken in the United States and throughout the world.

Family therapy in Ireland has its own short history with its own observable stages of growth and development. There appear to be two distinct stages. The first was chiefly devoted to the introduction through workshops and seminars of the prevalent theories and practices to interested professionals who wished to expand their repertoire of skills. This stage began in 1975 and extended to 1980 when the Family Therapy Network of Ireland (FTNI) became directly responsible for family therapy activities. The second stage began in 1981 by the formal establishment of family therapy training at the Child Guidance

clinic and at the Marriage and Family Institute in 1984 (McCarthy 1980). The main objective of this study is to define the current state of that training and supervision and the theoretical orientations upon which they are based.

The challenges facing family therapy in Ireland in the immediate future seem threefold. First, there is a need to maintain a high standard of education for those mental health and non-mental health professionals who are enrolled and will enroll in future training programs. Second, the Family Therapy Network of Ireland needs to increase its membership in order to become more representative of all mental health professions. Third, while Irish therapists apply the theories developed elsewhere, there seems to be a need for them to research and publish their work in order to benefit the profession as a whole.

## Future Directions and Recommendations

The quantity and complexity of the data gathered in this study has not been exhausted by the objectives set, but some perspective on the field has been gained for the first time. Hopefully what has been obtained will supply a broad view of the family therapy training and supervision field. Highlighted below are some suggestions for areas of future development and expansion so that the people of the island may have available to them the best in family therapy.

1. One of the concerns was to view the quality of the training that those who very recently became family therapists

received. Since supervisors play such major roles in the transmission of concepts and techniques, and model the approach to clients in their interaction with trainees, it is imperative that a high standard of training be required of those who wish to become supervisors. This study has indicated that the professional and personal growth of trainees depends to a large extent on the skills and personal qualities of the supervisor. At present supervisors receive their status from the two training centers who employ them and in this way a certain professional standard is maintained. However, it would benefit the field to have an officially recognized body conferring and guaranteeing the professional standard of supervisors.

2. Since responsibility for the standard of the field must rest with some recognized body, and at present the main association identified in that role is the Family Therapy Network of Ireland (FTNI), it is incumbent upon them to set the standard for practitioners. Official recognition as a family therapist would provide customers with a measure of confidence in the professions. Added to recognition should be a condition to continue their education by attending an annual course or seminar or conducting a workshop/seminar as the field is continually developing and is stated to be the fasted growing mental health profession. A certain level of accountability for standards will be maintained by these or similar measures.

3. Although each training center offers a different and clearly stated theoretical orientation, respondents expressed

a desire to be instructed in other theories and techniques, especially the Structural and Strategic approaches. Most training centers adopt one basic theory which allows their training/supervision to be researched and the effectiveness of their outcomes to be evaluated. There seems to be need for centers with other approaches to be established in the western and southern parts of the country.

4. As the universities have remained largely aloof from the revolution in family therapy and since the two university cities of Galway and Cork have as yet no established training facilities, this lacuna could provide an interesting and novel challenge. An experiment to train therapists in a joint program between the universities and potential centers in these two cities could pave the way for a first in the field.

5. Family therapy training has begun in an extremely small way within psychiatric residency programs, but it has begun well. Those consultants who responded stated that they view family therapy as a theoretical orientation and not as a set of specific skills. To view psychiatric problems from a systems viewpoint would lead to a revolution in psychiatric residency training.

6. Most family therapy books are purchased at the practitioner's expense or else borrowed from peers. People at the training centers have libraries from which they can obtain books, but practitioners away from these centers are handicapped. In this initial stage of development, and because of the delay

and expense of obtaining books from the United States, the existence of a central family therapy lending library, which could be financed by all the interested parties, would facilitate the spread of ideas more rapidly north and south of the border.

7. Using the existing structure of over 400 school counselors as paraprofessionals in family therapy has been supported by respondents. Future counselors could receive introductory courses in systems therapy and current counselors could be helped to understand adolescent problems from a systemic viewpoint. Their position with the different systems involved with the adolescent, especially the family, could be a real preventive force before difficulties evolve into serious problems.

8. Should general medical practitioners receive some basic training in family therapy they may well be able to act as preventive agents in family medicine. Respondents felt that these medical practitioners ought to be the first non-mental health professionals to be introduced to family therapy concepts and practices.

9. Other professionals, such as priests, lawyers and nurses, in whom many people place their confidence could, if trained in basic concepts, act as effective paraprofessionals and preventive agents.

10. While the two centers have their own criteria for assessing candidates before acceptance into training, there are few guidelines in the literature for either assessing candidates

or assessing trainees in the course of their training. This underdeveloped area needs development at the conceptual and practical levels.

11. Difficulties, especially the personal ones which the respondents expressed, need to be addressed by trainers and supervisors. Maintaining a facade of competence and shifting to a totally new orientation as well as previous inadequate skills training compounds the normal difficulty in learning a new discipline. Increased awareness of the educators' part and some research on methods to alleviate these blocks would greatly accelerate the learning process.

## A Final Note

This study intended to provide an overall view of the state of family therapy training and supervision by requesting those recently trained in Ireland or elsewhere, and those involved in mental health education, to define it. It is hoped that this study will serve as a source of information for educators and mental health policy makers. The results as published have limitations. So any generalizations should be cautiously made.

Those involved in the practice of family therapy and in educating future therapists show themselves to be a committed group of professionals who are utilizing certain models of therapy in their work and teaching. Respondents have expressed a concern to continue learning other theories, to acquire skills,

and to receive ongoing supervision of their practice. The expressed desire of current practitioners to continue their education strikes a hopeful note for the future and should be recognized in the curricula planned for future mental health professionals in the various educational establishments.

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# APPENDIX A

## Letter Requesting Professional Critique of Proposed Questionnaire

745 Waverley Street
Palo Alto, CA 94301
November 30, 1983

The enclosed questionnaire is being prepared for distribution; and what I need from you now is a critical assessment of its contents to see if it adequately probes all the elements involved with the training, practice, theoretical orientation, and the needs and wants of all who are involved to any degree with the practice of family therapy in Ireland. I would also appreciate your comments on the style and wording of the questions, especially with the aim to eradicate wording which may sound too Americanized to Irish ears!! In March of this year you helped me with the prototype of this questionnaire and your suggestions have been incorporated into this copy. Should you have questions which you feel should be asked, which I may have overlooked, please add them in, or even questions on topics of family therapy about which you are simply curious! These may well be very valuable questions. I'll be pleased to have all the criticisms that you can make about this questionnaire, for without your critical assessment I stand to have a less well defined instrument in my research.

I have four other questionnaires almost completed whose objective is to unearth accurate knowledge about the status of family therapy in other areas of activity not covered in this questionnaire. They are of their nature shorter, and these will be sent out at the same time as the final edition of the enclosed. These will be sent (1) to family therapy training centres, (2) to counseling centres, (3) to the clinical psychology and social work departments of the universities, and (4) to the psychiatric residents' training programmes. If you would be willing and interested to critically review these next-to-final editions, please indicate which one or ones you would like to receive and I will forward immediately whatever you request.

I'm under pressure to have the enclosed questionnaire completed by mid January. So if you could review it within a few days of receiving it, you would give me an early and very much appreciated Christmas present.

Thanking you for your past support and your current help,

Gratefully yours,

Jim Moran, S.J.

Enclosure

# APPENDIX B

## Documents Relating to Questionnaire 1

# QUESTIONNAIRE 1

This Questionnaire is addressed to all who do family therapy in the Republic of Ireland, from the trained family therapist to the individual who helps families in their interpersonal relationships in a voluntary organization.

1. _____ male _____ female

2. _____ age

3. (a) _____ single _____ married _____ separated _____ divorced
_____ widowed _____ other living arrangement

(b) _____ priest _____ minister _____ religious

4. _____ number of children

5. ___ ___ ___ ___ ___ ___ ___ ___ their ages

6. Your religion:
_____ Catholic _____ Methodist _____ Society of Friends
_____ Church of Ireland _____ Jewish _____ Other
_____ Presbyterian _____ Other Christian _____ None

7. _____ Of what country are you a citizen?

8. _____ What town/city/or country area do you work in?

9. Please check all the work settings that apply to you.

| | Currently work in | Formerly worked in |
|---|---|---|
| School counsellor | _____ | _____ |
| General hospital | _____ | _____ |
| Child and family psychiatry | _____ | _____ |
| Adult psychiatry: in-patient | _____ | _____ |
| Adult psychiatry: out-patient | _____ | _____ |
| Private practice in family therapy | _____ | _____ |
| Mentally handicapped | _____ | _____ |
| Teach family therapy at a University | _____ | _____ |

| | Currently work in | Formerly worked in |
|---|---|---|
| Teach family therapy at a non-University setting | | |
| Voluntary church organization | | |
| Voluntary non-church organization | | |
| General medical practice | | |
| Drug programme | | |
| Alcohol programme | | |
| Community care | | |
| Court system | | |
| Counselling centre | | |
| Psychiatric Department in general hospital | | |
| Counselling students in a university setting | | |
| Other: | | |
| _____ | | |
| _____ | | |

10. If you changed your primary work setting within the past year or two, your training in family therapy may or may not have influenced that decision. Please circle the number that best represents your position.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Family therapy training had no influence. | | | | Change was due to my training in family therapy. |

11. What is your primary work setting? _____

12. Please circle the number that best represents the level of your satisfaction/dissatisfaction in your primary work-setting.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Complete satisfaction | | | | totally dissatisfied |

13. If you feel satisfied in your primary work-setting mark in order of importance the elements you consider that contribute to this level of satisfaction. Rank them in order of importance, with "1" as the most important and so on.

____ adequate remuneration
____ co-operative staff relationships
____ challenging intellectual environment
____ physical facilities are good
____ satisfactory secretarial staff.
Other(s) please specify and rank:

____ _____
____ _____

14. If you feel dissatisfied in your primary work-setting, mark in order of importance the elements you consider that contribute to this level of dissatisfaction. Rank them in order of importance with "1" as the most important and so on.

_____ inadequate remuneration
_____ conflictual staff relationships
_____ boring routine
_____ physical facilities inadequate
_____ overmuch paperwork
Other(s) please specify and rank:

_____ _____
_____ _____

15. Please indicate your income from your primary work setting, before taxation.

_____ under 5,000 pounds
_____ 5,000-8,999
_____ 9,000-11,999
_____ 12,000-13,999
_____ 14,000-15,999
_____ 16,000 upwards

16. Is any member of your family a therapist, social worker, psychiatrist, counsellor, or psychologist?

_____ father _____ sibling _____ aunt, uncle, cousin
_____ mother _____ spouse _____ no one

17. Please list what you consider to be the three most important professional or quasi-professional organizations of which you are currently a member, and which are not associated with family therapy. Please give the organizations their full titles.

1

2

3

18. Please list what you consider to be the three most important activities, artistic, cultural, intellectual and athletic that you participate in at present. Please give these activities their full titles.

1

2

3

19. Have you spent periods of six months or more outside of Ireland for either work or study? _____ yes, _____ no.
If yes, please answer the following.

| Purpose/nature of work or study | Duration | In what year(s) | University or location | Country or countries |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

20. How many brothers and sisters were in your family? Please circle the relevant numbers.

a. Brothers: 0 1 2 3 4 5 6 7 8 9 10 10+

b. Regarding birth order, circle what position you hold in the family?

1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

## TRAINING

21. Do you hold a certificate, diploma and/or degree in any academic area of human knowledge that does not include family therapy? _____yes _____no
If yes, please indicate this area or these areas.

| Qualification | Main subjects in degree | Institute | Year(s) granted |
|---|---|---|---|
| ___ B.A. | | | |
| ___ M.A. | | | |
| ___ B.Sc. | | | |
| ___ M.Sc. | | | |
| ___ B.Soc Sc | | | |
| ___ B. Eng | | | |
| ___ M. Eng | | | |
| ___ Ph.D. | | | |
| ___ MBA | | | |
| ___ H.Dip.Ed | | | |
| ___ M.B.B.Ch. | | | |
| ___ Dip.Psych Sc. | | | |
| ___ M.Psych. Sc. | | | |
| ___ _____ | | | |
| ___ _____ | | | |
| ___ _____ | | | |

22. Do you hold a certificate, diploma and/or degree whose
a) main focus is on family theory/therapy? _____ yes _____ no
b) If "yes" please fill in the following:

| Title of qualification | University/institute | Year(s) attended |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

23. Do you hold a certificate, diploma and/or degree which
a) includes courses in family theory/therapy, though they were not the main focus? _____ yes _____ no

b) If "yes" please fill in the following:

| Title of course(s) | University/institute | Year(s) attended |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

24. If you have ever attended courses in family therapy which were more extended than a seminar, even though a certificate was not awarded,

| Title of course(s) | Location | Duration | Year(s) | Director(s) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

25. If you have attended workshops/seminars in family therapy, please name. Use extra page if necessary.

| Workshop/seminar | Institute/location | Duration | Year(s) | Director(s) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

26. Are you attending any course in family therapy at present?
_____ yes _____ no If "yes" please name the course(s).

| Title | Location | Duration | Director(s) |
|---|---|---|---|
| | | | |
| | | | |

27. What elements in your training in family therapy were professionally most helpful to you? Please rank in order of importance, with "1" being the most helpful and so on.

_____ interpersonal skills of supervisor
_____ conceptual clarity of supervisor
_____ videotape playback
_____ audiotape playback.
_____ personal interaction with supervisor
_____ feedback from supervisor on your work
_____ live supervision
_____ theoretical dimensions of training
_____ co-operation among peers
_____ feedback from peers

Other(s) please state and rank

_____ _____ _____ _____

28. What elements in your training in family therapy were personally most helpful to you? Please rank in order of importance, with "1" being the most helpful and so on.

_____ interpersonal skills of supervisor
_____ conceptual clarity of supervisor
_____ videotape playback
_____ audiotape playback
_____ personal interaction with supervisor
_____ feedback from supervisor on your work
_____ live supervision
_____ theoretical dimensions of training
_____ co-operation among peers
_____ feedback from peers

Other(s) please state and rank

_____ _____ _____ _____

29. What elements in your training in family therapy most hindered your professional development. Please rank in order of importance with "1" being the most obstructive and so on.

_____ competition with other trainees.
_____ your previous inadequate training in interpersonal skills
_____ your resistance to supervisor's input
_____ family of origin issues that impeded learning
_____ lack of finance
_____ discomfort with theoretical framework of training
_____ feeling inadequate
_____ needing to maintain an image of competency
_____ poor interaction with fellow-trainees
_____ poor relationship with supervisor

Other(s) please state and rank

_____ _____

30. What elements in your training in family therapy most hindered your personal development? Mark in order of importance, with "1" being the most obstructive and so on.

_____ competition with other trainess
_____ your previous inadequate training in interpersonal skills
_____ your resistance to supervisor's input
_____ family of origin issues that impeded learning
_____ lack of finance
_____ discomfort with theoretical framework of training
_____ feeling inadequate
_____ needing to maintain an image of competency
_____ poor interaction with fellow-trainees
_____ poor relationship with supervisor.
Other (s), please state and rank.

_____ _____

31. Have your experienced difficulties in integrating family therapy with your work or discipline? _____ yes _____ no.
If "yes," please indicate
(a) What was the main difficulty you experienced?_____

(b) How did you handle this difficulty? _____

_____

32. Have you experienced difficulties in integrating family therapy with your own family life? ____ yes ____ no
If yes, please indicate
(a) What was the main difficulty you experienced? _____

(b) How did you handle this difficulty? _____

_____

33. Have you experienced your training in family therapy to be beneficial in your relationship with members of your own family? _____ yes _____ no
If "yes," please indicate the main benefit you have experienced._____

_____

34. (a) If you work in an institutional setting have you tried to increase the acceptance of family therapy concepts and practices?
_____ yes _____ no
(b) If "yes," have you encountered resistance beyond what you consider normal when new theories and practices are introduced into such a setting? _____ yes _____ no.

35. If you answered "no" to question 34(b), how do you account for this climate of acceptance? _____

_____

36. If you answered "yes" to question 34(b), how did this
(a) resistance show itself?_____

(b) How did you react to this resistance?_____

37. With hindsight what three main pieces of advice would you give others who might introduce family therapy into institutional or agency settings?
1._____
2._____
3._____

38. In your training to become a family therapist please check which types of supervision you received? Rank the most utilized with "1" and so on.

_____ delayed supervision
_____ co-therapy with supervisor
_____ other
_____ live supervision
_____ pre/post session with supervisor

39. If you received live supervision in your training, rank the following methods in order of priority, with "1" being the method most utilized and so on.

| | With supervisor alone | With supervisor and group |
|---|---|---|
| _____ telephone | _____ | _____ |
| _____ bug in ear | _____ | _____ |
| _____ therapist walk-out | _____ | _____ |
| _____ supervisor walk-in | _____ | _____ |
| _____ group member walk-in | _____ | _____ |
| Other, please specify | | |
| _____ _____ | _____ | _____ |

40. If you received delayed supervision in your training, rank the following methods in order of priority, with "1" being the method most utilized, and so on.

| | With supervisor alone | With supervisor and group |
|---|---|---|
| _____ therapists self-report | _____ | _____ |
| _____ videotape playback | _____ | _____ |
| _____ audiotape playback | _____ | _____ |
| _____ therapist's personal issues | _____ | _____ |
| Other(s), please state and rank | | |
| _____ _____ | _____ | _____ |
| _____ _____ | _____ | _____ |

41. In your training which of the two following forms of supervision was more frequently used. Mark the more frequently used one with "1".

_____ individual supervision
_____ group supervision

42. (a) In your training how many hours of supervision in family therapy did you receive? _____ hours.
(b) Since your formal training ended how many hours of supervision have you received? _____ hours.

43. Please give in percentages the time your have received in supervision in different countries, both during your training and afterwards. Total must come to 100.

_____% in Ireland
_____% in U.K.
Other(s) please specify _____%
_____% in U.S.
_____% in Canada
_____% _____

44. In your training in family therapy, what percentage of your time went to the following activities? Total must come to 100.

_____% didactic
_____% delayed supervision
_____% live supervision
Other(s) please specify _____%
_____% peer consultation
_____% pre/post session consultation
_____% writing reports
_____% _____

45. Do you at present systematically and/or formally consult
(a) With your peers? _____ yes _____ no.
If "yes" please answer the following:
(b) How frequently? ____ once a week _____ once a fortnight
____ once a month _____ (other) _____
(c) How many of you meet together on average? _____
(d) How long does each consultation last? _____ hours
(e) What is the structure of your consultation? Check what applies.
_____ one person presents a case at each meeting?
_____ general discussion of cases: open forum?
_____ paper read, followed by discussion?
(f) If none of the above in (e) please give a brief outline of the nature of your consultation. _____

46. (a) Did you receive a grant/scholarship to pursue your studies in family therapy? _____ yes _____ no
(b) What was the amount? _____
(c) In what year did you receive it? _____
(d) How many months of your study was this grant/scholarship intended to cover? _____ months
(e) What percentages of the total cost of your training in family therapy did this grant/scholarship cover? _____%

47. If you received no grant/scholarship
(a) How did you finance your family therapy training?
_____
(b) What was the total cost to you of that training? _____
(c) In what year(s) did you do your training? _____

48. Have you taught family therapy in courses, workshops, or seminars?
____yes _____ no. If "yes" please indicate. (Use extra page if necessary)

| Title of course | Year | Location | Duration | No. of participants |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

49. Have you done/are you carrying out any research in family therapy?
____yes _____ no. If "yes" please indicate

| Title or topic | Year | Setting | Method | Number of subjects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

50. Who has/is financing this research? Give the percentage of the support each has/is giving. Total must come to 100.

____% Regional Health Board
____% a hospital
____% Counselling Centre
____% University
____% Private sponsor
____% Business firm
____% E.E.C. grant
____% (other) _____

51. Have you written on family therapy? ____yes _____no
If "yes" please fill in the following. (Use extra page if necessary)

| List of all publications | Year | Publisher | Name of Journal or Book |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

52. (a) Have you ever received therapy? _____ yes, _____ no. If "yes" please mark what applies to you.

| Therapy | Number of sessions | Year(s) |
|---|---|---|
| _____ individual | _____ | _____ |
| _____ family | _____ | _____ |
| _____ group | _____ | _____ |
| _____ _____ | _____ | _____ |

(b) Do you consider the therapy you received to be beneficial in your professional work? _____ yes, _____ no.

53. Whether you have ever been in therapy or not, do you consider it necessary for therapists to receive therapy in the course of their training? _____ yes _____ no. Please give briefly the reasons for your particular response._____
_____

54. (a) Do you have any personal middle/long range goals in family therapy? _____ yes _____ no.

(b) If "yes", please mark with an "x" all that do not apply to you, and rank the remaining ones, with "1" indicating your prime goal and so on.

_____ to become a teacher of family therapy
_____ to become a family therapy supervisor/consultant
_____ to do research in family therapy in Ireland
_____ to write on family therapy in Ireland.
_____ to start a private practice
Other(s) please specify and rank

_____ _____
_____ _____

55. Where did you first hear or read about family therapy that influenced you to study it?
Geographically _____
Setting/Occasion _____
In what year? _____

56. The following is a list of possible sources of influence that may have prompted you to seek training in family therapy. Place an "X" in front of those that do not apply to you, and rank all the remaining ones in order of importance in influencing you. Mark the most influential with "1"; the second most influential with "2"; and so on.

_____ professional colleagues
_____ extracurricular (reading, lectures)
_____ frustration with other approaches to therapy
_____ to meet explicit or implicit job requirements
_____ to learn additional therapy techniques
_____ previous work with groups
_____ observing a family therapist at work.

(List continued on next page)

_____ a felt need to change career.
_____ because of problems within your own family of origin.
_____ to help those close to you with their family problems
_____ to find solutions to problems with your own nuclear family
_____ a family member is a therapist/social worker etc.
_____ to help solve problems facing family life in Ireland.
Others, please specify and rank.

_____ _____
_____ _____

57. Give your impressions about the attitudes of your colleagues in your primary work-setting towards family therapy. Since 1980 has the attitude of your colleagues been
_____ one of increasing acceptance
_____ one of increasing resistance
_____ no noticeable change
Any comments _____

58. How many families do you see in family therapy _____each week _____ each month? Answer one.

59. How many new families do you see in family therapy _____each week _____ each month? Answer one.

60. How many sessions on average do you have with a family in the course of treatment in family therapy? _____

61. In your experience as a family therapist, what percentage do you calculate (percentage must total 100)
_____% leave therapy completely satisfied that their presenting-problem has been resolved.
_____% leave therapy knowing that they have begun to resolve their presenting problem and have the capacity to deal with it in the future.
_____% drop out during the course of therapy.
_____% drop out after the initial session.

62. (a) How many sessions does it generally take a family to completely resolve their presenting-problem? _____ sessions
(b) How many sessions does it generally take a family to leave therapy knowing that they have begun to resolve their presenting-problem and have the capacity to deal with it in the future? _____ sessions
(c) When a family drops out in the course of therapy, how many sessions on average do they remain in therapy? _____ sessions.

63. Of the families you have seen, what is the frequency of the presenting problem? Please place an "x" before the presenting problem(s) that do not apply in your work. Please rank each category independently, placing "1" before the most frequent presenting-problem and "2" before the next most frequent, and so on.

Category A

_____ child-rearing problems
_____ adolescent problems
_____ life transition
_____ depression in family member
_____ desertion by husband
_____ separation/divorce
_____ marital problems
_____ aging
_____ separation of adult children from home
_____ death/loss
_____ school problems
_____ reconstituted families
_____ religious problems
_____ desertion by wife
_____ problems with gardai
_____ infidelity in marriage
_____ children problems in separation/divorce

Other(s), please state and rank.

_____ _____
_____ _____
_____ _____
_____ _____

Category B

_____ drug problems
_____ violence in families
_____ brain-damaged children
_____ psychiatric disorder
_____ phobias
_____ alcohol problems
_____ child abuse
_____ incest
_____ anorexia nervosa
_____ bulimia

Other(s), please state and rank.

_____ _____
_____ _____

64. From the lists of presenting problems given in question 62 and those you may have added yourself, please give in rank order the five most frequent presenting problems overall that you have met with in therapy.

1.
2.
3.
4.
5.

65. It may be reasonably assumed that Irish families feel a certain "stigma" or embarrassment in having to seek professional help with their personal problems. In your experience in working with Irish families, please mark the professionals that they feel most embarrassed in approaching to seek help. Please rank <u>all</u>, starting with"1" as the most embarrassing experience and so on.

_____ being hospitalized in a psychiatric hospital.
_____ visiting a school counsellor
_____ being an out-patient at a psychiatric clinic
_____ visiting a marriage counsellor
_____ visiting a psychoanalyst
_____ visiting a social service department
_____ seeing a priest/minister about problems
_____ being treated by a G.P. after a "breakdown"
_____ bringing a child to a Child Guidance Clinic
_____ visiting a family therapist with the whole family
_____ visiting a psychologist

Other(s) please state and rank

_____ _____
_____ _____

66. In your opinion has any change occurred since 1980 in Irish people's attitudes in coming forward to seek help with personal, marital and family problems? Please circle the number that best represents this change, if such has taken place.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| People are as reluctant to come forward in 1984 as they were in 1980. | | | | In 1984 people generally come forward freely to seek help with personal problems. |

67. (a) In your primary work setting do you charge clients directly_____ or indirectly for their sessions? _____

If indirectly, please go to the next question.

(b) If directly, how is the fee determined? _____ on a sliding scale _____ a flat rate is charged.
(c) If you charge on a sliding scale, what is your minimum fee for each session? _____ your maximum fee for each session? _____
(d) If you charge a flat rate for each session, what is it?_____

68. (a) Since in your primary work-setting you do not charge clients directly for the sessions, who then is responsible for payment?

_____ Regional Health Board
_____ Employers' contribution
_____ Personal insurance policy (V.H.I.)
(Other, please state)_____

(b) What is the fee that is charged to the above for each session?

_____

69. Please mark in order of frequency the referral sources of the people you see in family therapy. Mark with an "x" all that do not apply in your practice, and rank all the remaining ones, with "1" indicating the most frequent source and so on. Mark each category independently.

Category A

_____ social workers
_____ school counsellors
_____ pediatricians
_____ priests/ministers
_____ gardai/courts
_____ psychoanalysts
_____ school authority
_____ hospital personnel
_____ solicitors
_____ psychiatrists
_____ general medical practitioners
_____ psychologists

Other(s) please state and rank

_____ _____ _____ _____

Category B

_____ advertisements in newspapers
_____ radio advertising
_____ T.V. advertising
_____ talk-show on radio/T.V.
_____ other families in therapy
_____ voluntary organization

Other(s) please state and rank

_____ _____ _____ _____

70. Have you observed _____ or do your records show _____ an increase or decrease in referrals over the past twelve months? Please indicate the percentage change, if any.

| | 100% | 75% | 50% | 25% or less |
|---|---|---|---|---|
| Increase | ____ | ____ | ____ | ____ |
| Decrease | ____ | ____ | ____ | ____ |
| No change | ____ | ____ | ____ | ____ |

71. Please estimate what percentage of families you have seen over the past twelve months that have no prior therapy.

No prior therapy for any particular member.

More than 50%_____ 50-25%_____ Less than 25%_____

72. Please estimate that percentage of families you have seen over the past twelve months that had prior therapy.

| | More than 50% | 50-25% | Less than 25% | Helped greatly | Helped moderately | No Help at all |
|---|---|---|---|---|---|---|
| a) for one family member | ____ | ____ | ____ | ____ | ____ | ____ |
| b) individual therapy for more than one family member | ____ | ____ | ____ | ____ | ____ | ____ |
| c) marital therapy | ____ | ____ | ____ | ____ | ____ | ____ |
| d) family therapy | ____ | ____ | ____ | ____ | ____ | ____ |
| e) group therapy | ____ | ____ | ____ | ____ | ____ | ____ |

73. Please give in percentages the socio-economic levels of the families you see in therapy. Place an "x" before those that do not apply in your case. Total must come to 100.

____% executive and professional
____% managerial, junior executive, small business
____% supervisory, clerical, sales
____% unemployed
____% skilled labour
____% student
____% unskilled labour
____% don't know

74. Please estimate the percentages of the various religious denominations that you see in family therapy (Total must be 100).

____ Catholic
____ Church of Ireland
____ Presbyterian
____ Methodist
____ Jewish
____ Other Christian
____ Society of Friends (Quakers)
____ non Christian
____ none

## TECHNIQUES AND PRACTICES

75. How many hours per week do you give to the following professional activities?

____ Family Therapy
____ Individual therapy
____ Group therapy
____ Consultation
____ Supervising
____ Teaching family therapy
____ Administration
____ Research
____ Professional reading
____ Case conference participation

Other(s) please state and give number of hours

____ _____ ____ _____

76. (a) Do you have a private practice in family therapy? ____ yes ____ no
If you answered "no" please go to question 79.
(b) How many hours per week do you spend in private practice? _____
(c) Where do you see families?

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| In your office | ____ | ____ | ____ | ____ |
| In your home | ____ | ____ | ____ | ____ |
| (If other, please state) | | | | |
| _____ | ____ | ____ | ____ | ____ |

77. How are potential clients made aware of your private practice? Please name the three main referral sources, starting with the most frequent one.

(1)
(2)
(3)

78. (a) If in your private practice you charge on a sliding scale, what is your minimum fee per session? _____ your maximum fee per session?

(b) If you charge a flat rate per session, what is that rate? _____

79. In your private practice, please rank the most frequent sources of your fees.

_____ solely from client
_____ solely from personal insurance
_____ solely from company insurance
_____ solely from regional Health Board
_____ (Other, please state)_____

80. (a) Are you medically qualified to prescribe medication as part of your practice of family therapy? _____ yes _____ no. If "no" please go to the next question.

| (b) Do you prescribe medication as part of your family therapy? | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| | ____ | ____ | ____ | ____ |

(c) If you do prescribe medication
(i) do you prescribe medication yourself? ____ yes _____ no
(ii) do you delegate prescription to someone else? ____yes ____no
(iii) do you most frequently prescribe medication on your own initiation?_____ or at insistence of the family?

(iv) do you prescribe medication for the problem individual____ or for other members of the family? _____
(v) in your experience does medication facilitate family therapy? _____ impede family therapy? _____ or have no consistent impact on family therapy? _____
(vi) Please comment briefly on special problems created by the use of medication in family therapy._____
_____
_____

81. Duration of a family session is

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) less than 50 mins | | | | |
| (b) 50-60 mins | | | | |
| (c) more than 1 hour, but less than 2 hours | | | | |
| (d) 2 hours or more | | | | |

82. How frequently do you see a family with a co-therapist?

| | | | | |
|---|---|---|---|---|
| | | | | |

83. How frequently do you see families in family therapy?

| | | | | |
|---|---|---|---|---|
| (a) twice a week | | | | |
| (b) once a week | | | | |
| (c) once a fortnight | | | | |
| (d) once a month | | | | |
| (other) _____ | | | | |

84. Do you see more than

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) one family in a group? | | | | |

If your answer was "never" please go to question 85; otherwise please answer the following.

(b) How many families do you see in a group? _____

(c) Do you have independent sessions with each of these families? _____yes _____ no.

(d) Please give the main advantage as you perceive it to the families from this method.

_____

_____

(e) Please give the main disadvantage as you perceive it to the families from this method.

_____

_____

85. How do families react to the suggestion of group family therapy after you have explained the rationale for the practice?

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) reject the idea totally | | | | |
| (b) initially reject the idea but after discussion, they accept it | | | | |
| (c) are indifferent to the idea | | | | |
| (d) welcome the idea | | | | |

86. Do you audiotape your sessions with families? _____yes _____ no. If "yes," are the tapes used for

| | | | | |
|---|---|---|---|---|
| (a) your supervision | | | | |
| (b) demonstration to your trainee | | | | |

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (c) the benefit of family to listen to after session at home | ____ | ____ | ____ | ____ |
| (d) your own benefit, to listen to between sessions | ____ | ____ | ____ | ____ |
| (e) research at your agency | ____ | ____ | ____ | ____ |
| (f) your own research purposes | ____ | ____ | ____ | ____ |

87. How do families react when you request to make a video-tape of their sessions, after you have explained the reason for the practice?

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) reject the idea totally | ____ | ____ | ____ | ____ |
| (b) initially are hesitant but after discussion agree | ____ | ____ | ____ | ____ |
| (c) are indifferent | ____ | ____ | ____ | ____ |
| (d) welcome your request | ____ | ____ | ____ | ____ |

88. Do you videotape your sessions with a family? ____yes ____no If "yes" are the tapes used for

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) your supervision | ____ | ____ | ____ | ____ |
| (b) demonstration to your trainees | ____ | ____ | ____ | ____ |
| (c) the benefit of the family to review after the session | ____ | ____ | ____ | ____ |
| (d) your benefit to review between sessions | ____ | ____ | ____ | ____ |
| (e) research at your agency | ____ | ____ | ____ | ____ |
| (f) your own research purposes | ____ | ____ | ____ | ____ |

89. How do families react when you request to make a videotape of the sessions, after you have explained the reasons behind the practice

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) reject the request totally | ____ | ____ | ____ | ____ |
| (b) initially are hesitant and after discussion agree | ____ | ____ | ____ | ____ |
| (c) are indifferent | ____ | ____ | ____ | ____ |
| (d) welcome your request | ____ | ____ | ____ | ____ |

## CONCEPTUAL FRAMEWORK

90. We learn family therapy as a result of many experiences. Which of the following was most influential in helping you master family therapy? Check only one.

_____ working on your own level of personal growth and development.
_____ differentiation from your own family of origin.
_____ enacting alternative transactional patterns in sessions.
_____ working through intrapsychic and interpersonal concerns in personal therapy.
_____ gaining a conceptual understanding of systems.
_____ acquiring a set of specific skills
Other _____

91. When you treat a family do you include

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) only the parents | ____ | ____ | ____ | ____ |
| (b) only the nuclear family of parents and children | ____ | ____ | ____ | ____ |
| (c) nuclear family plus others living in the household | ____ | ____ | ____ | ____ |
| (d) extended significant kin living outside the family | ____ | ____ | ____ | ____ |
| (e) significant non-family members | ____ | ____ | ____ | ____ |
| (f) only the family member complaining | ____ | ____ | ____ | ____ |

92. Please name the three main professional organizations associated with family therapy to which you currently belong. Please give their names in full.

1. _____

2. _____

3. _____

93. Please check the professional journals in marital and family therapy that are available to you at your primary work-setting. Add any not on this list and then check them under this column.

Please check the professional journals in marital and family therapy you personally receive at present. If you receive any not on this list please add them and check them under this column.

| | | |
|---|---|---|
| ____ | Family Process | ____ |
| ____ | International Journal of Family Therapy | ____ |
| ____ | Journal of Strategic and Systemic Therapies | ____ |
| ____ | The Family Therapy Networker | ____ |
| ____ | The Australian Journal of Family Therapy | ____ |
| ____ | Family Studies Abstracts | ____ |
| ____ | Journal of Family Issues | ____ |
| ____ | Irish Social Worker | ____ |
| ____ | Orthopsychiatry | ____ |
| ____ | Journal of Family Therapy | ____ |
| ____ | _____ | ____ |
| ____ | _____ | ____ |
| ____ | _____ | ____ |
| ____ | _____ | ____ |

94. List three professional journals you find most helpful in your work in family therapy. Name in order of helpfulness to you.

1. _____

2. _____

3. _____

95. Name the book or books you have most heavily relied upon over the past twelve months to help you in your practice of family therapy.

1. _____

2. _____

3. _____

96. Where do you most frequently obtain books on family therapy? Rank the location with "1" as the most frequent location and so on.

_____ purchase at your own expense
_____ borrow from your work-setting
_____ borrow from your peers
_____ public library
_____ university library
_____ (other)_____

97. Of the following statements check the one that comes nearest to your philosophy of family therapy

_____ it is the method of choice over other methods of psychotherapy.
_____ it is the method of choice but only in combination with individual therapy.
_____ alone it is a useful method of solving problems.
_____ only represents useful skills and techniques.

98. Name five theorists of theories, in order of importance, who have influenced and still continue to influence your practice of family therapy. Mark "1" as the most influential and "2" as the next most influential, and so on.

| | |
|---|---|
| _____ Psychodynamic | Ackerman Institute |
| _____ Behavioral Family Therapy | Patterson |
| _____ Family System Theory and Therapy | Bowen |
| _____ Strategic Approach | Haley |
| _____ Structural Approach | Minuchin |
| _____ Open Systems: Group Analytic Approach | Skynner |
| _____ Communication Approach | Satir |
| _____ Problem-Centred Systems Family Therapy | Epstein |
| _____ Integrative Family Therapy | Duhls |
| _____ Symbolic-Experiential Family Therapy | Whitaker |
| _____ The Interactional Viewpoint of the Mental Research Institute | Weakland/Fisch Watzlawick |
| _____ The Milan School | Palazzoli |
| _____ The Transactional Approach | Framo |

Other(s). Please state and mark in order of importance

_____ _____ _____
_____ _____ _____
_____ _____ _____

99. When a family member is referred, you ask the whole family to come in because you consider

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) one or several members sick, and the others need to come to therapy to help him/her/them | _____ | _____ | _____ | _____ |
| (b) both client and family are sick | _____ | _____ | _____ | _____ |

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (c) illness in a member manifests itself at a crucial time within the family system when change is being processed or blocked | ____ | ____ | ____ | ____ |
| (d) the member's illness is maintained through the processes involved in the family's attempted solution to help him | ____ | ____ | ____ | ____ |

## ETHICAL ISSUES

100. Please list in order of frequency the value conflicts you have observed in families or between family members. (An example of a value conflict may be that of a young adult member who may want to leave and live with her boyfriend.) Mark "1" as the most frequent and so on.

1. _____

2. _____

3. _____

101. If you possess a religious belief system, what part does it play in your philosophy/practice of family therapy?

____ an essential part of the process
____ an important but not essential part
____ it is helpful
____ it is neither a help nor a hindrance
____ a serious disadvantage

102. Do you encounter value conflicts in your work with families in family therapy?

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) between family members | ____ | ____ | ____ | ____ |
| (b) between therapist and one family member | ____ | ____ | ____ | ____ |
| (c) between therapist and all but one family member | ____ | ____ | ____ | ____ |
| (d) between therapist and all family members | ____ | ____ | ____ | ____ |

103. Please circle a number on the scale which best reflects your belief system on the question of divorce.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| I believe divorce is wrong under all circumstances. | | | | I believe that divorce should be available to people for whatever reason they decide. |

104. In therapy we are faced with many difficult cases of marital breakdown. Please indicate the various ways you respond in the therapy situation to the question of divorce.

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) I do not discuss divorce with my clients because my belief system is strongly opposed to it. I inform my clients of my position | ____ | ____ | ____ | ____ |
| (b) I discuss divorce but only after I make my own belief system, which is opposed to divorce, known to my clients | ____ | ____ | ____ | ____ |
| (c) I help my clients towards divorce if such is their goal, but I do not discuss my own belief system with them | ____ | ____ | ____ | ____ |
| (d) I encourage clients towards divorce when I have clear evidence that their relationship has irretrievably broken down | ____ | ____ | ____ | ____ |
| (e) I help my clients towards a divorce for whatever reasons they seek it | ____ | ____ | ____ | ____ |

105. Please circle a number on the scale which most accurately reflects your belief on the question of abortion.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| I believe abortion to be wrong in all circumstances. | | | | I believe abortion should be available to every woman who wants to have one for whatever reason. |

106. While abortion is not permitted by law in the Republic of Ireland, a woman can easily travel to the U.K. to have one. As a consequence therapists in Ireland have to face the reality of this situation, and the purpose of this question is to know how you handle this problem in the therapy session.

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| (a) I do not discuss abortion with my clients because my belief-system is strongly opposed to it. I inform my clients of my position | ____ | ____ | ____ | ____ |
| (b) I discuss abortion with my clients but only after I make my own belief system, which is opposed to it, known to them | ____ | ____ | ____ | ____ |
| (c) I discuss abortion with my clients but I do not reveal my belief system to them | ____ | ____ | ____ | ____ |
| (d) I encourage a client to have an abortion when I know that for her and others in her circumstances an abortion is the best thing | ____ | ____ | ____ | ____ |
| (e) I help my clients towards an abortion for whatever reason they desire to have one. | ____ | ____ | ____ | ____ |

107. Which statement best describes the way you generally deal with sexual matters in therapy sessions with families.
_____ never discuss sex at all
_____ discuss any aspect when children are present
_____ exclude children when sex comes up as a topic
_____ exclude children when the parents' personal sex life is the topic, but not when sex in general is discussed.
Other, please state_____

FUTURE FAMILY THERAPY TRAINING IN IRELAND

108. Do you feel the need for further training in family therapy? ____ yes ____ no. If "yes" please mark your need(s)
(a) _____ I need to have further formal training (courses, seminars)
(b) _____ I need to have further informal training (supervision; peer-group exchanges)

109. If you marked question 108 b which of the following structures or frameworks would you like to receive that training in. Mark in order of your preference, with "1" as the most preferred and so on.
_____ a course lasting three months with full-day sessions once a week
_____ workshop/seminar for 2-3 days
_____ day release
_____ ongoing peer-group supervision/consultation
_____ full-time course for 5 days a week, lasting 2-3 weeks
_____ once a week meeting in a group with trained supervisors
Other(s) please state and rank
____ _____
____ _____

110. The following is a list of possible topics which might be covered in the suggested further training:

| | Mark with an "x" topics of no interest to you. Rank those that you would be interested in. Mark with "1" the topic of most interest to you and so on. | In your opinion which topics do you think should be dealt with in further training for the needs of people in Ireland. Mark "1" as the most important and complete the list. |
|---|---|---|
| Theories of family therapy | ____ | ____ |
| Techniques of family therapy | ____ | ____ |
| Alcoholism in families | ____ | ____ |
| Violence in families | ____ | ____ |
| Incest | ____ | ____ |
| Drug problems in families | ____ | ____ |
| Separation/Divorce | ____ | ____ |
| Life-cycle Problems | ____ | ____ |
| Aging | ____ | ____ |
| Anorexia | ____ | ____ |
| Bulimia | ____ | ____ |
| Schizophrenia | ____ | ____ |
| Depression in family member | ____ | ____ |
| Adolescent problems | ____ | ____ |
| Sexual problem in marriage | ____ | ____ |
| Child-rearing problems | ____ | ____ |
| Desertion | ____ | ____ |
| Reconstituted families | ____ | ____ |

111. Which three theories of family therapy would you like to learn more about. Rank them in order of interest to you.

1. _____
2. _____
3. _____

112. From your experience in working in family therapy in Ireland, which three theories would be most helpful to teach future therapists who would be working in Ireland. Please rank them in what you consider would be beneficial to the Irish family scene..

1. _____
2. _____
3. _____

113. What educational programmes listed below do you think would best help to train future Irish family therapists. Please list all your preferences, and mark "1" as the most beneficial in your opinion, and "2" as the second most beneficial and so on.

_____ a master's degree in family therapy from a University.
_____ a master's degree from a recognised independent family institute.
_____ advanced courses from institutes already engaged in family therapy training.
_____ greater emphasis on family theory/therapy in the clinical psychology and social work departments in irish universities.
_____ great emphasis on family therapy in psychiatrists' training
Other(s) please state and rank _____
_____ _____
_____ _____

114. If family therapy in Ireland is to develop, it seems it would need to acquire not only sympathetic support from non-mental health professionals, but should reach out and help them to have a working knowledge of its theories and practices. This will require input by trained family therapists. Please list your preferences for the educational programmes which you think would facilitate this process. Place "1" before what you consider the programme which would help most in this work, and "2" before the next programme, and so on.

_____ inclusion of some courses in family therapy in the training programmes for counsellors in the secondary schools
_____ basic training for those involved with families in voluntary organizations
_____ training in family therapy in the schools of theology for future priests and ministers
_____ introductory courses in family systems for students in law schools
_____ introductory courses for future general practitioners
_____ introductory courses in the schools of nursing
Other(s) please state and rank
_____ _____
_____ _____

115. Where in your opinion should the future training of Irish family therapists take place? Mark "1" as your first preference and so on

_____ in Ireland _____ in U.S. Other, state_____
_____ in U.K. _____ in Canada _____

116. If you have any information on the status of family therapy in Ireland not covered by this questionnaire, I would be truly grateful to receive it. Any comments on or criticism of this survey that you would like to make I would welcome. Please give these on an extra page or pages, and enclose with the answered questionnaire.

-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-

A. Now that you have completed this questionnaire, I would like to know your feelings about it. How helpful, challenging or even enjoyable was it?

B. Which questions, if any, were unclear or hard to understand?

C. Which of the questions, if any, were too personal?

D. I'm sure that many of the questions asked will have caused different kinds of effects on people. I would like your opinion on the same questions. Please let me know how you think those questions would make people feel

| | Very Uneasy | Moderately Uneasy | Slightly Uneasy | Not at all Uneasy |
|---|---|---|---|---|
| Religion of therapist | ___ | ___ | ___ | ___ |
| Income of therapist | ___ | ___ | ___ | ___ |
| Therapist's job satisfaction/disatisfacion | ___ | ___ | ___ | ___ |
| Therapist's training in family therapy | ___ | ___ | ___ | ___ |
| Therapist receiving therapy | ___ | ___ | ___ | ___ |
| Personal goals in family therapy | ___ | ___ | ___ | ___ |
| Questions on divorce | ___ | ___ | ___ | ___ |
| Questions on abortion | ___ | ___ | ___ | ___ |
| Therapist's reading habits | ___ | ___ | ___ | ___ |
| Question on value conflict | ___ | ___ | ___ | ___ |
| Need for further training | ___ | ___ | ___ | ___ |
| Other(s) please state and rank | | | | |
| _____ | ___ | ___ | ___ | ___ |
| _____ | ___ | ___ | ___ | ___ |
| _____ | ___ | ___ | ___ | ___ |

I wish to thank you for your co-operation in finishing this questionnaire. I appreciate the time and effort you have so generously given.

Sincerely yours,

Jim Moran, S.J.

745 Waverly Street
Palo Alto, California
94301

August 7, 1986

Dear

I'm at present carrying out research into the training of family therapists in Ireland and ask your help in this project. I've sent out questionnaires to the Family Therapy Network and to other organizations directly concerned in that area, and now would like to reach all geographical parts of the country. I would appreciate your co-operation in selecting one person in your Area who is most involved in family therapy, and passing onto him or her the questionnaire which you will receive in a week or two. When you have selected that person, I would be grateful if you sent me a postcard with his/her name and address on it so that I can have further communication with him/her should the need arise. My Dublin address is University Hall, Lr. Hatch Street, Dublin 2.

Thanking you in anticipation of your co-operation,

Sincerely yours,

Jim Moran, S. J.

TO MEMBERS OF THE FAMILY THERAPY NETWORK OF IRELAND

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

The subject matter of my dissertation is the State of the art of family therapy in the Republic, with special focus on past, present and future training that family therapists receive. The questionnaires attempt to identify the elements that are common in the training of Irish family therapists, whether they received that training inside or outside the country. There are five questionnaires in this research project and they are addressed to different groups, with the hope of finding common themes. The groups are (i) family therapists, from those who are professionally trained to the lay non-professional helper, (ii) Counselling Centres, (iii) Family Therapy Training Centres and Programmes, (iv) the Clinical Psychology and Social Work Departments in the Universities, and (v) the Psychiatric Registrars' training programmes.

It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

You will notice that you are not asked to sign your name to this questionnaire, because I am very concerned to assure you of your anonymity. However a simple code mark is attached to your questionnaire and the returning envelop, but the purpose of this mark is to assist me in knowing which questionnaires have been returned and which have not. The key to this code will remain solely in my personal possession and will be destroyed when this study is completed. I hope this personal guarantee of anonymity

will enable you to answer the questionnaire with freedom and confidence. Should you wish to contact me personally, please do so by independent cover.

Your questionnaire should take less than two hours to answer. I would like to make the suggestion that you attempt to answer it in at least two separate sessions. Should you be able to answer it in the first week of receiving it, your co-operation would greatly facilitate my research.

Your name and address have been obtained from the 1982 Directory of the Psychological Society of Ireland. In consultation with professionals in Ireland you have been selected to represent your organization in this research. I look forward to your contribution.

Thanking you in anticipation of your co-operation,

Jim Moran. SJ.

TO ALUMNI OF THE CHILD GUIDANCE CLINIC AT THE
MATER HOSPITAL, DUBLIN

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

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will enable you to answer the questionnaire with freedom and confidence. Should you wish to contact me personally, please do so by independent cover.

Your questionnaire should take less than two hours to answer. I would like to make the suggestion that you attempt to answer it in at least two separate sessions. Should you be able to answer it in the first week of receiving it, your co-operation would greatly facilitate my research.

I'm hoping that you as a fellow member of the "Network" will help me obtain a 100% response from the members by answering and returning the questionnaire.

Thanking you in anticipation of your co-operation,

Jim Moran. SJ.

TO CLINICAL PSYCHOLOGISTS AND CHILD GUIDANCE CENTERS' PROFESSIONAL STAFF, WHO ARE MEMBERS OF THE PSYCHOLOGICAL SOCIETY OF IRELAND

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

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You will notice that you are not asked to sign your name to this questionnaire, because I am very concerned to assure you of your anonymity. However a simple code mark is attached to your questionnaire and the returning envelop, but the purpose of this mark is to assist me in knowing which questionnaires have been returned and which have not. The key to this code will remain solely in my personal possession and will be destroyed when this study is completed. I hope this personal guarantee of anonymity

will enable you to answer the questionnaire with freedom and confidence. Should you wish to contact me personally, please do so by independent cover.

Your questionnaire should take less than two hours to answer. I would like to make the suggestion that you attempt to answer it in at least two separate sessions. Should you be able to answer it in the first week of receiving it, your co-operation would greatly facilitate my research.

Since you have had some training in Family Therapy at the Child Guidance Clinic your contribution to this questionnaire whose main focus is on training, will be of particular value and importance. I hope that the questions on future training will be of particular interest to you.

Thanking you in anticipation of your co-operation,

Jim Moran. S.J.

TO SOCIAL WORKERS IN COMMUNITY CARE

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

The subject matter of my dissertation is the State of the art of family therapy in the Republic, with special focus on past, present and future training that family therapists receive. The questionnaires attempt to identify the elements that are common in the training of Irish family therapists, whether they received that training inside or outside the country. There are five questionnaires in this research project and they are addressed to different groups, with the hope of finding common themes. The groups are (1) family therapists, from those who are professionally trained to the lay non-professional helper, (ii) Counselling Centres, (iii) Family Therapy Training Centres and Programmes, (iv) the Clinical Psychology and Social Work Departments in the Universities, and (v) the Psychiatric Registrars' training programmes.

It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

You will notice that you are not asked to sign your name to this questionnaire, because I am very concerned to assure you of your anonymity. However a simple code mark is attached to your questionnaire and the returning envelop, but the purpose of this mark is to assist me in knowing which questionnaires have been returned and which have not. The key to this code will remain solely in my personal possession and will be destroyed when this study is completed. I hope this personal guarantee of anonymity

will enable you to answer the questionnaire with freedom and confidence. Should you wish to contact me personally, please do so by independent cover.

Your questionnaire should take less than two hours to answer. I would like to make the suggestion that you attempt to answer it in at least two separate sessions. Should you be able to answer it in the first week of receiving it, your co-operation would greatly facilitate my research.

The enclosed questionnaire has been passed on to you as the person most qualified to answer it in your Area, by your Head Social Worker. I have asked your superior to give me your name and address so that any future correspondence will be directly between you and me. As the Health Board is widely and evenly distributed around the country, your contribution will be representative of that same geographical diversity. I look forward to receiving your answered questionnaire and I shall value your contribution to this research.

Thanking you in anticipation of your co-operation,

TO INDIVIDUALS WHO PRACTICE FAMILY THERAPY, EITHER IN INSTITUTIONS OR IN PRIVATE PRACTICE, NOT INCLUDED IN THE OTHER FIVE POPULATIONS

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

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It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

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Your questionnaire should take less than two hours to answer. I would like to make the suggestion that you attempt to answer it in at least two separate sessions. Should you be able to answer it in the first week of receiving it, your co-operation would greatly facilitate my research.

Thanking you in anticipation of your co-operation,

John Moran, SJ.

FAMILY THERAPY NETWORK of IRELAND

1st March, 1984.

Dear Member,

The current committee of the Family Therapy Network of Ireland wish to invite all members to participate in this research study. It is being submitted by a Network member, Jim Moran, S.J. as the dissertation requirement for a doctoral degree in Marital and Family Therapy.

We welcome this opportunity to offer support to a Network member. In addition, these questionnaires as research instruments will deliver the much needed information about the state of Marital and Family Therapy in Ireland. While of great interest to practitioners it is also hoped that some recommendations can influence policy at a National level in regard to training and practice.

In advance, I wish to thank you for your interest and support.

Yours sincerely,

Nollaig Byrne

Dr. Nollaig Byrne, M.B. B.Ch. F.R.C.P.(C),
Chairperson.

THE PSYCHOLOGICAL SOCIETY OF IRELAND

4-5 EUSTACE STREET, DUBLIN 2 TEL. 01-713226

4th May 1984

Rev. J. Moran S.J.
745 Palo Alto
California

Dear Fr Moran

Thank you for your letter of 22nd March and apologies for the delay in replying. Your letter was considered by the Council of the Society at its meeting on 28th April.

In sending you a list of our members which I would hope will facilitate you in your research and to this end you have the permission of our Society to approach members providing you comply with the usual rules of confidentiality and do not use the list for any other matter than research.

Yours sincerely

Colm O'Neill

COLM M. O'NEILL
Honorary Secretary

120 N. Ela St. Barrington, IL 60010

Friday, October 12, 1984

Dear

Some four to five weeks ago I mailed a questionnaire to you dealing with the State of the Arts of Family Therapy in Ireland. To date the questionnaires are being returned at a satisfactory rate.

No matter the nature or the degree of your involvement with Family Therapy, it is my belief that your experience, your perspective of the field and your opinions will all make a very valuable contribution to this study, and will enable me to paint a more accurate picture of Family Therapy in Ireland in 1984, than I could do without your help.

The final results in my opinion should supply helpful information to educators, policy-makers, practitioners in the field and hopefully to all who are involved in the various helping professions.

My purpose then in writing you again is to request your participation in this study, which is the first of its kind ever carried out in Ireland.

If you received a copy of the questionnaire and mislaid it, or perhaps never received the copy mailed you, and would like to receive one, please drop a card to: University Hall. LR Hatch St. Dublin 2 and I'll forward one to you.

Should you have already mailed your answers, please be tolerant with this renewed request.

Should the unanswered questionnaire be on your desk I hope you will be able to take the time necessary to fill it out and return it to me at University Hall within the next few days.

Thank you in advance for your co-operation.

Sincerely yours,

Jim Moran, S.J.

November 3, 1984

120 N. Ela Street
Barrington, IL 60010

Dear

In writing you this second follow-up letter I'm fully aware that many factors may have caused you to delay your response to the questionnaire on family therapy. I realize that your work schedule, the very size of the questionnaire, the reflection and research necessary to answer some of the questions, and your concern to do a professional job in answering, may have caused you to delay in responding.

Initially I had hoped that the Family Therapy Network would have the highest response rate of the three groups surveyed. To date this has not happened. In truth the Network response is in last place, a full 22 percentage points behind the group in first place and 10 percentage points behind the group in second place.

I believe that when you as a member of a professional group clearly commited to the advancement of family therapy, find your organization in last place in responding to a national survey on family therapy that you will react positively to the questionnaire.

I really do need your co-operation immediately to make this research truly represented of Family Therapy in Ireland, and if you respond within a few days of receiving this letter, I shall be able to move forward with the research. As I shall have to terminate the actual survey shortly, I rely very much upon your immediate co-operation.

I wish to thank you in advance.

Sincerely yours,

Jim Moran, S.J.

P.S. Should you not have received a questionnaire or mislaid the one you received, please drop me a card to the address below and I'll have one forwarded to you.

University Hall, Lowen Hatch St. Dublin 2.

120 N. ELA STREET, BARRINGTON, ILLINOIS 60010

6th November 1984

Dear

In writing you this second follow-up letter I'm aware that many who took the basic course, and others at Mater Child Guidance Clinic, may not consider themselves to be family therapists. However, you are important in this research which I am carrying out on family therapy in Ireland. Your importance to this survey rests primarily on the fact that you have received some training in family therapy. From this training you learned the main characteristics of family therapy, obtained a theoretical orientation, and, as a consequence, I'm sure you possess some ideas on the direction you would like to see future training in family therapy take.

There are questions about these areas in the questionnaire which you could authentically respond to without having to be practicing family therapy. Even a partially answered questionnaire covering these areas would be helpful to this research. If you wished to answer other questions all the better, but I do need your cooperation in answering the minimal number of questions mentioned above.

The time allowed for carrying out this survey is getting shorter, so if you could find time within a few days of receiving this letter to return the fully, or partially answered questionnaire, I would be greatly facilitated.

I wish to thank you in advance for your cooperation.

Yours sincerely,

JM:anb

Jim Moran, S. J.

P.S. Please return the questionnaire to the address given below. Should you not have received a questionnaire, or mislaid the one you received, drop me a card and I'll have one forwarded to you.

University Hall, LR., Hatch Street, Dublin 2

120 N. ELA STREET, BARRINGTON, ILLINOIS 60010

6th November 1984

Dear

Of the three professional organizations that I am surveying on the topic of family therapy in Ireland, the Psychological Society of Ireland has responded most generously, leading the next closest organization by 13 percentage points. I am truly grateful to the members who have responded.

However, this research will be more truly representative the higher the response rate becomes, and because of this I am seeking your personal cooperation through this letter and appeal. Perhaps not all questions pertain to you and your work setting, but I would be grateful if you answered the ones that do pertain. Even a partially answered questionnaire, one which would be a true reflection of your position, would advance the research.

If you could respond within a few days of receiving this letter, I would be enabled to move forward with this research. As I have to terminate the survey shortly, I rely very much on your immediate cooperation.

I wish to thank you in advance.

Yours sincerely,

JM:anb

Jim Moran, S. J.

P. S. Please return the questionnaire to the address given below. Should you not have received a questionnaire, or mislaid the one you received, drop me a card and I'll have one forwarded to you.

University Hall, LR., Hatch Street, Dublin 2

# APPENDIX C

## Documents Relating to Questionnaire 2

## QUESTIONNAIRE 2

## FAMILY THERAPY TRAINING INSTITUTES AND PROGRAMMES

Because the characteristics of Family Therapy Training Programmes vary significantly, we provide two examples on how you might record descriptive material about your particular programme.

Please select the questionnaire that most accurately reflects the nature of your programme.

PROGRAMME A:

| Title | Duration | Number of Students in Past Twelve Months | Minimal Education Required |
|---|---|---|---|
| Week-end workshop | 2 days | 30<br>(3 groups of 10 each) | Leaving Cert.<br>B.A.<br>No requirement |

PROGRAMME B:

| Title | Duration | Number of Students in Past Twelve Months | Minimal Education Required |
|---|---|---|---|
| 2-year introductory course | 4 hrs each week, 30 wks. | 9 | M.S.W.<br>M.B. |

# QUESTIONNAIRE A

1. Name of Programme _____

   Address _____

   Phone Numbers _____ _____ _____

2. Founder (s) of Programme _____

   _____

   _____

3. | Names of Previous Directors | Qualifications | From/To Years |
   |---|---|---|
   | | | |
   | | | |
   | | | |

4. | Name of Current Director | Qualifications | From/To Years |
   |---|---|---|
   | | | |

5. Date when Programme was initiated _____

6. Please list the teachers of family therapy on your staff and their specific qualifications to teach family therapy. These qualifications may be academic in nature or may come from experience and acknowledged expertise, or may be a combination of both.

| Academic Qualifications | Other Qualifications From Experience, etc | Year(s) Teaching Family Therapy | Age | Sex | Hours Each Week |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

7. Who finances the trainees that come to your work-shop? Mark with an "x" the sources of funding that don't apply in your case. Rank the remaining ones, with "1" as the most frequent method of financing and so on.

   _____ trainees themselves totally
   _____ regional Health Board
   _____ agency where trainees are employed
   _____ trainees and regional Health Board
   _____ trainees and their agency
   _____ Health Board and agency
   _____ trainees, Health Board, and agency
   _____ scholarship, grant
   _____ (other, please state)_____
   _____ don't know

8. What is the average cost of
   (a) a one-day workshop? _____
   (b) a two-day workshop? _____
   (c) other, please state _____

9. Trainees in your programme since it started have come from various backgrounds. Mark with an "x" those professions from which you have never received any trainees, and the percentages of trainees you have received from the other professions. Total must come to 100.

| | |
|---|---|
| ____% social workers | ____% family therapists |
| ____% school counselors | ____% psychoanalysts |
| ____% clinical psychologists | ____% women religious |
| ____% general medical practitioners | ____% male religious |
| ____% medical students | ____% lay helpers in voluntary organizations |
| ____% psychiatrists | ____% nurses |
| ____% priests/ministers | ____% gardai |
| ____% solicitors | ____% _____ |
| ____% (other)_____ | |

10. Where in Ireland, apart from your given location, have you conducted workshops/seminars? Use extra page if necessary.

| City/Town | Year(s) | Topics | To What Group? | Numbers Attending |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

11. Please indicate the curriculum content of your workshops and seminars, and also indicate the number of times you have given any particular workshop or seminar.

| Topic | Have Conducted Workshop or Seminar | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

12. (a) Do you supply the participants of your workshops/seminars with an assessment sheet to evaluate the workshop? ____yes ____no.
(b) If "yes" please enclose one with an answered questionnaire.

13. Name five theorists or theories, in order of importance, who have influenced and still continues to influence your teaching of family therapy. Mark "1" as the most influential and "2" as the next most influential, and so on.

| | | |
|---|---|---|
| _____ | Psychodynamic | Ackerman Institute |
| _____ | Behavioral Family Therapy | Patterson |
| _____ | Family System Theory and Therapy | Bowen |
| _____ | Strategic Approach | Haley |
| _____ | Structural Approach | Minuchin |
| _____ | Open Systems: Group Analytic Approach | Skynner |
| _____ | Communication Approach | Satir |
| _____ | Problem-Centred Systems Family Therapy | Epstein |
| _____ | Integrative Family Therapy | Duhls |
| _____ | Symbolic-Experiential Family Therapy | Whitaker |
| _____ | The Interactional Viewpoint of the Mental Research Institute | Weakland/Fisch Watzlawick |
| _____ | The Milan School | Palazzoli |
| _____ | The Transactional Approach | Framo |

Other(s), please state and rank in order of importance.

_____ _____ _____
_____ _____ _____
_____ _____ _____

14. Please check the professional journals in marital and family therapy that your receive for the benefit of your staff. Add any that you receive which are not on this list.

_____ Family Process
_____ International Journal of Family Therapy
_____ Journal of Strategic and Systemic Therapies
_____ The Family Therapy Networker
_____ The Australian Journal of Family Therapy
_____ Family Studies Abstracts
_____ Journal of Family Issues
_____ Irish Social Worker
_____ Orthopsychiatry
_____ Journal of Family Therapy

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

15. (a) Do your workshops/seminars receive any subsidy, grant, or donation?
_____yes _____no.
(b) If "yes" please check.

| | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| _____ from regional Health Board? | _____ | _____ | _____ | _____ |
| _____ from Department of Education? | _____ | _____ | _____ | _____ |
| _____ from a hospital? | _____ | _____ | _____ | _____ |
| _____ from a commercial firm? | _____ | _____ | _____ | _____ |
| _____ from a wealthy sponsor? | _____ | _____ | _____ | _____ |
| _____ (Other)_____ | _____ | _____ | _____ | _____ |

16. What percentages of the cost of running a workshop/seminar are covered by the following:
    ____% by outside bodies as mentioned in previous question
    ____% by fees of those attending.

17. (a) Has your programme ever sponsored a major conference for family therapists since its beginning? ____yes ____ no.
    (b) If "yes" please name all you have sponsored. Use extra page if necessary.

| Title/Topic | Duration | Month/Year | Numbers Attending | Major Speakers |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

18. Summary of your programme over past 12 months (use extra page if necessary).

| Workshop Title | Duration | Number Attending | Major Speaker(s) | Minimal Education Required |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

19. If you have a catalogue or brochure of your programme, please enclose it with the answered questionnaire. If you don't have one, please give a brief mission statement of your programme.

-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-

Thank you for your co-operation in this research. I appreciate the time and energy your spent in completing This questionnaire.

Sincerely yours,

Jim Moran, S.J.

# QUESTIONNAIRE B

1. Name of Programme _____

2. Address _____

   Phone number(s) _____ _____ _____

3. Date when programme was started _____

4. (a) Founding Director's Name _____ Qualifications _____ Year(s) in Office _____

   (b) Present Director's Name _____ Qualifications _____ Year(s) in Office _____

   (c) Previous Director's Names _____ Qualifications _____ Year(s) in Office _____

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

5. Status of Centre
   _____ free standing _____ hospital affiliated
   _____ university affiliated Other, please state _____

6. Who is responsible for the financial management of your Programme? Mark what is relevant. Give the levels of responsibility in percentages. Total must come to 100.
   ____% Government through regional Health Board.
   ____% Government through Department of Health
   ____% Religious denomination
   ____% Lay people with a board of directors
   ____% A Foundation (give name _____).
   Other(s) please state and give percentage
   ____% _____
   ____% _____

7. List the specific courses you teach in your Programme.

| | Title of Programme | Duration | Total Cost to Trainee | Year Programme Was Initiated |
|---|---|---|---|---|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |

8. Please list all the teachers of family therapy on your staff and their specific family therapy qualifications.

| Specific Qualifications in Family Therapy | Number with that qualification | Age | Sex | How many hrs. a week do they teach? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

9. (a) Has your Centre conducted seminars/workshops for family therapists outside of the city/location where you regularly conduct your Programme? ___yes ___no
(b) If "yes" please indicate the location (use extra page if necessary).

| In what town? | Workshop content or title | Month year | Numbers Attending | Speaker(s) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

10. Name the major conferences on family therapy your Centre has sponsored since its foundation. (Please use extra page or pages as is necessary.)

| Title of Conference | Numbers Attending | Month Year | Location | Speakers |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

11. Has your Centre conducted lectures, seminars/workshops on family therapy for specific professional groups such as doctors, clergy, lawyers, school counsellors etc. since 1980? ___yes ___ no

| Title of Lecture | Professional Group Attending | Location | Month Year | Numbers Attending | Speaker(s) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

12. (a) Has your Centre conducted lectures/courses, seminars/workshops on family problems for the general public since 1980? ____yes ____no
(b) If "yes" please give the information required. Use extra page if necessary.

| Title of Talk | Location | Month Year | Numbers Attending | Speaker(s) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

13. Who finances the trainess who participate in your Programme. Give in percentages the sources of funding for your trainees. Total must come to 100.

____% trainees themselves
____% Agency where they are employed
____% trainees and their regional Health Board
____% Health Board and Agency
____% don't know
Other, please state
____% _____

____% regional Health Board where trainees work
____% trainees and their Agency
____% trainees, Health Board and Agency
____% Scholarship/grant
____% _____
____% _____

14. Trainees in your programme since it was started have come from various backgrounds. Mark with an "x" those professions from which you have never received any trainees, and the percentages of trainees you have received from the other professions. (Total must come to 100.)

____% social workers
____% school counselors
____% clinical psychologists
____% general medical practitioners
____% medical students
____% psychiatrists
____% priests/ministers
____% solicitors
Others, please state
____% _____

____% family therapists
____% psychoanalysts
____% women religious
____% male religious
____% lay helpers in voluntary organizations
____% nurses
____% gardai
____% _____
____% _____

15. In your programme for the current year, please list all your students under these headings. (Use extra page, if necessary.)

| Sex F = Female M = Male | Age | Highest Academic Qualification | Current Professional Status | City, town, country area where trainee currently is working |
|---|---|---|---|---|

16. Do you assess the initial level of clinical skills of your potential trainees? ___yes ___no. If "yes", how are these skills assessed?

| Check all that apply to your programme | | Rank the importance you attach to these modes of assessment, with "1" as the most important and so on irrespective of whether you use them or not. |
|---|---|---|
| _____ | Written test | _____ |
| _____ | Personal interview | _____ |
| _____ | Audiotape of applicant's work | _____ |
| _____ | Videotape of applicant's work | _____ |
| _____ | Written recommendations of others | _____ |
| _____ | Other(s)_____ | _____ |

17. Do you set goals for your trainees? ___yes ___no. If "yes" how? ___mutually with trainee; ___independently of trainee.

18. Do you evaluate your trainees progress? ___yes ___no. If "yes", check all that apply.
___according to established goals
___by observation of work sample
___in comparison with initial assessment
___by student self-evaluation
___by peer evaluation
Other(s)
___ _____

19. (a) Do you provide feedback to trainees on their progress? ___yes ___no. If "yes", please check what applies.

| | | | |
|---|---|---|---|
| | ___ weekly | ___ | mid-programme |
| | ___ monthly | ___ | end of programme |
| Other(s) | ___ _____ | ___ | _____ |

(b) How do you provide this feedback?

| | | | |
|---|---|---|---|
| | ___ verbally in group | ___ | verbally but privately |
| | ___ in writing alone | ___ | in writing and with group |
| Other(s) | | | discussion |
| | ___ _____ | ___ | _____ |

20. (a) Do you give any formal rewards to trainees who have successfully passed through your programme? ___yes ___no
(b) If "yes", what is the nature of this reward? _____
_____
(c) Do you grade your trainees at the end of the programme? ___yes ___no.
(d) Do any of your trainees fail to pass your programme? ___yes ___no. If "yes" what percentage? _____%
(e) If students fail to pass your programme, please give some of the reasons.
_____
_____
_____

21. Where do your trainees work after they complete your programme(s). Take last year's group as an example. Please give percentages. Total must come to 100.

_____% Remain in their work-setting with no acknowledgement of their new knowledge and skills in working with couples and families.
_____% Remain in their work-setting with unchanged status but with greater opportunity for working with couples and families.
_____% Have changed their work-setting in order to have more opportunities to work with families and couples.
_____% Have changed their work-setting in order to become family therapists exclusively in a mental health facility.
_____% Have gone into private practice as a family therapist, either ___part-time___full-time
Other, please state and give percentage
_____% _____
_____% don't know (give percentage).

CONCEPTUAL FRAMEWORK

22. List in order of importance three texts you require your trainees to read, or strongly recommend.

(1) _____
(2) _____
(3) _____

23. List in order of importance three articles you strongly recommend to your trainees.

(1) _____
(2) _____
(3) _____

24. Name five theorists or theories, in order of importance, who have influenced and still continue to influence your teaching of family therapy. Mark "1" as the most influential, and "2" as the next most influential, and so on.

| | | |
|---|---|---|
| _____ | Psychodynamic | Ackerman Institute |
| _____ | Behavioral Family Therapy | Patterson |
| _____ | Family System Theory and Therapy | Bowen |
| _____ | Strategic Approach | Haley |
| _____ | Structural Approach | Minuchin |
| _____ | Open Systems: Group Analytic Approach | Skynner |
| _____ | Communication Approach | Satir |
| _____ | Problem-centred Systems Family Therapy | Epstein |
| _____ | Integrative Family Therapy | Duhls |
| _____ | Symbolic-Experiential Family Therapy | Whitaker |
| _____ | The Interactional Viewpoint of the Mental Research Institute | Weakland/Fisch Watzlawick |
| _____ | The Milan School | Palazzoli |
| _____ | The Transactional Approach | Framo |

Other(s). Please state and mark in order of importance.

_____ _____ _____
_____ _____ _____
_____ _____ _____

25. (a) Do you have a library available for the use of your trainees? ____yes ____no.
    (b) If "yes" approximately what percentage of the volumes in it relate to marital and family therapy? _____%

26. Check the journals on marital and family therapy you receive at your Centre for the use of your trainees. Please add those you receive which are not on this list.

_____ Family Process
_____ International Journal of Family Therapy
_____ Journal of Strategic and Systemic Therapies
_____ The Family Therapy Networker
_____ The Australian Journal of Family Therapy
_____ Family Studies Abstracts
_____ Journal of Family Issues
_____ Irish Social Worker
_____ Orthopsychiatry
_____ Journal of Family Therapy
_____ _____
_____ _____
_____ _____
_____ _____

SUPERVISION

27. (a) Does your Centre possess videotaping equipment for training purposes? ____yes ____no.
    (b) Does your Centre have at least one room with a one-way mirror for training purposes? ____yes ____no.

28. Rank the following supervisory modalities in order of priority. ("1" = the most utilized etc.)

_____ delayed supervision
_____ live supervision
_____ (other)_____
_____ co-therapy with supervisor
_____ pre/post session supervision
_____ _____

29. If you use delayed supervision, rank the following methods in order of priority. ("1" = the most utilized etc.)

| | With Supervisor Alone | With Supervisor and Group |
|---|---|---|
| _____ therapist self-report | _____ | _____ |
| _____ videotape playback | _____ | _____ |
| _____ audiotape playback | _____ | _____ |
| _____ Other _____ | _____ | _____ |

30. If you use live supervision, rank the following methods in order of priority ("1" = the most utilized etc.)

| | With Supervisor Alone | With Supervisor and Group |
|---|---|---|
| _____ telephone | _____ | _____ |
| _____ bug in ear | _____ | _____ |
| _____ therapist walk-out | _____ | _____ |
| _____ supervisor walk-in | _____ | _____ |
| group members walk-in | | |

31. Which of the two forms of supervision is most prevalent in your Centre?
_____ individual _____group

32. The supervisors of Family Therapy in your programme may derive their status as supervisors from one or both of the following sources. Source A: your recognition of their training, experience and expertise; Source B: they may be recognized as supervisors by a professional organization. Please indicate one or both forms of recognition in answering this question.

| Source of Recognition as Family Therapy Supervisor | Sex | Age | Number of Hours Supervising Each Week |
|---|---|---|---|
| | | | |
| | | | |

33. What percentages of time do your trainees spend in the following activities. (Total must come to 100.)

_____% didactic
_____% delayed supervision
_____% live supervision
_____% (other)_____

_____% selected readings
_____% pre/post session supervision
_____% consultation on problems in
_____% _____

34. While the training process in family therapy is progressing, do you hold any ongoing discussion on how your trainees might integrate their new knowledge and skills into their current work setting? ____yes ____no.

(a) If "yes", please describe briefly how you do this._____

_____

(b) If "no" do you hold a discussion after training or near the end of it on how to integrate family therapy into the trainee's work-setting? ____yes ____no.

35. Do your trainees have any input into assessing your programme? ____yes ____no.

If "yes" please mark what applies in your case.
____ written input immediately after each lecture
____ oral input after each lecture
____ written input while programme is in progress at given intervals.
____ oral input while programme is in progress at given intervals.
____ written input only at the end of training.
____ oral input only at the end of training
Other, please state._____

_____

36. (a) Do you have definite plans to develop your family therapy training programme over the coming two years? ____yes ____no.

(b) Are you seriously considering development of your family therapy programme over the coming two years? ___yes ___no.

If "yes" to one or both, please mark those items with an "A" where you have definite plans in place, and mark with a "B" those items you are seriously considering.

_____ increase the number of our trainees
_____ increase the number of our trainers
_____ increase the number of our supervisors
_____ develop our library facilities
_____ expand our training programme to other areas of the country
_____ offer courses to other marital health professionals
_____ offer more advanced courses
_____ offer a recognised degree programme
_____ undertake research on the family in Ireland
_____ offer consultation services to family therapists
_____ amalgamate with other training programme(s)
_____ offer practical courses to the public on family therapy.
_____ introduce a programme to train family therapy supervisors.
Other(s) please state
_____ _____

37. Summary of your Programme(s)

| Title(s) | Duration | Number of Students in Past 12 Months | Minimal Education Required |
|---|---|---|---|

If you have a printed catalogue of your programme, please enclose it with the answered questionnaire. If you don't have one, please give a brief mission statement of your Centre.

-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-x-

Thank you for your co-operation in this research. I appreciate the time and energy you spent completing this questionnaire.

Sincerely yours,

Jim Moran, S.J.

TO FAMILY THERAPY TRAINING CENTRES AND PROGRAMMES

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

The subject matter of my dissertation is the State of the art of family therapy in the Republic, with special focus on past, present and future training that family therapists receive. The questionnaires attempt to identify the elements that are common in the training of Irish family therapists, whether they received that training inside or outside the country. There are five questionnaires in this research project and they are addressed to different groups, with the hope of finding common themes. The groups are (1) family therapists, from those who are professionally trained to the lay non-professional helper, (ii) Counselling Centres, (iii) Family Therapy Training Centres and Programmes, (iv) the Clinical Psychology and Social Work Departments in the Universities, and (v) the Psychiatric Registrars' training programmes.

It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

This questionnaire attempts to search out the nature of training in family therapy you offer at your clinic/centre, and also it seeks to find if you have plans to expand your training in the immediate future. Your contribution in answering this questionnaire will be central to this research. I look forward to receiving your contribution.

Gratefully yours,
Jim Moran. S.J.

# APPENDIX D

## Documents Relating to Questionnaire 3

QUESTIONNAIRE 3

---

QUESTIONNAIRE TO THE CLINICAL PSYCHOLOGY
AND SOCIAL WORK DEPARTMENTS OF IRISH
UNIVERSITIES AND COLLEGES

---

1. Your University is _____

2. Your Department is _____

3. Please give titles in full of the degree(s), diploma(s) and certificate(s) that your University confers in your Department or Faculty.

_____ _____

_____ _____

_____ _____

4. Does your Faculty teach even in the smallest way Marital, Family, or Marital and Family Theory and/or Therapy? ____yes ____no.
If "no," please turn to Question 21.
If "yes," please answer the following questions.

5.

| | Yes | No | | How many lectures? | Duration of each lecture |
|---|---|---|---|---|---|
| (a) Do you give lectures in family therapy only? | ___ | ___ | If "yes" | _____ | _____ |
| (b) Do you give lectures in marital therapy only? | ___ | ___ | If "yes" | _____ | _____ |
| (c) Do you give lectures in both marital and family therapy? | ___ | ___ | If "yes" | _____ | _____ |

6.

| Are your lectures | Given in a Degree Course | In a Diploma Course | In a Certificate Course |
|---|---|---|---|
| (a) Marital therapy? | _____ | _____ | _____ |
| (b) Family therapy? | _____ | _____ | _____ |
| (c) Marital and Family therapy? | _____ | _____ | _____ |

7. (a) Is training in marital and family therapy available to your students through any other agency, such as professional training centres, institutes, private practitioners, etc? ____yes ____ no.
(b) If "yes," please indicate

| Name of Institute(s) | Type(s) of Training | Duration of That Training |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

8. What amount of time is given to the didactic part of a student's education in

| | Hours per Week? | For how many weeks? |
|---|---|---|
| (a) Marital therapy | ____ | ____ |
| (b) Family therapy | ____ | ____ |
| (c) Marital and Family therapy | ____ | ____ |

9. What amount of time is given to a student's practice of

| | Hours per Week? | For how many weeks? |
|---|---|---|
| (a) Marital therapy | ____ | ____ |
| (b) Family therapy | ____ | ____ |
| (c) Marital and Family therapy | ____ | ____ |

10. What amount of time is given the supervision of a student's practice in

| | Hours per Week? | For how many weeks? |
|---|---|---|
| (a) Marital therapy | ____ | ____ |
| (b) Family therapy | ____ | ____ |
| (c) Marital and Family therapy | ____ | ____ |

11. If the University does not supervise the practice of a student's work, who does? Please give a brief account of the arrangement you have with outside agencies, and give their names. _____

_____

_____

_____

12. Please check whatever applies to your curriculum.

| | Part of Required Curriculum | Optional and Separate Unit |
|---|---|---|
| (a) Marital therapy is | ____ | ____ |
| (b) Family therapy is | ____ | ____ |
| (c) Marital and Family Therapy is | ____ | ____ |

13. Please give the number of students in your discipline who over the past twelve months formed part of your programme in

(a) Marital therapy ____ (b) Family therapy ____
(c) Marital and Family therapy ____

14. (a) Is your Faculty currently engaged in any research in the area of marital and/or family therapy? ___yes ___no.
(b) If "yes," please indicate the area(s) _____

_____

_____

_____

15. Check the journals in marital and family therapy that your library receives on a monthly or quarterly basis. Please add ones you receive which are not included on this list.

_____ Family Process
_____ International Journal of Family Therapy
_____ Journal of Strategic and Systemic Therapies
_____ The Family Therapy Networker
_____ The Australian Journal of Family Therapy
_____ Family Studies Abstracts
_____ Journal of Family Issues
_____ Irish Social Worker
_____ Orthopsychiatry
_____ Journal of Family Therapy
_____ _____
_____ _____
_____ _____
_____ _____

16. Which of the following statements seem to apply to your philosophy of family therapy. Please check only <u>one</u>.

Family Therapy is

_____ the method of choice over other methods of psychotherapy.
_____ the method of choice but only in conjunction with individual therapy.
_____ alone is a useful method of solving problems.
_____ only represents useful skills and techniques.

17. What theoretical orientations most influence the direction of your University's work in marital and family therapy? Please mark five of the most influential, with "1" indicating the most influential, and "2" the second, and so on.

| | |
|---|---|
| _____ Psychodynamic | Ackerman Institute |
| _____ Behavioral Family Therapy | Patterson |
| _____ Family System Theory and Therapy | Bowen |
| _____ Strategic Approach | Haley |
| _____ Structural Approach | Minuchin |
| _____ Open Systems: Group Analytic Approach | Skynner |
| _____ Communication Approach | Satir |
| _____ Problem-Centred Systems Family Therapy | Epstein |
| _____ Integrative Family Therapy | Duhls |
| _____ Symbolic-Experiential Family Therapy | Whitaker |
| _____ The Interactional Viewpoint of the Mental Research Institute | Weakland/Fisch Watzlawick |
| _____ The Milan School | Palazzoli |
| _____ The Transactional Approach | Framo |

Other(s), please state and rank

_____ _____ _____
_____ _____ _____
_____ _____ _____

18. (a) Have you plans to increase your current commitment to marital and family therapy within the two coming academic years? ____yes ____no.

(b) If "yes," please indicate the specific area or areas on which you will focus your attention. Mark the prime area with "1", and the next prime area with "2" and so on.

_____ increase the hours of teaching marital therapy
_____ increase the hours of teaching family therapy
_____ undertake the supervision of your students' practice
_____ ally more closely with an external agency already involved in teaching marital and family therapy.
_____ employ extra staff whose specialty is in marital and family therapy.
_____ have your current staff receive additional training in marital and family therapy.
_____ develop a programme to grant a diploma or certificate exclusively in the area of marital and family therapy.
_____ grant a M.A. degree in marital and family therapy.
Other(s), please state and rank

_____ _____

_____ _____

19. If either one or both of the following are part of your plans for the two coming academic years, please indicate

_____ decrease current commitment to marital and family therapy
_____ drop your current programme in marital and family therapy from your curriculum.

20. If you are either decreasing or eliminating marital/family therapy from your programme, please indicate the reasons for your decision on the following list or add your own.

_____ lack of financing
_____ no demand for these courses
_____ our students can learn marital and family therapy after they graduate from other institutes.
_____ we do not see marital and family therapy as fitting into the academic nature of our programme.
Other(s), please state and check

_____ _____

_____ _____

_____ _____

21. (a) Do you plan to introduce marital and family therapy into your programme within the next two academic years? ____yes ____no.

(b) If "yes," do you plan to introduce
_____marital therapy _____marital and family therapy
_____family therapy

(c) If "no," please give briefly some explanation of your answer.

_____

_____

22. If there is any information which you think would be of assistance in this research, I would be very grateful to receive it. Please enclose with answered questionnaire or forward this extra information to me at a later date.

-=-=-=-=-=-=-=-=-=-=-=-=-=-

This questionnaire was completed by

Name (Optional) _____

Position in University _____

Date _____

-=-=-=-=-=-=-=-=-=-=-=-=-=-

I wish to express my thanks and appreciation to you for the time and effort you gave in filling out this questionnaire.

Sincerely yours,

Jim Moran, S.J.

TO IRISH UNIVERSITIES

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

The subject matter of my dissertation is the State of the art of family therapy in the Republic, with special focus on past, present and future training that family therapists receive. The questionnaires attempt to identify the elements that are common in the training of Irish family therapists, whether they received that training inside or outside the country. There are five questionnaires in this research project and they are addressed to different groups, with the hope of finding common themes. The groups are (i) family therapists, from those who are professionally trained to the lay non-professional helper, (ii) Counselling Centres, (iii) Family Therapy Training Centres and Programmes, (iv) the Clinical Psychology and Social Work Departments in the Universities, and (v) the Psychiatric Registrars' training programmes.

It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

In mailing this questionnaire to you I am fully aware that the structure in Irish Universities and in your Departments varies greatly from those in the U.S. However, as I'm committed by the nature of my research to investigate the level or levels of family therapy training that your students may receive, I have tried to tailor my questionnaire to meet the situations that exist in the different Colleges. Independently of the degree of family theory or therapy that may exist in your Department, or even if you don't teach any, I would nevertheless be helped and grateful to receive a returned questionnaire.

Thanking you in anticipation of your help,

Jim Moran S.J.

# APPENDIX E

## Documents Relating to Questionnaire 4

# QUESTIONNAIRE 4

## POST GRADUATE TRAINING PROGRAMME IN PSYCHIATRY

1. (a) Name of Programme _____

   (b) Duration _____

   (c) Diploma/degree granted _____

2. Please indicate if any of the following form part of your programme, no matter how small a part _____family therapy _____marital therapy _____marital and family therapy.
   If none of these form part of your programme, please go to question 25.

3. (a) Do your registrars receive lectures in family therapy? ____yes ____no.
   If "yes" how many lectures? _____
   What is the duration of each lecture? _____hrs.

   (b) Do your registrars receive lectures in marital therapy? ____yes ____no
   If "yes" how many lectures? _____
   What is the duration of each lecture? _____ hrs

   (c) Do your registrars receive lectures in marital and family therapy?
   ____yes ____no.
   If "yes" how many lectures? _____
   What is the duration of each lectures? _____hrs.

4. In the training of your registrars is

| | An Option | Required by Curriculum |
|---|---|---|
| Family Therapy? | _____ | _____ |
| Marital Therapy? | _____ | _____ |
| Family and Marital Therapy? | _____ | _____ |

5. In your training what amount of time is given by your registrars to the practice
   (a) of family therapy each week? _____hrs
   for how many weeks? _____wks
   (b) of marital therapy each week? _____hrs
   for how many weeks? _____wks

6. In your training what amount of time do your registrars spend in supervision of
   (a) family therapy each week? _____hrs
   for how many weeks? _____wks
   (b) marital therapy each week? _____hrs
   for how many weeks? _____wks

7. (a) Does your programme possess videotaping equipment for training purposes in marital and family therapy? ____yes ____no

   (b) Do you have at least one interviewing room with a one-way mirror for training in marital and family therapy? ____yes ____no

8. In your training of registrars in marital and family therapy, rank the following supervisory methods in order of priority ("1" = the most utilized and so on)

   _____ delayed supervision
   _____ co-therapy with supervisor
   Other _____

   _____ live supervision
   _____ pre/post session supervision
   _____

9. If you use delayed supervision please rank the following method in order of priority ("1" = the most utilized and so on)

| | With Supervisor Alone | With Supervisor and Group |
|---|---|---|
| _____therapist self-report | _____ | _____ |
| _____videotape playback | _____ | _____ |
| _____audiotape playback | _____ | _____ |
| _____registrar's personal issues | _____ | _____ |

10. If you use live supervision please rank the following methods, in order of priority ("1" = most utilized and so on)

| | With Supervisor Alone | With Supervisor and Group |
|---|---|---|
| _____telephone | _____ | _____ |
| _____bug in ear | _____ | _____ |
| _____registrar walk-out | _____ | _____ |
| _____consultant walk-in | _____ | _____ |
| _____group member walk in | | |

11. Please indicate the more frequent method of supervision

    _____ individual supervision _____ group supervision

12. In your training of registrars how many had you in the past twelve months

    (a) in Family Therapy? _____
    (b) in Marital Therapy? _____
    (c) in Family and Marital Therapy? _____

13. While registrars learn family therapy as the result of many experiences, which of the following would you see as the most influential in helping them to master family and/or marital therapy? Please check only one.

_____ working on their own level of personal growth and development.
_____differentiation from their own family of origin.
_____enacting alternative transactional patterns in sessions.
_____working through intrapsychic and interpersonal concerns in personal therapy.
_____gaining a conceptual understanding of systems
_____acquiring a set of specific skills
Other(s) _____

14. While there are often many goals for trainees, which is your most important overall goal for your students to attain?
Please check only one
_____ to increase their repertoire of transactional patterns
_____ to possess a set of techniques and skills
_____ to gain a balance between theoretical and therapeutic components
_____ to increase differentiation from their family of origin.

15. Which of the following statements seem best to apply to your attitude of family therapy? Please check only one.

Family Therapy is
_____the method of choice over other methods of psychotherapy.
_____the method of choice but only in combination with individual therapy.
_____alone is a useful method of solving problems.
_____only represents useful skills and techniques.

16. List in order of importance three texts in family and marital therapy that you require your registrars to read _____ or strongly recommended to them._____
1. _____
2. _____
3. _____

17. List in order of importance three articles in family and marital therapy that you require your registrars to read____ or strongly recommend to them.____

1. _____
2 _____
3. _____

18. Please check the five professional journals you find most helpful in your work in teaching and/or in the practice of family therapy. Please check them in order of importance. There are probably journals which you read not included on this list; please add them and score them.

_____ Family Process
_____ International Journal of Family Therapy
_____ Journal of Strategic and Systemic Therapies
_____ The Family Therapy Networker
_____ The Australian Journal of Family Therapy
_____ Family Studies Abstracts
_____ Journal of Family Issues
_____ Irish Social Worker
_____ Orthopsychiatry
_____ Journal of Family Therapy
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

19. Name five theorists, in order of importance, who have influenced and do continue to influence your teaching and practice of family therapy. Mark "1" as the most influential and so on.

| | |
|---|---|
| _____ Psychodynamic | Ackerman Institute |
| _____ Behavioral Family Therapy | Patterson |
| _____ Family System Theory and Therapy | Bowen |
| _____ Strategic Approach | Haley |
| _____ Structural Approach | Minuchin |
| _____ Open Systems: Group Analytic Approach | Skynner |
| _____ Communication Approach | Satir |
| _____ Problem-Centred Systems Family Therapy | Epstein |
| _____ Integrative Family Therapy | Duhls |
| _____ Symbolic-Experiential Family Therapy | Whitaker |
| _____ The Interactional Viewpoint of the Mental Research Institute | Weakland/Fisch Watzlawick |
| _____ The Milan School | Palazzoli |
| _____ The Transactional Approach | Framo |

Other(s) please state and mark in order of importance

_____ _____ _____
_____ _____ _____
_____ _____ _____

20. Of the time you give to marital and family therapy training, please give the percentages of time you give to the following activities. Total must come to 100.

| | |
|---|---|
| _____% didactic | _____% live supervision |
| _____% delayed supervision | _____% conducting therapy research |
| _____% supervised reading | _____% (other)_____ |

21. Are your registrars trained to do research in family and marital therapy?
____yes ____no.

22. Has your training programme sponsored any major conference(s) on marital and family therapy since 1980? ___yes ___no.
If "yes" please indicate, and use extra page if necessary.

| Title or Topic | For Whom | Numbers Attending | Location | Month/Year | Main Speaker(s) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

23. If you wish to supply additional information on your programme in a way that would be beneficial to this research, I would be helped by your contribution.

24. If a catalogue of your larger programme is available, would you please mark the courses that are relevant to marital and family therapy. If no catalogue is available, I would appreciate it if you would send me a brief list and description of the courses you offer in marital and family therapy.

25. (a) If neither marital nor family therapy form part of your programme at present, do you have plans to introduce them in the coming two years? ___yes ___no

(b) Please outline briefly your plans for introducing

(i) family therapy_____

(ii) marital therapy_____

(c) If you gave "no" as an answer, please state briefly your reasons._____

26. This questionnaire was completed by

Name (Optional)_____

Position in Hospital_____

Date_____

I wish to express my gratitude to you for the time and energy you expended in answering this questionnaire.

Sincerely yours,

Jim Moran, S.J.

TO PSYCHIATRIC CONSULTANTS

Dear

My name is Jim Moran, and I'm an Irish Jesuit working on my Ph.D. dissertation at Loyola University, Chicago. My training in family therapy has been received at Loyola since 1977, at the Family Institute of Chicago, and at the Mental Research Institute at Palo Alto. I was a secondary school counsellor in Dublin over a period of eight years from 1966-1974.

The subject matter of my dissertation is the State of the art of family therapy in the Republic, with special focus on past, present and future training that family therapists receive. The questionnaires attempt to identify the elements that are common in the training of Irish family therapists, whether they received that training inside or outside the country. There are five questionnaires in this research project and they are addressed to different groups, with the hope of finding common themes. The groups are (1) family therapists, from those who are professionally trained to the lay non-professional helper, (ii) Counselling Centres, (iii) Family Therapy Training Centres and Programmes, (iv) the Clinical Psychology and Social Work Departments in the Universities, and (v) the Psychiatric Registrars' training programmes.

It is anticipated that this first nationwide study will demonstrate patterns within the training and practice of family therapy, as well as its strengths as it develops efforts to meet the needs of Irish families. This study also offers an opportunity to practitioners to express their ideas about the direction or directions they think that family therapy should take in the years ahead. The results of this study should make available to educators and policy planners, more accurate information that would otherwise not be available.

This questionnaire has been influenced by similar ones sent to American psychiatric training programmes, but I've tried to suit Irish circumstances as I understand them. I would be helped if you would answer whatever questions apply in your concrete situation, and any information which would facilitate this research would be appreciated.

Thanking you in anticipation of your help,

Jim Moran. S.J..

APPROVAL SHEET

The dissertation submitted by James W. Moran has been read and approved by the following committee:

Dr. Gloria Lewis, Chairperson,
Department of Counseling and Educational Psychology
Loyola University

Dr. John Wellington, Professor,
Department of Counseling and Educational Psychology
Loyola University

Dr. Manuel Silverman, Professor,
Department of Counseling and Educational Psychology
Loyola University

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

January 30, 1987
Date

Gloria J. Lewis
Director's Signature