FAMILY THERAPY SUPERVISION: ASSESSMENT OF SKILL ATTAINMENT BY TRAINEE AND SUPERVISOR

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Abstract

A thorough review of the literature indicates that very little research has been done to demonstrate that family therapy training is effective. This research was undertaken to answer the questions as to whether family therapy training produces change in trainees over time. The Family Therapy Skill Evaluation (FTSE) was constructed consisting of 40 items of family therapy skills divided into four subscales. This scale was administered to 50 trainees and their supervisors in a large midwestern two-year family therapy training program. Skill attainment was measured at various times during the supervision and training process by the trainee himself and from evaluations from the supervisors.

It was found that the alpha reliability on the FTSE instrument exceeded minimum standards for research purposes. Each of the subscales was also found to be adequately reliable. The underlying factor structure of the FTSE suggested that one main factor accounted for the majority of variance within the scale. Three other factors accounted for a smaller amount of variance. These factors roughly corresponded to the subscales on

the FTSE. ANOVA was used to compare the increase in mean of trainees' skill across phases of the training program. F Tests were significant beyond the .05 level. Trainees reported an increase in their perception of their skills at each phase of the training program. Supervisors assessed trainees at a higher level of skill at each period of supervision. Supervisors consistently rated trainees lower than trainees rated themselves. The data suggests that the experience of family therapy training increases trainees' skill acquisition as measure by the FTSE in this study. Supervisors' ratings of trainee skill attainment seem to suggest that supervisors are more critical judges than trainees are of themselves. The question of superiority of training methods such as case notes, video tapes, or live supervision is still unanswered. A study utilizing the FTSE to assess trainees being supervised by each of these methods could answer this question.

CHAPTER I

INTRODUCTION

Although there are over 250 systems of psychotherapy currently practiced by a variety of "therapists" (Corsini, 1981), family therapy is considered the treatment of choice for a majority of presenting problems seen by mental-health professionals. In fact, individual psychotherapy for relationship problems has been demonstrated to be very ineffective and often has produced negative effects (Gurman & Kniskern, 1978). Family therapy is at least as effective as individual therapy for many "individual" problems such as depression and other forms of psychopathology and family therapy is considered the treatment of choice for the widest range of presenting problems.

In 1982 there were 2.5 million marriages. In the same year there were approximately 1.2 million divorces (U.S. National Center for Health Statistics, 1982). Approximately 1 million children are affected by these divorces each year.

It is estimated that more than 40% of divorced persons receive some form of counseling or psychotherapy (Bloom, White, & Asher, 1979). A survey

of counselors subscribing to the Marriage and Divorce Today Newsletter (Staff, 1983, January 3) indicated that the primary reasons clients seek therapy is due to marital problems (27.2%), followed by other relationship problems (19%), and divorce and its complications (10%).

Family therapy has experienced sharp increases in popularity in recent years. The American Association for Marriage and Family Therapy (AAMFT), the largest organization of specialists in marriage and family therapy, reported a membership increase from 440 members in 1962 to 1,219 members in 1972, a gain of 277% (Williamson, 1980). That number further increased to nearly 11,000 members by 1983, or 902% over the next eleven-year period (Hiebert, 1983).

In 1977 another family therapy organization was formed called the American Family Therapy Association (AFTA). This association was established primarily as a forum for teachers and researchers in the field of family therapy. AFTA has also experienced significant increases in its membership over the past several years. AFTA's purpose is different from AAMFT as it serves as a forum for the exchange of information, theory, and research for practitioners in marriage and

family therapy. According to the 1983 membership report, AFTA membership now stands at 767 members (AFTA Newsletter, 1983).

The AAMFT has also embarked on setting standards for clinical practitioners in the field of marriage and family therapy by establishing a clinical membership category. The Commission on Accreditation for Marriage and Family Therapy Education (AAMFT, 1981) was established to set standards for family therapy training programs in graduate institutions as well as postgraduate training facilities. As of 1983 the Commission on Accreditation had accredited 17 training programs and reported nearly 60 additional programs considering such accreditation (AAMFT, 1983).

The multidisciplinary journal Family Process commissioned a research project to identify training programs (Bloch & Weiss, 1981). This research project identified 187 training programs in the United States. This list includes graduate training programs offering from one course to a complete degree in marriage and family therapy. Many postgraduate training facilities offering training, enrichment, supervision, and workshops on the subject of marriage and family therapy are also listed.

Another directory of graduate family programs, published by the National Council on Family Relations (NCFR), identified 71 graduate degree programs in family relations (Love, 1982). Of those 71 programs surveyed, 50 programs (70%) offered graduate courses in marriage and family therapy. These programs have a range of one course on the subject of marriage and family therapy to programs offering a significant concentration or a degree in marriage and family therapy.

Besides the rise of training programs, there has also been a massive proliferation of professional literature. Olson (Olson & Markoff, 1984) has been responsible for the Inventory of Marriage and Family Literature project at the University of Minnesota in conjunction with NCFR. Olson reported significant increases in family articles related to family therapy, treatment, and applied clinical research. In the category of Family Counseling and Education, 509 articles were indexed for the 64 year period from 1900 to 1964. That number has risen to over 550 articles per year since 1980.

In summary, there have been sharp increases in the number of practitioners treating families as well as

increased numbers of training programs to prepare such professionals. In a comprehensive review of research projects on the outcome of marriage and family therapy, Gurman and Kniskern (1978) report evidence to support the conclusion that family therapy is in fact an effective treatment procedure for a number of presenting mental health disorders. An important question that remains unanswered is whether or not family therapy training programs are adequate or effective in increasing a family therapist's skill and effectiveness in treating families.

Statement of the Problem

Liddle and Halpin (1978) reviewed the literature on family therapy supervision and training. In their review of over 100 publications they found most references lacked specificity of methods and were not based on formal theories. They concluded the literature is disorganized and fragmented.

Kniskern and Gurman (1979, p. 83) reviewed the research on the subject of supervision and found that "there now exists no research evidence that training experiences in marital-family therapy in fact increase the effectiveness of clinicians." To further complicate research on family therapy training, a

diversity of theories of therapy and methods of training exist within programs. The authors cite a number of other unanswered questions from their literature review:

1. What types of training experiences produce effective therapists?

2. What previous training best prepares a trainee for family therapy training?

3. Are there any types of previous training that inhibit family therapy training?

4. What personality factors best predict success in training?

5. Does reading about families help the trainee learn therapy?

6. Does live observation of experts help or hinder the development of skills?

7. When are audio- or video tapes most helpful?

8. What differences do different forms of supervision make on different trainees?

Kniskern and Gurman (1979) suggest that tools should be constructed to assess: (a) change in a trainee's conceptual knowledge, (b) change in the trainee's in-therapy behavior, (c) changes in the trainee's personal life, and (d) changes in the outcome

of family treatment. Such instruments could best assess these variables by utilizing "a combination of trainee self-report, supervisor report and objective observer" (p. 91). This study specifically addresses tools which can be used to objectively assess the change in a trainee's knowledge and in-therapy behavior as perceived by both trainee and supervisor.

Purpose and Significance of the Study

This research study has four primary objectives. First, to complete a thorough review of the research literature regarding the training of marriage and family therapists. A second goal of this study is to construct objective instruments appropriate for the assessment of a family therapy trainee's skill attainment. The third goal is to evaluate the empirical qualities of these new scales and report reliability estimates for future use in other evaluation research. The final objective is to evaluate several factors related to the training process which may influence skill attainment by family therapists in training. These factors will include the theoretical thrust of the program, skill of supervision personnel, and the type of supervisory experiences provided.

This project is significant for a number of

reasons. First, measurements will be taken from the vantage point of both trainee and supervisor. Contrasts between the perceptions of trainees and supervisors will provide useful information about the dynamics of the training process. Second, the evaluation methodology of collecting therapist's self-report and supervisor's observation data will be tested for validity. A third feature of this study is collecting data on an existing family therapy training population over a 1-year period of time. Trainees at both years of the 2-year training process will be evaluated. This will yield data on change in the trainee over a 2-year period of training.

Family therapy has its roots in systems theory. The techniques of family therapy are designed to intervene in living social systems consistent with theoretical and epistemologic presuppositions. This same consistency, or isomorphism with theory and therapy, is attempted in the supervisory and training process (Liddle & Saba, in press). This same isomorphism will be attempted in research, training, therapy, and theory by collecting descriptive data at multiple points in time from multiple vantage points in a natural setting.

Hypotheses

The variables addressed in this research project reflect a family therapy trainee's educational, experiential, and family background. Further, information regarding the trainee's assessment of self at the beginning of the training program as well as throughout the 2-year training program will be gathered as well as supervisor's assessments of each trainee. Data will be collected to test a number of other hypotheses not within the scope of this particular study. For the purpose of this study the following hypotheses will be tested.

General Hypotheses

1. All scales constructed for purposes of this research will be expected to meet minimum standards of reliability.

2. Family therapy skill attinment is expected to be influenced by whether supervision data is supplied from case notes, audio tapes, or video tapes.

3. A deskilled phase is expected in which trainees' perceptions of their own skill attainment actually decreases during the middle of the first year of training.

4. It is expected that trainees will attain

increased skill with each period of supervision beyond the middle of the first year.

5. It is expected that supervisors' evaluations of trainees' skill attainment will increase with each period of supervision.

6. It is expected that trainees and supervisors will differ from each other in their evaluations of the level of skill the trainee has achieved.

7. It is expected that any scales constructed will be validated by psychometric methods.

Definition of Key Terms

For this study the following terms are defined.

Change Facilitation Skills. These are the skills and interventions utilized to alter individual and interpersonal behavior, processes, thinking, and experience (Tomm & Wright, 1979).

Engagement Skills. These skills are necessary to establish and maintain a meaningful working relationship between the therapist and family (Tomm & Wright, 1979).

Family Therapy. This is a form of treatment of the whole family as a group together by one or more therapists. Individual pathology in one member is seen as a reflection of wider pathology in the family

system. The family unit thus becomes the unit treated and changing the family interaction is seen as changing the identified member's pathology.

Problem Identification Skills. These are the assessment skills utilized by the therapist to identify and clarify the processes and problems present in families (Tomm & Wright, 1979).

Training Program. This is an organized educational experience usually lasting from several days to several years including the presentation of dydactic and theoretical material, as well as experience under supervision.

Supervision. This is an ongoing educational process in which one person, the supervisor, helps another person, the trainee, gain professional skills through the examination of the trainee's ongoing professional activities (Hart, 1982).

Skill Attainment. This is the amount of change in the trainee's skill as measured on the FTSE as reported by either the trainee or supervisor.

Structural Family Therapy. "A family therapy approach, identified with Minuchin, directed at changing the family organization or structure in order to alter behavior patterns in its members; the

therapist changes the system by actively participating in its interpersonal transactions" (Goldenberg & Goldenberg, 1980, p. 256).

Strategic Family Therapy. "A brief form of family therapy devised by Jay Haley and Richard Rubkin" (Pinney & Slipp, 1982, p. 144).

FTSE: Family Therapy Skill Evaluation. An inventory based on the skills identified by Tomm and Wright (1979) for the measurement of family therapy skill. It can be completed by either trainee or supervisor to evaluate trainee skill attainment.

Termination Skills. These are the skills necessary to effectively enable a therapist to disengage from the family at the appropriate time, while encouraging family members to continue their own problem solving (Tomm & Wright, 1979).

Summary

Chapter II of this study will survey the existing body of family therapy literature with a focus on supervision and training literature within the field. Chapter III of this study will outline the specific methodology and procedures for the conduct of this research and describe the format of the family therapy training program which will be evaluated. Chapter III

will also describe the research instruments developed for the purpose of this study and the process used in instrument development. Chapter IV will report specific empirical findings, and Chapter V will interpret findings, draw conclusions, and outline further steps for research on the subject of marriage and family therapy supervision.

CHAPTER II

LITERATURE REVIEW

There are currently over 11,000 members of the American Association for Marriage and Family Therapy. This number may comprise only a small portion of the total professional population practicing some form of marriage or family therapy.

The practice of family therapy includes members of the professions of social work, psychiatry, family medicine, pastoral counseling, psychiatric nursing, guidance counselors, and recently those who have received graduate degrees from family therapy programs. A recent handbook on family therapy identified 15 major "schools" of family therapy with literally hundreds of subgroups (Gurman & Kniskern, 1981). Nearly all theoretical and research advances in the field of family therapy have occurred in the last 30 years.

This chapter will review the history of family therapy as well as survey the multitude of family therapy approaches and theories which currently exist. Finally, this chapter will survey the supervision and training literature related to the field of family therapy.

The History of Family Therapy

One of the oldest professions to make a contribution to the professional field of family therapy was social work. In the 19th-century Charity Organization Societies were formed in both the United States and England to meet the needs of the poor. Those societies served in the needs of the families including providing shelter, food, clothing, and psychosocial support and counseling. These societies were the forerunners of today's family service agencies. By the early 20th-century professional social workers were receiving training and supervision in family case work. Though social work has deep roots in serving family needs, by the 1930's education in social work had turned largely to individual psychiatry for its theoretical foundations (Beatt, 1973).

Another simultaneous development in the early concern for marriage and family was the development of marriage counseling centers. The oldest known center, The American Institute for Family Relations, was opened in 1930 by Paul Popenoe in Los Angeles. Popenoe is also responsible for coining the term "marriage counseling." He was the first editor of a monthly column in the Ladies Home Journal entitled "Can This Marriage Be

Saved?" which begun in 1945 and continues to this day.

Shortly following the opening of Popenoe's clinic in Los Angeles, Abraham and Hannah Stone opened a similar marriage counseling clinic in New York City.

In 1932 Emily Mudd opened the Marriage Council of Philadelphia. Mudd published the first book on the field of marriage counseling (Mudd, 1951) and began training marriage and family counselors in that clinic. Mudd was also very influential in the founding of The American Association of Marriage Counselors.

One of the more significant events in the formation of the profession of marriage counseling was the establishment of the American Association of Marriage Counselors between 1942 and 1945. During these formative years a number of professionals came together from various disciplines who were interested in marriage counseling.

By the mid 1950's many of the early pioneers of family therapy were practicing across the country. Dr. John Bell, a professor of psychology in Massachusetts; Nathan Ackerman, a child psychiatrist in New York City; Murray Bowen at the National Institute of Mental Health; Carl Whitaker in Atlanta; and the Palo Alto group including Gregory Bateson, Jay Haley, John Weakland,

Don Jackson, and Virginia Satir were all working independently of one another in the treatment of families. Over the next 20 years there was a gradual coming together of those various movements and approaches to the family forming what is now referred to as the field of family therapy.

Approaches to Family Therapy

Just as there are many perspectives from which we may view and assess children, so also there are many ways to look at the family. A child's height and weight can be measured. That same child may be assessed in other areas of development such as language acquisition and vocabulary, clarity of speech, and fine or gross motor development. The same child's intellectual abilities may be assessed including achievement or mastery of a particular body of knowledge or the ability to use problem-solving skills to attack and resolve a particular set of problems. This example illustrates that there are many valid and appropriate ways to assess a child. Each of these various methods of assessment are appropriate at certain times, in certain contexts, and in response to certain concerns. So also are there many ways to view and treat the family. The various theories and

approaches to family therapy are complementary as well as overlapping. Many theorists would have us believe that there is only one valid approach to family therapy. In this section we shall attempt to survey the major family therapy approaches currently in use.

Madanes (1981) has found it useful to think of family therapy in terms of six major schools of thought. Those six approaches include the psychodynamic, experiential, behavioral, extended family, structural, and strategic models. Each of these schools of thought may be broken down further into subcategories, however for purposes of this review the focus will be on these six categories.

Psychodynamic Family Therapy

All therapists within the psychodynamic approach ultimately have their roots in Freudian psychoanalytic theory. The common thread through each of the psychodynamically oriented family therapies is a focus on past unresolved events which have stifled the developmental process. In therapy the client most often talks directly to the therapist and the therapist often utilizes techniques such as interpretation to give insight to the patient. Therapists who are famous for the psychodynamic approach includes Dicks (1967),

Sager (1981), Skynner (1981), and Stierlin (1977).

Symptoms from the psychodynamic perspective are seen as a product of past experiences. Therapy is generally a long-term process and the therapist assumes a rather nondirective posture within the family system. Interventions made by the psychodynamic therapist are in the form of giving interpretations of past or present behavior. It is assumed that insight gained from exploring the past will produce changes in the present. A major focus of the training of the psychodynamically oriented therapist is the therapist's own analysis of his own family and experience. Understanding one's own experience in family history is considered an important dimension for psychodynamic family therapy (Skynner, 1981).

Experiential Family Therapy

The therapist most well-known for the experiential approach to family therapy is Carl Whitaker. Whitaker's world view is characterized by a humanistic existentialistic approach to life. He focuses on both the past as well as the present in his therapy. Whitaker requires the entire family to participate in therapy, yet during the actual process of therapy often allows the family to determine the direction of a

particular interview.

This experiential approach is a growth-oriented process whereby members learn to accept themselves and their own "craziness" as well as the "craziness" of other family members. Whitaker views the role of the therapist much like that of a coach or grandparent.

The experiential approach to family therapy is generally done by a co-therapy team. In this way therapists may take turns joining and becoming a part of the family process while the other therapist serves to maintain structure and later enables the co-therapist to disengage from the family system. The therapists are then allowed to alternately join and distance themselves from the family in order to facilitate the family's self-healing.

The method of training experiential family therapists includes three steps. The first step is learning about family therapy by attending workshops and seminars. The second step is learning to do family therapy by being involved as a co-therapist in the conduct of family therapy preferably in an outpatient setting. The third stage of becoming a family therapist occurs as a trainee achieves parity with one's co-therapist supervisor (Whitaker & Keith, 1981).

Behavioral Family Therapy

The behavioral approach to marriage and family therapy is the application of learning theory and a social learning model to the marriage and family relationship. Major contributors to the behavioral approach include Jacobson, Stuart, and Patterson (Jacobson, 1981).

The behavorist focuses on the dynamics of the present. Focus is on the reduction of symptoms. The behavorist attempts to help the family remove symptoms by teaching, behavior exchange procedures, behavior rehearsal, and feedback and reinforcement schedules.

The behavioral therapist often functions in a directive manner developing an organized plan for the treatment process which leads to the successful reduction in symptoms. The focus is on the presenting problem as identified by the patient.

The training of the behavioral marriage and family therapist involves the learning of two basic sets of skills. These skills include the effective presentation of technology as well as clinical skills (Jacobson, 1981). The technological aspects of behavioral therapy include the application of learning theory to the particular symptoms and the development of a plan to

reduce symptoms. Clinical skills include attending to the relationship between the therapist and the client and insuring understanding and compliance. Training is often done in a very systematic structured way by setting learning objectives and planning experiences which enable therapists to systematically learn the necessary skills. Thus, an isomorphic relationship exists between how clients change and how therapists change and grow.

Extended Family Therapy

The Extended Family Therapy approach has its origin in psychoanalytic thinking and with the addition of many family systems concepts. The focus is on actual relationships as opposed to symbols or intrapsychic functioning. The major developers of extended family therapy are Murray Bowen (Anonymous, 1972; Bowen, 1971) and James Framo (1982).

Extended family therapists see current problems as resulting from unresolved problems with one's family of origin. Symptoms in a client's personal life are seen as a product of failure to successfully accomplish the various developmental tasks with one's family of origin. From the perspective of the extended family therapist, the client must either bring his entire

family to the therapy session (Framo, 1982) or be coached on how to go back to their family and thus alter the relationship with the family of origin (Bowen, 1971).

Therapists are trained in the extended family therapy approach by attending didactic sessions about theory and techniques of therapy as well as working through one's own relationship with one's family. Sessions are devoted to assisting therapists to look at their own family and coaching them to disengage from dysfunctional interaction. According to this theory as trainees are better able to differentiate from their own family of origin they will be able to better enable clients to successfully work through their own family struggles. As a trainee progresses in understanding their own family dynamics, taped sessions of the therapist working with other families are supervised. The supervision focus is often on how well the trainee is able to maintain differentiation between self and the clinical family.

Structural Family Therapy

The founder of Structural Family Therapy is Salvadore Minuchin (Minuchin, Montalvo, Guerney, Rosman, and Schumer, 1967). Dr. Minuchin formulated his theory of

family functioning as a result of working with families of the slums in a New York City ghetto (Minuchin et al., 1967).

Minuchin views symptoms as the result of a dysfunctional structure existing in current relationships. That structure may be a product of a history of dysfunction, however the focus of therapy is on the current existing process. Minuchin assumes that healthy families are organized in a hierarchy with parents providing executive leadership over their children. When this hierarchy is not maintained, dysfunction occurs.

The role of the therapist is to take an active and directive part in modifying the family's structure. The therapist formulates a plan to realign the family to produce a healthier system capable of self-healing and symptom reduction (Minuchin, 1974).

Structural Family Therapy has been taught to professionals and paraprofessionals. The process of learning therapy includes actively observing the therapy of others from behind a one-way mirror and conducting family therapy with live supervision and telephone phone in, or by video tape supervision. A typical family therapy training program involves

initially splitting time between didactic sessions and observation of family therapy. As understanding increases, the trainee substitutes more actual therapy with supervision for the didactic portion of the training. Progressively the therapist gains greater independence by video taping sessions and receiving supervision of the video tapes. Supervision tapers off as the therapist gains independence in his clinical practice.

Strategic Family Therapy

Strategic Family Therapy consists of a number of subgroups with differing techniques. Haley (1963, 1976) is the major founder of Strategic Family Therapy.

The Strategic therapists focus on the presenting problem or symptoms and take an active role in planning a course of treatment to reduce the symptomatic behavior. The therapist may give directives in the office and homework assignments to be carried out outside of the office. Strategic therapists often utilize paradoxical interventions and directives to modify the dysfunctional sequence or pattern in the client's life. Some strategic therapists (Haley, 1976) are also concerned with family hierarchy as are the structural family therapists. Other strategic

therapists (Palazzoli, Boscolo, Cecchin, & Prata, 1978) are not as concerned with the family hierarchy but specialize in formulating paradoxical prescriptions which modify the way the family behaves and thinks.

Training in Strategic Family Therapy includes learning the mechanics of conducting a directive interview with a focus on problem solving. These interviews are often supervised by a senior supervisor with a number of trainees observing from behind a one-way mirror. The focus of supervision is on enabling the trainee to successfully lead the interview in the direction of defining the problem and ultimately developing a strategy for solving the problem. The major focus of supervision is on developing strategies tailored to the particular needs of the family which enable the family to change their behavior and relation to one another and thus solve the problem and reduce the symptom frequency.

Supervision and Training Literature

The subject of family therapy supervision and training was researched by consulting the major family journals, and running computer literature searches with the aid of Dialog, Medline, ERIC, Dissertation Abstracts International, and the Family Resources Data Base. Each

of the articles found on supervision was then carefully reviewed for mention of references not already located. Each reference was copied, analyzed, and coded. Liddle and Halpin (1978) provided a major comprehensive review of the family therapy and supervision literature. Criteria selected by these authors were utilized to review and code each of the family therapy training and supervision references found. (See Appendix A for Family Therapy Supervision Article Coding Criteria).

Each reference located was then coded according to the following criteria:

1. The type of publication
2. The year of publication
3. The professional mental-health discipline addressed
4. The theory of family therapy emphasized or presented
5. Whether supervision methods and procedures were specified
6. Whether a theory of supervision was proposed
7. Whether outcome or empirical research data were reported
8. Whether the training format (including lectures, seminars, etc.) was specified

9. Whether specific objectives for trainees were established within the program

10. Whether multiple levels of family therapy trainee's skill or development were accounted for

11. Which particular supervisory skills were presented, including:

a. Work on the therapist's own family of origin

b. Therapist's own personal growth

c. Live supervision

d. Live supervison with a "bug-in-the-ear"

e. Live supervision with telephone call in

f. Live supervision with team consultation

g. Live supervision with a co-therapist

12. The use of video tape

13. The use of audio tape

14. The use of case notes

Each article was also coded with a subjective rating of its usefulness to each of the following five practitioners: a) trainees, b) supervisors, c) therapists, d) researchers, and e) theorists.

After each article had been coded according to the criteria, it was then entered into D.B. Master micro-computer data base on an Apple II computer for

analyses. Two hundred twenty-nine articles were entered for analyses (See Appendix B). Each variable in the literature data base was analyzed for frequency of occurrence and cross tabulated with other variables.

The research findings from these literature analyses will be reported. All articles analyzed are included in the Reference list, though each will not be referred to specifically. A number of trends emerged in the family therapy supervision and training literature. The most frequent category of reference was that describing a single training or supervision program. These might be categorized as case studies in supervision and training. The next largest category of articles was that describing the application of particular supervisory methods such as live supervision or video tape supervision. Many such references describe the usefulness of various techniques within a particular family therapy training or supervision program. The categories within the supervision literature which seem to be weakest were those which propose a theory of supervision and training, and the reporting of empirical research data on the supervision and training process.

Single Program Descriptions

The largest number of references in the family therapy supervision literature were descriptions of a particular training program or format. One hundred twenty-three references or 53.7% of all the family therapy literature described such a program. One hundred eleven of these articles were considered adequate and useful in their descriptions of those training programs.

Training programs described in literature include programs of various lengths and intensity. Some training programs include only workshops and seminars with no ongoing training or supervision (Epstein & Levin, 1973; Matter, 1980). These approaches to training generally include the demonstration of family therapy techniques through the use of role play, lecture, case presentation, video tape review, and the interview of a family live before an audience. Such short training programs seem to have as their objective the introduction of family systems concepts as an enticement to learn more about family therapy, or the hope that such short demonstrations will lead to changes in the therapist's practice of therapy.

Another common case description found in the family

therapy training literature is the description of the short training program which has limited and specific purposes. Tomm and Leahey (1980) describe a program designed specifically to teach family assessment skills. Three teaching methods were used to enhance professionals' assessment of family health. One approach includes a traditional classroom setting with lecture and demonstration video tapes. A second method utilized small group discussions following viewing video tapes. A third method of teaching family assessment included experience in conducting a family interview and presenting video tapes of that interview for class discussion. All of these methods are short term and have the very specific objective of teaching one dimension or skill in the family therapy process.

The family therapy literature also contains a number of descriptions of academic graduate level courses which have been taught within various mental-health and academic degree programs on the subject of family therapy (Everett, 1979; Flint & Rioch, 1963; Freeman, 1980; Nichols, 1979a; Shapiro, 1975a; Tucker, Hart, & Liddle, 1976). A very complete description of an academic course on family therapy at the introductory level is presented by Liddle and Saba

(1982). In their description the authors describe the goals of the course which include enabling students to make a shift to a systemic world view. The course includes the teaching of the various phases of structural family therapy. Teaching is done by presenting lecture, video tapes of family therapy, popular movies illustrating family concepts, and experiential exercises. Data are presented on the outcome of teaching this course over an 8-year period and the context of the final examination given to students is included.

Another category of single program descriptions includes the in-service training programs designed to teach family therapy or enhance family therapy skill within mental-health centers and among community service organizations. Flomenhaft and Carter (1974) describe the results of an experiment in teaching family therapy over a 5-month period to mental-health workers employed in mental-health centers in Pennsylvania. One hundred and fifty mental-health professionals were trained at 35 centers via the use of lectures, readings, video tape demonstrations, and live or video recorded supervision.

Byles, Bishop, and Horn (1983) conducted a

14-month training program at a large metropolitan family service agency. Twenty-four social workers were taught family therapy from the McMaster model of family functioning and specific goals and outcomes were specified. Outcome data presented by the authors suggest this training program was a success.

Roberts (1982b) designed a skill development program for teaching structural and strategic family therapy. This is a 1-year program including detailed descriptions of assigned readings, staff development exercises, growth experiences for the therapist, and a detailed description of the role of the consultant and trainer.

Another brief training program was developed for the purpose of enabling practicing professionals to gain continuing education in the field of family therapy (Wendorf, 1984). This program emphasizes structural and strategic family therapy principles and experiences. A family consortium was organized in 1981 and has met monthly. Live and video taped supervision was provided by an outside supervisor from the Philadelphia Child Guidance Clinic. This model of training has become increasingly popular among mental-health professionals since its inception.

Another major approach to training includes intensive family therapy training programs provided by free-standing institutes and large mental-health training facilities. These programs include from 1 to 3 or more years of family therapy training. Most programs include didactic and lecture presentations, assigned outside readings, video tape playback and discussion, role-play and other experiential exercises, and supervision provided by a variety of means including case note consultation, audio- and video tape playback, and live supervision provided by either a co-therapist or a team from behind a one-way mirror.

Bloch and Weiss (1981) identified 50 such family therapy training programs including such major centers as Boston Family Institute, Family Institute of Cambridge, Ackerman Institute for Family Therapy, Center for Family Learning, Philadelphia Child Guidance Clinic, Georgetown University Family Center, The Family Therapy Institute of Washington, D.C., Houston/Galveston Family Institute, Menninger Foundation, Family Institute of Chicago, and Mental Research Institute. Training programs range from 2 trainees to as many as 150 persons per year. Training can range from 1 1/2 hours per week to 40 hours per

week.

Constantine (1976) described the Boston Family Institute Training Model. This 2-year training program integrates many approaches to the family within a unified theoretical framework and includes both didactic as well as practicum experience with supervision. Specific goals and objectives are set for trainees for the interviewing and therapy process. The first year seminar's goals are: (a) present the basic elements of the family process, (b) look at families as a system, (c) teach elementary interviewing skills and techniques, (d) present the concepts of feedback, family evaluation, and co-therapy, and (e) gain experience in live interviewing. Constantine also presents the Boston model of evaluating trainees within the training program. Trainees are evaluated at the termination of training on five basic areas of competence: (a) basic knowledge, (b) generation and use of information, (c) interpersonal flexibility, (d) self-awareness and use of self, (e) interviewing, and (f) intervention.

The Ackerman Institute for Family Therapy was founded in 1960 for the purpose of treating families and training family professionals. Live family interviews have been conducted for purposes of training

professionals since early in the development of the Ackerman program and continues to be one of the main methods of training. The Ackerman Institute also conducts an ongoing 3-year family therapy training program. The first year of the training program meets weekly for 3 hours in small groups for didactic presentations and experiential learning of clinical material. The second and third years of the clinical training program rely heavily on family therapy experience with supervision. The trainee's personal family issues may be addressed in supervision as they apply to the conduct of family therapy. This training program has a strategic theoretical orientation (LaPerriere, 1979a).

Methods of Supervision

A very large portion of the supervision and training literature in marriage and family therapy is devoted to the description of the use of a number of techniques of supervision. These techniques include live supervision, the use of video tape in supervision, the use of the team from behind a one-way mirror, co-therapy, setting specific learning objectives for trainees, and a focus on the personal growth of the family therapy trainee in working through issues from

the trainee's own past experience with their family of origin.

Supervision is considered the essential element in the process of family therapy training. Supervision has been described as "an ongoing educational process in which one person in the role of the supervisor helps another person in the role of supervisee acquire appropriate professional behavior through the examination of the supervisee's professional activities" (Hart, 1982, p. 12). Supervision assumes (a) there is an ongoing relationship between supervisor and supervisee; (b) that the supervisor does not have to be an organizational supervisor of the supervisee, although the role of the supervisor and supervisee are clear; (c) the content of the sessions may include a widerange of knowledge and skills that pertain to effective professional behavior with clients and colleagues; and (d) that the focus is on the behavior of the supervisee as it occurs in present interpersonal interactions. Supervision is often contrasted with consultation which is a less-formal educational process with no accountability built into the relationship.

Live Supervision

"The advent of the one-way screen which clinicians

and researchers have used since the 1950's to observe live family interviews was an analogous to the discovery of the telescope. Seeing differently made it possible to think differently" (Hoffman, 1981, p. 3). Live supervision became one of the most frequently utilized procedures for the conduct of family therapy research and for the training of family therapists.

Of the 229 articles located on the subject of supervision and training, 64 (28%) referred to the process of live supervision. Live supervision was a common practice among family therapists by 1973 (Montalvo, 1973). Montalvo discussed some of the basic issues in the conduct of live supervision including the method feedback would be given to the supervisee. This could include either the supervisor calling the trainee out of the session or the trainee stepping out voluntarily when encountering difficulty. Accountability between the supervisee and the supervisor must be worked out so that the trainee understands the difference between suggestions which a trainee may take and directives which must be complied with. The supervisor must ensure that the therapist has freedom to think for himself and conduct the session as he sees fit. Intervening too frequently on

the part of the supervisor would inhibit the trainee's developing a sense of competence and independence which are long-term goals of supervision.

The advantages of doing live supervision include the ability to look directly at the session rather than hear about the session from case notes afterwards. The supervisor has the opportunity to more rapidly assist the trainee should difficulty arise in treating a particular family. With live supervision the supervisor is able to attend to both the needs of the family in treatment to ensure that treatment is effective as well as attend to the needs of the trainee as the trainee develops competence.

In Haley's (1976) strategic model of family therapy the supervisor is responsible for the conduct of supervision and is responsible to ensure the effectiveness of the family therapy trainee in the conduct of therapy.

In this approach family therapy supervision is seen as a process of teaching the therapist skills in interviewing and intervening to bring about change. In short, the therapist's job is to be an expert in the area of problem solving.

Haley (1976) is convinced that live observation is

superior to self-report or recall on the part of a trainee about what happened in the session. The ability of the supervisor to observe directly what is happening in the session and to interrupt the session with instructions to the trainee is the most effective way to teach skills. Live supervision has the added advantage of being able to train a group of students simultaneously as they watch their colleagues through the one-way mirror.

Haley (1976) suggests seven essential elements which must be decided if live supervision is to be effective. They are: (a) the supervisor will intervene only when it is absolutely essential, (b) the supervisor when interrupting a session will give only simple instructions, (c) all interruptions will be kept very brief, (d) if instructions become complex the trainee will be asked to leave the room and meet with the team, (e) the larger issues involved in training will be discussed before or after the session is complete, (f) students should be honest with the family that live supervision is taking place, and (g) that the therapist is ultimately responsible for the conduct of sessions and is responsible to make the decision as to whether the suggestion by the supervisor is to be

taken.

Outcome data on the process of supervision is nearly nonexistent (Kniskern & Gurman, 1979). One study (Roberts, 1982a) compared two types of live supervision. The collaborative team or independent model of live supervision is one in which members of the team are all of approximate equal power or influence. Essentially trainees are providing live supervision for each other. Supervisor-guided or the dependent model of live supervision includes a single supervisor who takes responsibility for the conduct of supervision through live phone ins and pre-session planning. Both models of live supervision have been shown to be effective methods of skill training even though each of these two methods are considerably different from one another.

Video tape in Supervision

The use of closed circuit television was used in the education of medical students and psychiatric residents as early as 1956 (Berger, 1970). Haley and his associates filmed family interviews as early as 1956 (Haley, 1981). Of 229 articles on the subject of family therapy training and supervision, 49 (21%) include references to the use of video tape as a

technique in supervision.

The use of the technology of film and video tape have been used in the field of psychotherapy since their invention (Berger, 1970). The earliest references to the use of film and video was by Sherman in 1966. In this paper on the subject of learning family interviewing Sherman advocated the use of taping or filming family sessions so that they could be replayed and studied by the worker and supervisor as well as a seminar group.

Family therapy sessions were often video taped for purposes of research as well as demonstration and training. The advantage of the use of video tape is that the session can be taped and supervised at a later time if a supervisor is not available to do supervision live. In addition video tape does not require the structural facilities that live supervision with a one-way mirror requires. Video tape is more cost effective since it does not require two or more trained specialists during the time of the family interview. Supervision by the use of video tape may allow for showing only portions of the video tape and thus not require an entire hour to go over the session at length.

Decreasing costs and increased availability of video tape equipment has made it an increasingly common practice among family therapists (Berger, 1978). Another advantage of video taping sessions routinely is that should a session go sour or the therapist reach an impasse consultation may be sought.

Factors which may be beyond the consciousness of the therapist may often be retrieved by the use and review of video tape. Video tape decreases the need for the therapist to recall each incident in the therapy or take elaborate notes. Interpersonal transaction may be tracked carefully and specifically via the use of video tape (Chodoff, 1972).

Kramer and Reitz (1980) followed 80 trainees over a 3-year period of time. Trainees indicated video tape playback was an effective way of heightening their awareness of their own communication as well as the multiple channels of communication used by others. In a discussion of the disadvantages of the use of video tape in supervision Chodoff (1972) indicated the expense of video tape equipment. The lack of picture quality and clarity may interfere with the supervision process. It is also very time consuming to select sequences of tape for review or editing. These concerns about quality

and expense may no longer be issues due to advances in technology.

When video tape is available it is sometimes a temptation for the supervisor to stop and comment on every minute detail of the therapist's behavior. In this way supervision focuses on minor details rather than seeing therapy in a broad context. Video tape records weaknesses, both on the part of the patient being taped as well as the therapist providing professional service. These weaknesses have the potential for exploitation.

Another weakness of the use of video tape in supervision is the delay in getting feedback to the trainee. Particularly with young and inexperienced therapists this delay may hinder both the therapy and the learning process. The family or therapy situation may deteriorate during this delay.

Team Consultation in Supervision

The family therapy literature consisted of 41 references, or 18% referring to the use of teams in the process of treatment and supervision. The use of the one-way mirror with a supervisor and a team of colleagues or fellow trainees is a common practice (Haley, 1976). The use of a team of observers or

consultants may date back to the 1950's with the Bateson research project in Palo Alto, California. Roberts (1982a) made a distinction between types of team live supervision. In collaborative team or the independent model of live supervision trainees are supervised by team members who are colleagues from behind a one-way mirror. This is essentially a peer supervision model in which trainees in turn supervise another. All trainees behind the one-way mirror may at different times make phone ins or suggestions to the therapist being supervised. The supervisor-guided or dependent model of team live supervision involves a therapist providing therapy while a supervisor observes live from behind a one way mirror with a group of trainees. The supervisor assumes all responsibility for the conduct of supervision and all phone in interventions to the therapist. Trainees seldom, if ever, become active in providing supervision to colleagues in this model.

A major advantages of this method of supervision is the ability to train several therapists simultaneously. It becomes much less costly to provide live supervision when a team is involved in the training process.

Strategic family therapy has incorporated team consultation as a crucial element in the therapy process in the intervention with the family (Papp, 1980). In the Ackerman Brief Family Therapy Project the team serves both the purpose of supervision and backup to the therapist. The therapist is able to use the team behind the one-way mirror as the "Devil's Advocate" to paradoxically and therapeutically double-bind the family.

The utilization of a team or group also allows for interpersonal interaction, role-play, and the utilization of group process to modify trainees's perceptions and interpersonal interactions (O'Hare, Heinrich, Kirschnor, Oberstone, & Ritz, 1975). The dynamics of the group in training may sometimes parallel the dynamics of family in treatment (Stier & Goldenberg, 1975).

Some of the disadvantages of the use of the team approach in supervision include intimidation of clients who may be unwilling to be observed by a team, and reluctance of trainees to expose themself and their weaknesses to their peers (Stier & Goldenberg, 1975).

Tomm and Wright (1982) point out that such a live supervision system with a team may facilitate the

simultaneous training of family therapists and supervisors. Less experienced trainees may be supervised by slightly more experienced therapists. Those more experienced therapists may in turn be supervised by even more experienced therapists, etc. This process of live supervision by a team of colleagues has been demonstrated to be effective by both Wendorf (1984) and Roberts (1982a).

Co-Therapy

Similar to the use of the team in supervision is the use of co-therapy. The supervisor may serve as either a co-therapist with a less experienced therapist (Napier & Whitaker, 1973; Whitaker & Keith, 1981) or provide live supervision to two trainees working as co-therapists (Tucker, Hart, & Liddle, 1976).

Of the 229 articles dealing with supervision of family therapy, 32 articles (14%) mention the use of co-therapy as a teaching and learning technique. The use of co-therapy is an essential ingredient in the conduct of experiential family therapy (Napier & Whitaker, 1978; Whitaker & Keith, 1981). Many references to the use of co-therapy are linked to this theoretical orientation to family therapy.

Whitaker and Keith (1981) cite eight reasons for

utilizing a co-therapy team:

1) The co-therapy team has greater creativity than an individual.

2) Influence is increased when two therapists share the same perceptions with the family.

3) The therapist is less likely to pathologically relate with the family.

4) While one therapist is working with the family the other therapist is allowed time to think creatively and observe.

5) It is less likely in co-therapy that the therapist will utilize a family member as a co-therapist.

6) It is more likely when co-therapists are working together that the emotional affect of therapy will be expressed in the session with the family between therapists rather than taken outside therapy. It is believed that this expression is therapeutically important for the family to hear.

7) Co-therapy facilitates a smoother termination as co-therapists are able to assist one another in disengaging in a healty way from the family.

8) One therapist of the co-therapy team may more closely align with an individual within the family

while the other therapist maintains alliance with other family members, reducing the risk of a single therapist being overly aligned with one person and loosing viability with the remaining family member.

Co-therapy is more specifically addressed as a technique useful for training beginning family therapists (Andolfi, 1979; Birchler, 1975; Ferguson, 1979; Sherman, 1966; Stier & Goldenberg, 1975; Tucker et al., 1976). The above advantages of co-therapy are particularly relevant to the inexperienced therapist. Further, a supervisor providing live supervision through a one-way mirror to a co-therapy team allows for greater efficiency of time. Both trainees are allowed to gain in-session experience with the supervisor giving the same time to two trainees as would otherwise be required for only one therapist.

One of the weaknesses cited in the use of co-therapy with the supervisor in the room is that the stronger therapist generally dominates the therapy process. The less experienced therapist tends to depend on the senior therapist and therefore does not develop a sense of independence (Haley, 1976).

Setting Learning Objectives

Of the 229 articles located which deal with the

subject of family therapy supervision, 121 (53%) specify specific skills or objectives to be accomplished by the family therapist in training. It was noted previously that many references are single program descriptions and specific objectives set for trainees are unique to that particular program. In the review of the articles which specify learning objectives it was noted that objectives can be classified in several categories. Those categories include specific objectives for academic programs and trainees in academic learning settings, and those references which specify objectives for a particular dimension of the practice of family therapy such as family assessment. Some references list a number of skills which are integral to each theorist's or practitioner's comprehensive model of family therapy. A number of references state specific learning objectives which have been identified from a broad survey of the literature, while other references cite specific learning objectives for supervisors of family therapists.

In 1971 the American Association for Marriage and Family Therapy began to set standards for approved training programs in marriage and family counseling

(AAMFT, 1975). Those standards and specific objectives continued to be enlarged over the years culminating in the first manual on accreditation in 1975 (AAMFT, 1975). This early manual on accreditation specified the areas of course work which should be completed by a family therapy trainee. Those courses included two to four courses on marital and family systems, two to four courses on marital and family therapy, two to four courses on individual development, one course in professional studies, 1 year of supervised clinical practice, and one course on research. Everett (1975) indicated that such marriage and family therapy graduate programs should follow a sequence similar to a Master's Degree in social work, integrating both theoretical knowledge and clinical practice over a 2-year period of time. The American Association for Marriage and Family Therapy established the Commission on Accreditation for Marriage and Family Therapy in 1978 (AAMFT, 1979c). This Commission continued to refine academic standards and criteria. The required course areas for a Master's degree have remained substantially unchanged since 1975 and have only been updated and elaborated upon.

Competencies and objectives which must be achieved

by a therapist in training have been defined by various mental health professions. A family clinical psychology program has been developed at Georgia State University as a subspeciality of clinical psychology (L'Abate, Berger, Wright, & O'Shea, 1979). The Georgia State family clinical psychology program includes in-depth training in family theory, approaches to family therapy, family assessment, family enrichment, supervision of family therapy, and special topics including family networking and intervention in families with handicapped children. Additional practicums and internships emphasizing family therapy experience under supervision are also included in the Georgia State model.

A number of authorities have cited the need for psychology to adopt a greater family emphasis (Green, Ferguson, Framo, Shapiro, & LaPierre, 1979). These authors build a case for the inclusion of family related topics in psychology training programs including life-span developmental psychology, human sexuality, family and child assessment, family psychopathology, preventive approaches to child and family disturbance, practicums in marriage and family therapy, and family research.

Other references to setting learning objectives with trainees focus on specific aspects of the family treatment process. Meyerstein (1979) has developed a tool specifically designed to enhance therapist's interviewing and assessment skills. A number of potential problem areas for families are defined in a structured interview procedure. Trainees may use this list to conduct an interview to assess the various areas of family health or dysfunction.

A number of family theorists have devoted considerable effort to listing and describing the various skills necessary to conduct successful family therapy. Haley (1976) breaks down specific competencies necessary for the successful family therapist. From this perspective the conduct of a successful interview and the development of problem-solving skills are essential. Haley lists specific tasks which must be performed at each phase of family therapy, particularly the first interview.

Minuchin (Minuchin & Fishman, 1981) identified areas of competence from the structural family therapy perspective. Minuchin likens the training of a family therapist to the training of the ancient Samurai warrior. The Samurai was first trained in the

technical use of the sword. He then laid down the sword in order to devote himself to the study of the arts, later to come back to the sword with the ability to use the sword in a natural, more-flowing manner. Minuchin suggests that the family therapist must develop such a natural ability to conduct the family interview, joining the family, and utilizing his power to realign the family structure while coordinating "kicking" and "stroking."

Many others have attempted to develop comprehensive lists of skills and competencies which must be mastered by the therapist in training. Cleghorn & Levin (1973) compiled one of the earliest and most comprehensive lists of such skills which were broken down into perceptual, conceptual, and executive skills. The authors' perceptual skills are the skills required in diagnostic assessment focusing on interaction between family members. Conceptual skills are unique to family therapy and include drawing conclusions about the total system functioning. Executive skills include intervention skills designed to influence the family toward health. Cleghorn and Levin identified the necessary skills required in each of these categories for both the beginning and advanced family therapists.

Such skills are used in the training process as objectives which the trainee must master. Specific skills are included in a contract for change between the supervisor and the trainee.

Tomm & Wright (1979) continued to expand on the original Cleghorn and Levin skill categories while adding phases of the treatment process and considerably expanding the number of specific skills and competencies which must be possessed by the successful family therapist. In addition to the perceptual/conceptual skills and executive skills the authors break those skills down into the engagement process, problem identification process, change facilitation process, and termination process. This skill list may be used to establish goals in a contract for change between the supervisor and trainee. Trainees then may be assessed on the basis of achievement of those specified competencies. Supervisors may use the list of necessary competencies to see that trainees receive balanced instruction in all necessary phases of treatment.

Others have developed tools and rating scales for the purpose of assessment of trainees in supervision (Breunlin, Schwartz, & Krause, 1983; Piercy, Laird, &

Mohammed, 1983). In the development of these research tools the authors have specified objectives and competencies. It has been suggested that objectifying and specifying the goals of the training process leads to a more systematic and effective training experience.

Twenty AAMFT Approved Supervisors and 25 training directors of graduate level programs in marriage and family therapy were surveyed to determine what leaders in the field believed were the most important skills and competencies which must be possessed by the family therapist (Winkle, Piercy, & Hovestadt, 1981). The Delphi Technique was utilized to gain consensus. Findings contain a comprehensive list of important subjects and skills which respondents felt should be included in a graduate training program.

Focus on the Trainee's Own Family

Another common method utilized in the process of supervision is to focus on the personal growth of the trainee and assist the trainee to work through unresolved issues with their own family of origin. According to the Bowen (Anonymous, 1972; Bowen, 1978) approach to intergenerational family therapy, a therapist must first work through issues with their own family before they are able to assist others in

differentiating, or becoming emotionally objective, with one's family of origin. In the initial stage of supervision and training the trainee meets with the supervisor individually or in small groups to discuss and present findings from the trainee's own pilgrimage with their family of origin. Trainees conduct an investigation into their family background and construct a family genogram covering at least three generations. Trainees then identify major emotional blocks which may interfere with personal and professional differentiation. It is believed that trainees who are not personally differentiated from their family of origin may have blind spots and be unable to help clients who may experience similar difficulties.

A goal in the training of marriage and family therapists from the intergenerational family systems perspective is to assist trainees to see the adaptable nature of symptoms. Mental-health professionals often see themselves as "healthy" and clients as "pathological." Therapists who are unable to acknowledge or be aware of their own difficulties are more likely to react in anxious, judgmental, frustrated, angry, and in overly sympathetic ways with

clients. These behaviors are indications of the therapist's own unresolved problems and become major obstacles to the conduct of therapy. The therapist is helped to recognize their own emotional functioning in both their family context and in relation to the client. (Kerr, 1981).

As trainees progress through the training program, greater attention is given in supervision to viewing the video tapes of trainees' family therapy sessions. The supervisor views the video tapes of the trainee with a focus on the therapist's behavior with the family rather than the minute interactions and interventions with the family. A trainee's emotional growth is often reflected in a greater ability to maintain objectivity in interviewing and treating families (Kerr, 1981).

Of the 229 references located on family therapy supervision, 17 (7.5%) indicated that working on the trainee's family of origin was important to the supervisory process. Thirty-four articles (14.8%) suggest utilizing some form of personal growth experience to assist trainees to gain insight into themselves as important in learning family therapy.

Theory and Supervision

In a major review of the family therapy training and supervision literature no formal theories of supervision training could be found (Liddle & Halpin, 1978). Of the 229 articles which were located on supervision and training only 31 (13.5%) refer to any theoretical orientation. In the majority of these cases the supervision and training process was tied to a theory of family therapy. No formal theory of the supervision and training process could be found.

One of the most innovative ways of viewing the therapy and training process theoretically is to look at the isomorphic nature of the process of supervision and the process of the conduct of therapy. Isomorphism refers to similarity and parallel of pattern from one systemic level to another. Liddle and Saba (In press) examined the isomorphic nature of structural family therapy and training structural and strategic therapists. The authors found a parallel in the process between a therapist's theory of change in therapy and a supervisor's theory of change in the supervisory process. This congruence between a supervisor's theory of change and a therapist's theory of change allows the theory of therapy to be broadened

to explain the training experience.

Ekstein and Wallerstein (1972) suggest that there is a parallel process between the dynamics of the therapist's interaction with the client in psychotherapy and the dynamics in the trainee-supervisor relationship. Doehrman (1976) further examined this phenomenon and concluded that the dynamics of the supervisor-trainee relationship had a significant impact on the therapy process. There is therefore an isomorphic pattern which exists. As one's theory is adequate to explain the therapeutic process and as a consistency exists between the assumptions of change in the family and assumptions about the nature of change in the trainee, the theory of supervision may be derived by the extension of the theory of therapy.

Holman and Burr (1980) in their decade review of the growth of family theories in the 1970's indicated that systems theory of the family can now be truly considered a major framework. Though some years ago doubt existed as to whether or not clinical systems theories were adequate to be considered true theory, the authors conclude that it is now established adequately to be useful both as a formal theory and as an analytical approach.

The practice of family therapy and the techniques developed within family therapy have always preceeded theoretical formulations. Olson (1970) observed that marital and family therapy was in search of theoretical routes. In 1980, however, Olson found that significant advances had occurred in the development of theory during the 1970's and family therapy truly has arrived at the formal theory level (Olson, Russell, & Sprenkle, 1980). Family systems theory has not developed clear refinements or extensions to include the supervisory context.

Tomm and Wright (1982) identified the context which must be addressed by future comprehensive theories of family interaction, treatment, training and supervision. The authors identify four levels of system interaction which occur simultaneously. The first level is the family level in which family members interact with one another. The second level is the therapist-family system which includes the therapist interacting with family members in the family therapy process. The third level of system functioning includes the supervisor-therapist-family system which involves the supervisor providing either live or video tape supervision of the therapist and family in interaction

with one another. The supervisor is able to indirectly intervene through the therapist and indirectly impact the family system. A fourth level is the supervisor-supervisor-therapist-family system in which a senior supervisor or a supervisor of supervision trains the supervisor to train the therapist to intervene in the family. No attempt was made to go beyond the identification and description of these various system levels of functioning.

Research on Supervision and Training

An equally impoverished dimension of the family therapy and supervision training literature is research on the outcome of training. Kniskern and Gurman (Gurman, 1984; Kniskern & Gurman, 1979) have continued to update their comprehensive reviews of the outcome literature in family therapy. They have concluded that there is now no research evidence that training experiences in marriage and family therapy increase the effectiveness of a clinician. There are simply no studies of a comprehensive nature which follow a trainee through the supervisory process measuring change in the trainee as well as looking at the impact of such training on families in treatment. It has not yet been established that family therapy training

actually increases successful outcome in a trainee's family therapy.

Of the body of supervisory literature identified, 42 articles (18.3%) made some attemmpt to report outcome data on the family therapy training process. Of those references reporting numerical data, many simply reported descriptive statistics and demographic information on trainees in supervision.

One of the largest categories of reference to empirical outcome data is the reporting of statistics on various professionals' conduct of marriage and family therapy. Mezydlo, Wauck, & Foley (1973) attempted a rough outcome study on the clergy performing marriage counseling. The findings of this study were inconclusive as to whether the clergy were more effective than layman in the performance of marriage counseling. Training programs for various professionals such as social workers have attempted to measure the effectiveness of training on the performance of participants (Amatea, Munson, Anderson, & Rudner, 1980). Training programs were brief and no attempts were made to control extraneous influence in trainee's perceptions of self-change. Other studies have attempted to measure the effect of short-term

family therapy training on medical students (Schopler, Fox, & Cochrane, 1967) and psychiatric residents Martin, 1979). According to Gurman and Kniskern's (1978) criteria for adequacy of research design, none of the studies contribute particularly useful or important data to the family therapy research literature.

A number of other authors have attempted to describe change which may occur in trainees as a result of relatively brief family therapy training experiences. No study attempts to control extraneous influence. All rely entirely on therapists' self-report data alone. These studies measure variables such as the frequency of the use of family therapy techniques as reported by trainees (Byles et al., 1983; Flomenhaft & Carter, 1974, 1977; Matter, 1980; Stedman & Gaines, 1978; Tomm & Leahey, 1980).

Other data-based articles in the area of supervision and training include descriptions of training opportunities for various professionals (Bloch & Weiss, 1981; Green et al., 1979; Liddle, Vance, & Pastushak, 1979). Some attempt has also been made to assess the characteristics of therapists in practice with regard to socialization (Everett, 1980a, 1980b),

and theoretical orientation (Sprenkle, Keeney, & Sutton, 1982). Other attempts have been made to determine the attitudes, values, and perceptions of approved family therapy supervisors (Everett, 1980c; Winkle et al., 1981). The majority of these research projects are of the survey type and report descriptive statistics only.

Some of the most useful attempts to identify family therapy skills and develop instruments for the evaluation of therapists have been done by Breunlin et al., (1983); Fisher (1982); and Piercy et al., (1983). Each of these projects have attempted to develop family therapists' behavior rating scales.

Roberts (1982a) conducted a study on the outcome of various methods of live supervision. The study analyzed the various methods of live supervision. This is the only such study with a relatively sophisticated research design.

As of the time of the design of this research project none of the above developments had occurred and no instruments were in existence for the purpose of measuring family therapy trainee's behavior or change. Only Tomm and Wright (1979) had identified skills which were necessary for the conduct of family therapy. Roberts (1982) operationalized these skills in a way

similar to the way they were utilized in this study.

Summary

The family therapy training and supervision literature focuses mostly on specific techniques utilized within a single family therapy training program or experience. Relatively little research has been done on the subject of supervision and training. At the time of this research design no instruments existed for the purpose of measuring family therapists' behavior and no normative data had been accumulated. One of the most useful contributions to the family therapy training literature was made by Tomm and Wright (1979) as they identified the skills and behaviors necessary for the conduct of family therapy. This development opened the door for operationalization and measurement of family therapy trainees' skills. Little or no theoretical development work has been done in operationalizing formal theories of family therapy training and supervision.

This literature review substantiates the earlier conclusion of Liddle and Halpin (1978) that the family therapy literature on training and supervision is fragmented and disorganized. Of the 229 articles located in this survey of the literature on family

therapy training and supervision, 56.3% had been written by or before 1978. A number of articles (43.7%) have been written since the Liddle and Halpin review and critique. Unfortunately the recommendations of Liddle and Halpin (1978) and Kniskern and Gurman (1979) have been largely ignored. Little more is known today than during the times of those reviews. The literature continues to report single case descriptions of family therapy training. Little follow-up or research is being conducted.

CHAPTER III

METHODOLOGY

Since little research has been done on family therapy training, this research attempted to gain important information about the factors which influence family therapy trainee's skill acquisition over time. A number of obstacles had to be overcome in order to accomplish this task. First, a sufficient sample had to be obtained in order to gather enough data for appropriate statistical analysis. Training and supervision needed to be done in a natural environment with research tools and measures being as unobtrusive as possible. Further, the research population needed to be as similar to other family therapy training programs as possible so as to allow for the greatest generalization of findings.

An obstacle to such research is the reluctance of clinicians to take time to complete research instruments. This is in part due to their skepticism of the relevance and accuracy of such research. This is particularly true of systemically oriented family therapists (Colapinto, 1979). Ethical considerations including both trainee's confidentiality, supervisor's confidentiality, program's confidentiality, and the need

for anonymity of clients whose cases were brought for supervision also needed to be addressed. It was also essential that research procedures be as simple and unobtrusive as possible so as to overcome these concerns.

In order to accomplish this task, special self-report and supervisor-report instruments were developed to measure family therapy trainee skill acquisition over time. A large midwest psychiatric treatment and training facility was chosen as the research population for this study. Although some supervisors in the training program were reluctant to participate, the director of the program welcomed the opportunity to obtain research data which might support the hypothesis that the training program was producing positive skill acquisition.

Research Design

This research project was developed around an existing family therapy training program nationally recognized for its integrative approach. To meet the goals of this study, a modified pretest, posttest, quasi-experimental design was selected (Isaac & Michael, 1981). Classifying this design is a difficult task since it combines elements of action research and

experimental design. As with action research, no randomization or assignment was ethically possible and no control group was found to match those applying to the training program. Some control was sacrificed to gain entry into a natural training setting. To partially compensate for lack of control of history and selection an extensive amount of background information was collected from each participant. Caution will be exercised in making generalizations from the self-selected population participating in the training program.

To further ensure internal validity, a multi-trait, multi-method approach has been taken (see Table 1) as recommended by Gurman and Kniskern (1978). To check for the effects of testing, a comparison has been made between group means of Time 3 and Time 4. If no significant difference exists, it will be likely that external validity is not threatened by reactive pretesting or experimental procedures effects.

Measures have been created with strict psychometric procedures in mind. All reliability estimates will be reported.

Research Sample

The research sample for this study was selected

Table 1

Research Design

	T_1	X_1	T_2	X_2	T_3	T_4	X_3	T_5	X_4	T_6
1st year Trainees	X	X	X	X	X	0	0	0	0	0
2nd year Trainees	0	X	0	X	0	X	X	X	X	X
Supervisors	0	0	X	0	X	0	0	X	0	X

T_1 = Pretest (beginning of 1st year)

T_2 = Midyear evaluation (1st year)

T_3 = Posttest (end of 1st year)

T_4 = Pretest (beginning of 2nd year)

T_5 = Midyear evaluation (2nd year)

T_6 = Posttest (end of 2nd year)

X_1 = 1st year, 1st semester Training and supervision

X_2 = 1st year, 2nd semester Training and supervision

X_3 = 2nd year, 1st semester Training and supervision

X_4 = 2nd year, 2nd semester Training and supervision

from the Family Therapy Training Program at a large midwestern multidisciplinary psychiatric and mental-health facility. This facility offers a broad range of training experiences including residencies in psychiatry, internships in psychology, and fellowships in social work and pastoral care. This facility also provides a wide range of psychiatric and psychological services to the community including long-term inpatient psychiatric care, short-term crisis hospitalization, halfway houses and group treatment homes, as well as outpatient after-care and outpatient satellite mental-health centers. Services are offered to children as well as adults. The family therapy training program exists within this facility to train staff as well as community practitioners. At the time of this research, training was being done at the psychiatric facility as well as a satellite division in a large city nearby. Between these two branches of the training program, approximately 50 trainees were trained each year.

The Family Therapy Training Program had never undergone empirical research on the outcome of their training program. Only informal trainee evaluations were administered periodically throughout the 2-year family therapy training program. The stated purposes

of this research were to assist the Family Therapy Training Program in gaining information about the success of their own training program as well as to gather information in general about family therapy training and valid research methodology in family therapy training.

Training Program Description

The Family Therapy Training Program is described as a family therapy training program for community practitioners (See Appendix C). The program is a 2-year externship involving trainees meeting twice monthly for 3 hours. On each of those 2 days per month, time is divided between didactic presentations, discussions and role-play, and small group supervision. Each training period lasts 9 months.

Trainee requirements. According to the brochure, trainees are requested to bring audio or video tapes of their current clinical work. Trainees within the program are expected to be responsible for an ongoing caseload of marriage and family therapy cases. From this ongoing caseload in the trainee's work setting, audio- or video tapes are to be made of their clinical work brought for supervision. Entrance requirements to the program include having completed a minimum of a

Masters Degree from one of the mental-health disciplines and 2 years of clinical experience. In actuality, the trainees range from graduate students in nearby universities to medical residents and practicing psychiatrists.

Theoretical orientation. The stated theoretical orientation of the family therapy training program is an integrated structural family therapy and strategic family therapy model. There was a revision in the curriculum of the Family Therapy Training Program the summer before this research began. During that time the Bowen Family of Origin family therapy (Bowen, 1978) was also integrated into the curriculum. This facility has been oriented toward the integration of a number of family models and has not been limited to one single theoretical orientation. Further, the stated goal of a number of the faculty supervisors is to develop a truly integrated family systems model including concepts from Bowen, structural, and strategic family therapy models.

Training format. Trainees meet with the didactic group for approximately 1 1/2 hours for the presentation of theoretical material, video tapes of actual interviews illustrating the topic being presented, discussions, exercises, role plays, as well

as other experiential learning assignments. Trainees are expected to prepare for the presentation by reading extensively from the family therapy literature between training sessions. Trainees meet with a supervisor for small group supervision for an additional 1 1/2 hours. Groups generally consist of three trainees and a senior staff person of the training facility who supervises the clinical work of these trainees. Trainees switch supervisors midway through each of the training periods, thus allowing each trainee approximately 4 1/2 months with each supervisor.

Supervision assignment. This is an ongoing family therapy training program and there are both first- and second-year students in training. These groups meet separately, although presentors and supervisors often are actively involved with both classes of trainees. First-year trainees are assigned to their supervisor on a random basis. Second-year trainees are allowed to state their preferences for a supervisor, and the program attempts to match trainee and supervisor according to preference.

Trainees often have an opportunity to experience all supervisors in the presentation of didactic material, viewing video tapes of each supervisor's

actual therapy, or actually being assigned to the supervisor for consultation.

Supervision process. The actual process of supervision involves three trainees meeting with a supervisor. During the 1 1/2 hours of supervision, supervisors encourage the presentation of clinical material. This is sometimes done with one trainee taking the majority of the period of time and thus alternating sessions between trainees. Another more common method of supervision is that each trainee is allowed 30 minutes for the presentation of a video tape, audio tape, or case notes on families being seen in the trainee's current clinical practice. A number of supervisory techniques are utilized to assist the trainees in gaining insight into the family and treatment, and the therapist's own understanding of his professional role in the treatment of the family. Some supervisors are more theoretically oriented toward helping the trainee gain insight, while other supervisors encourage trainees to develop a large repertoire of intervention skills to deal with families and modify family dysfunction. Such supervision may follow a single family or several families through the process of therapy during the 4 1/2 months with the

supervisor. Sometimes the same case may be carried over to the second supervisor during the training year.

Background data with regard to the trainees were gathered in the initial portion of the research project.

Research Instruments

An exhaustive review of the family therapy literature yielded no empirical information or instruments utilized to measure the process of supervision, training, or the outcome of such family therapy training programs (Kniskern & Gurman, 1979). Therefore, it was necessary to construct new instruments to accomplish the research objectives. Since an instrument was needed to assess family therapy skill, the Family Therapy Skill Evaluation (FTSE) was designed for use in this project. A Background Information Form was constructed to obtain data on previous family therapy training, family background, and professional experience. Additional instruments were designed for program evaluation.

Family Therapy Skill Evaluation (FTSE)

Identification of family therapy skills. The work of Cleghorn and Levin (1973) was one of the first attempts to identify the specific skills necessary for

the effective family therapist. The authors identify specific objectives for trainees at each level of experience. Tomm and Wright (1979) expanded on the Cleghorn and Levin (1973) learning objectives and identified many other skills which the effective family therapist must possess. Tomm and Wright identified compentencies within four areas of therapist's functioning. Those areas of functioning included Engagement, Problem-Identification, Change Facilitation, and Termination. These skills were particular to the "Calgary Model" of family therapy. This model is an integration of the concepts of General Systems Theory, Communication Theory, cybernetics, psychodynamics, and social learning within the Systems framework. "The actual clinical method focuses on problem solving by clarifying behavioral interaction and is more cognitive than other current approaches in family therapy (Tomm & Wright, 1979, p. 228)."

Tomm and Wright's (1979) conception of family therapy skills includes a distinction between perceptual-conceptual skills, and executive skills. The perceptual-conceptual skills are the thinking skills of the therapist. These include the ability to conceptualize the family in Systems terms and formulate

a systemic diagnosis. The executive skills refer to the actual behavior of the client that is observable to the family and includes the therapist's methods of intervention. Thus each of the four stages of treatment would also have both perceptual-conceptual skills and executive skills. Due to the need for brevity to encourage trainee and supervisor compliance, the distinction between perceptual-conceptual skills and executive skills has been dropped. Thus, each of the four stages of treatment include both the perceptual-conceptual as well as executive skills. In some cases the perceptual-conceptual and executive skills were combined into one item. It was felt that for the purpose of this study the distinction between thought and action could be combined in many cases. Further, it may be difficult for the supervisor to assess what is going on in the mind of the trainee whereas actual behavior on video tape or audio tape is observable and therefore measurable.

Reduction of the item pool. Table 2 contains each of the four major therapist's functions and competencies and the subskills among them. Tomm and Wright (1979) identified a total of 270 skills which are important for the clinician to possess. These

was complete, all coding sheets were forwarded to the University Computing Center and professionally key punched. Cards were then loaded onto disk files on the IBM main frame computer. Frequency distributions were obtained on all data fields. This was done to detect any out-of-range errors which may have occurred in the coding process. All errors were corrected prior to analysis.

Hypotheses Tests

All statistical analyses for each of the following hypotheses were performed using the SPSS/X software package running on the Oklahoma State University IBM main frame computer.

Operational hypotheses.

1. The reliability for the FTSE will meet minimum standards suggested for research purposes.

2. There will be a significant difference on the FTSE global score and subscale scores according to whether trainees were supervised by case notes, audio tapes, or video tapes.

3. Trainees' self evaluation on the FTSE and subscales will be lower on the midprogram evaluation than on the preprogram evaluation.

4. Significant increase in skill will be reported

by trainees on the FTSE and its subscales for each period of supervision beyond period one.

5. A significant increase will be reported from supervior 1 to supervisor 2 on the FTSE and its subscales.

6. A significance difference will exist between trainee and supervisor evaluation scores on several subscales and items on the FTSE.

7. Items on each of the FTSE subscales will be related to underlying "factors" and will load with significant factor loadings.

Statistics for hypotheses evaluation. Data used for analysis were obtained from the FTSE. The primary statistical procedures used were the *t* Test, analysis of variance (ANOVA), factor analysis, and Cronbach's Coefficient Alpha. Additionally, Guttman and split-half reliability coefficients will be reported. Whenever a test of significance was required, the .05 level of confidence was used.

To determine whether the FTSE meets minimum standards to proceed with further analysis, Cronbach's Coefficient Alpha was obtained (Hypothesis 1). Coefficient Alpha provides the most useful standard of reliability. It is based on internal consistency and

determines whether measurement error is present due to errors in sampling content. When coefficient alpha exceeds .70, sufficent reliability exists (Nunnally, 1978).

The students' t Test is a statistical tool designed to determine the significance of difference between two group means (Popham & Sirotnik, 1973). Group means on the FTSE for various periods of supervision (Hypotheses 3 and 5) and between trainees and supervisors (Hypothesis 6) were compared via the t Test at the .05 level of significance.

Analysis of variance (ANOVA) is a statistical procedure designed to explore mean differences by analyzing variances (Popham & Sirotnik, 1973). Single-classification analysis of variance was used to analyze only one independent variable at a time, while multiple-classification analysis of variance was used to analyze more than one independent variable as well ad possible interactions (Hypotheses 2 and 4).

Factor analysis was used to determine whether scales on the FTSE were related to underlying "factors" (Hypothesis 7). The principal axis method of extraction with varimax rotation was chosen as the most appropriate for confirmatory factor analysis

(Nunnally, 1978).

Limitations

The design of this study was limited by the constraints placed upon it by the family therapy training program. Measures were designed to be as unobtrusive as possible. It was not possible to use trained objective observers for data collection to control for socially desirable responses. Validity had to be established psychometrically.

Little control of extraneous influences was possible. The personal life experiences of the trainees and other professional experiences which might influence the learning of family therapy skills were beyond the scope of this study.

Finally, the research design and instrument construction may not be generalized to other contexts. At the time of this project the program was influenced primarily by structural and strategic approaches to family therapy. The FTSE was constructed to specifically measure the acquisition of these skills.

CHAPTER IV

RESULTS

The primary purpose of this study was to measure patterns of skill-attainment in family therapy trainees over time as assessed by both trainee and supervisor. In order to accomplish this task a special instrument was developed and tested. This chapter will summarize the findings of this research. First, the background and demographic characeristics of the sample will be reported. Subsequently each hypothesis will be analyzed and conclusions will be presented.

Sample Characteristics

The sample consisted of 25 first-year and 25 second-year family therapy trainees in a large midwestern family therapy training program. The average age for first-year trainees was 41.2 years and the average for second-year trainees was 44.3 years (see Tables 4 and 5). Supervisors' average age was 35.4 years, somewhat younger than the trainees. Supervisors averaged approximately 8 years more professional experience than trainees. Social workers comprised the largest number of trainees as well as supervisors.

Family Therapy Trainee's Skill Attainment

Family therapy trainee's skill attainment was

Table 4

Selected Background Characteristics

Characteristic	First Year Class N=25	Second Year Class N=25	Supervisors N=14
Sex (%)			
Males	32%	24%	57.1%
Females	68%	76%	42.9%
Age ($\bar{x}$)	41.2	44.3	35.4
Marital status (%)			
Single, never married	28.6	26.1	30.8
Single, widowed	0.0	4.3	0.0
Single, divorced	4.8	26.1	0.0
First marriage	61.9	39.1	53.8
Remarried	4.8	4.3	15.4
Highest education (%)			
M.S./M.A.	27.3	0.0	0.0
M.S.W.	40.9	69.6	78.6
M.Div., S.T.M., Th.M.	9.1	8.7	7.1
Ph.D.	22.7	13.0	14.3
M.D.	0.0	8.7	0.0
Years experience ($\bar{x}$)			
Individual therapy	8.1	8.9	16.5
Family therapy	3.1	4.1	11.2

Table 5

Participant Professional Identification

Professional Identification	Program Group		
	First Year	Second Year	Supervisors
Social Workers	7 (31.8%)	12 (52.2%)	8 (57.1%)
Psychologists	6 (27.3%)	2 (8.7%)	1 (7.1%)
Therapists	2 (9.1%)	2 (8.7%)	1 (7.1%)
Marriage and Family Therapists	0	2 (8.7%)	1 (7.1%)
Clergy, Chaplain, Minister	1 (4.5%)	1 (4.3%)	0
Physician	0	2 (8.7%)	0
Administrator, Manager, Agency Director	5 (22.7%)	0	3 (21.4%)
Academic, Teaching	1 (4.5%)	1 (4.3%)	0
Graduate Student	0	1 (4.3%)	0
	22 (100.0%)	23 (100.0%)	14 (100.0%)

measured by the Family Therapy Skill Evaluation (FTSE). The Family Therapy Skill Evaluation consisted of 40 items with subscales including Engagement Skills, Problem-Identification Skills, Change Facilitation Skills, and Termination Skills. The FTSE was used as the dependent variable with independent variables being training supervision, length of training, and whether trainees or supervisors are responding. The psychometric qualities of the instrument were also evaluated.

Hypothesis I

Reliability of the FTSE will meet minimum standards suggested for research purposes.

The FTSE was designed specifically for this research project from the skills identified by Tomm and Wright (1979). Since this instrument had never been used in previous research, the psychometric characteristics were unknown. Each of the instrument's 40 items are scored on a scale of 0 to 4. The theoretical range on the entire instrument is 0 to 160. The higher the score attained, the higher the level of skill that is being reported.

Since both trainees and supervisors used the same form to evaluate trainees' skill level, separate

reliability estimates needed to be obtained.

Subscales on the FTSE consist of Engagement Skills, Problem-Identification Skills, Change Facilitation Skills, and Termination Skills. Engagement Skills refer to those skills which enable a trainee to adequately engage a family in a meaningful therapeutic relationship. Problem-Identification Skills refer to those assessment skills required by the trainee to adequately assess the nature of the problem. Change Skills refer to those skills which enable a trainee to bring about therapeutic change within the family system. Termination Skills refer to those skills required to adequately disengage from the family, thus enabling the family to function effectively on its own. Reliability figures are reported on each of these subscales.

Reliability estimates were obtained by three separate procedures including Cronbach's Alpha, Split Half coefficient of internal consistency, and Guttman minimum and maximum likelihood estimates of reliability. All these methods of determining reliability will be reported since each approach measures reliability in a different manner and will provide a broader perspective on the issue.

Hypothesis I is supported with an overall alpha on the total sample of .97 (see Table 6). Nunnally (1978) indicated that when coefficent alpha exceeds .70, sufficient reliability exists for research purposes. It was also determined that each of the scales was adequately reliable for research purposes with the range of .88 to .93.

In each category all items seemed equally reliable. The deletion of items made no significant difference in the reliability of any of the scales.

The Termination Skills subscale reported the least reliability of .88, still significantly above that which was required for research purposes. The lower reliability on this subscale may be partially accounted for by the fact that there were only four items comprising this scale.

It is concluded that further analyses utilizing the FTSE was warranted since the instrument significantly exceeded the minimum reliability standards required for research purposes. The findings also suggested that the FTSE yields highly consistent measurements.

Hypothesis II

There will be significant differences on the FTSE global score and subscale scores according to whether

Table 6

Family Therapy Skill Evaluation Reliability

Family Therapy Skill Evaluation	Total Sample				Trainee Sample	Supervisor Sample
	Alpha	Split Half	Guttman Min	Guttman Max	Alpha	Alpha
FTSE Total scale	.97	.95	.95	.98	.96	.99
	(N=130)	(N=130)	(N=130)		(N= 96)	(N= 34)
FTSE Subscales						
Engagement	.90	.85	.81	.90	.87	.95
	(N=160)	(N=160)	(N=160)		(N=115)	(N= 45)
Problem ID	.93	.89	.85	.93	.90	.96
	(N=171)	(N=171)	(N=171)		(N=117)	(N= 54)
Change	.93	.91	.86	.94	.90	.96
	(N=155)	(N=155)	(N=155)		(N=108)	(N= 47)
Termination	.88	.88	.66	.88	.83	.95
	(N=180)	(N=180)	(N=180)		(N=124)	(N= 56)

trainees were supervised by case notes, audio tapes, or video tapes.

It has been suggested that the closer a supervisor is able to view the actual family therapy session the greater the likelihood that the supervisor will actually understand the strengths and weaknesses of the trainee and be better equipped to guide trainees toward skill attainment (Haley, 1976; Hoffman, 1981). It would then be hypothesized that the more detail the supervisor is able to obtain about the trainee's therapy sessions the more effective supervision would become. Thus, supervisors would be better equipped to supervise a trainee after viewing a video tape compared with verbal reports of the therapy session from trainee's recollection and case notes. It has been suggested that live supervision is by far the most effective method of obtaining information about the trainee/family interaction (Haley, 1976).

The training program brochure stated that small group supervision is done with three trainees per group. The focus is on the trainee's ongoing caseload and trainee's are asked to bring video tapes of their work for supervision or audio tape if video tape facilities are not available. Since this is an externship program

and trainees are often traveling long distances, it is not feasible to provide live supervision within such a training program. Such a request for video tape or audio tape, if video tape is unavailable, reflects the current thinking of the field with regard to effectiveness of supervision techniques.

The hypothesis suggests that a significant difference will occur on the FTSE global score and subscale scores according to whether a trainee is supervised by case notes alone, audio tape, or video tape. If video tape is a superior medium for supervision purposes, FTSE scores should reflect a higher level of skill attainment among those trainees providing video tapes of their sessions.

A one-way analysis of variance was performed comparing method of supervision including case notes, audio tapes, and video tapes. A .05 level of significance was chosen for hypothesis testing. No significant differences were found between the methods of supervision on the total scale or any of the subscales (see Table 7).

A surprising finding was that a small number of trainees (19.9%) actually provided video tapes of their sessions. An even smaller number (10.2%) provided audio

Table 7

One Way Analysis of Variance of FTSE Scores

by Method of Supervision

Family Therapy Skill Evaluation	Supervision Method						Statistical Significance				
	Case Notes		Audio		Video		F Ratio	p	Comparison		
	$\bar{x}$	sd	$\bar{x}$	sd	$\bar{x}$	sd			1 vs. 2	1 vs. 3	2 vs. 3
FTSE Total scale	102.5	24.5	111.6	22.8	104.3	24.4	1.1	.33			
	N=120		N=18		N=35						
FTSE Subscales											
Engagement	28.1	6.2	29.6	5.4	28.4	6.1	.48	.62			
	N=122		N=18		N=35						
Problem ID	30.5	8.4	33.2	6.8	31.3	8.5	.91	.40			
	N=123		N=18		N=35						
Change	33.2	8.7	37.7	9.1	34.7	8.7	2.3	.10			
	N=123		N=18		N=35						
Termination	10.2	3.0	11.6	2.8	9.8	2.8	1.8	.17			
	N=99		N=13		N=34						

tapes of counseling sessions. The majority (69.9%) of trainees provided only verbal or case note recall of actual counseling sessions.

The discrepancy in sizes between groups and small cell sizes may partially account for the lack of statistical significance in the findings. Another factor which may partially account for the lack of significant difference between Total Scale and subscale scores and the method of supervision is that video tape supervision may provide the supervisor more material for criticism. A trainee who provides only recall from case notes of the content of therapy sessions may only recall details which may lead the supervisor to positive conclusions or impressions. A trainee may either consciously or unconsciously bias the reporting of the actual family therapy session. Trainees are then less likely to receive a critique of the clinical work. Those trainees providing audio and video data may open themself to greater scrutiny. Scores may be lower for those willing to disclose more information and open themself up to greater scrutiny

Hypothesis III

Trainee's self-evaluations on the FTSE and subscales will be lower on the midprogram evaluation

than on the preprogram evaluation.

Some supervisors have suggested that trainees go through a "deskilled phase" shortly after beginning a systems oriented training program. It is theorized that as a person shifts from a linear cause/effect epistemology to a more systemic world view that one may experience disorientation and lack of confidence.

If a "deskilled phase" actually exists, it would be suspected that self-report mean scores on the FTSE at midyear would be lower than self-report scores on the FTSE prior to commencement of the training program. To test this hypothesis the mean self-report FTSE scores for first-year trainees were compared by a two-tail *t* test at the .05 level of significance.

Hypothesis III was not supported (see Table 8). In comparing self-report mean scores on the FTSE and its subscales, no drop in self-assessment of skill was reported at midyear. Each successive period reflected a self-perceived increase in skill attainment. When comparing the preprogram self-evaluation with the midyear self-evaluation, no significant differences existed in the mean scores on the FTSE or any of its subscales. Comparing the midyear self-evaluation with the final year-end self-evaluation also yielded no

Table 8

t Test of First Year Family Therapy Skill Evaluation Self Report

Family Therapy Skill Evaluation	Period						Significance		
	Preprogram		Midyear		Year-end		1 to 2	2 to 3	1 to 3
	$\bar{x}$	sd	$\bar{x}$	sd	$\bar{x}$	sd			
FTSE Total scale	93.1	19.2	99.4	14.8	105.0	16.3	.26	.23	.04*
FISE Subscales									
Engagement	26.4	5.1	27.4	4.4	29.0	4.5	.53	.23	.10
Problem ID	27.7	6.3	29.4	5.7	32.3	5.8	.37	.10	.02*
Change	29.7	8.0	32.5	5.3	34.0	6.2	.20	.41	.07
Termination	9.3	2.6	10.1	1.7	9.6	2.6	.23	.42	.67

*$p \leq .05$

significant mean differences. When the mean scores for the preprogram and the end of the first year were compared, a significant increase in skill attainment was found on the Total Scale as well as the Problem-Identification subscale.

If a "deskilled phase" actually existed, it was not reflected in this sample as measured by the FTSE. Self-perceived skill attainment seems to continue to rise with each period of increased experience and training. It may be that a "deskilled phase" exists in some trainees with certain personality or background characteristics. It may also exist in a shorter timeframe and be resolved by mid training. The disorientation that was hypothesized was not detected by the FTSE or was not significant enough to affect the total group mean.

Another alternative explanation for these findings is that the experience with the FTSE or factors related to social desirability affect a trainee's self-reported skill attainment. The impact of such factors could outweigh such feelings of disorientation.

Hypothesis IV

Significant increases in skill will be reported by trainees on the FTSE and its subscales for each period

of supervision beyond period 1.

If family therapy training is effective in increasing the family therapy trainee's skill attainment, then it is expected that scores on the FTSE and its subscales would increase with each period of experience and training. Further it is expected that this trend of increased skill attainment would be reflected throughout the family therapy training process. Hypothesis V evaluated both supervisor's and trainee's ratings of skill attainment over time.

This hypothesis was tested by analysis of variance. The .05 significance level was chosen. All means on the FTSE total scale and subscales were tested.

This hypothesis was supported by significant increases in skill attainment over time when comparing group means on FTSE and its various subscales with successive periods of training (see Table 9). Trainees consistently reported increased skill at each phase of the training process. The mean score on the FTSE prior to beginning training was 93.1. The mean score at the end of the first year of training was 105.0, and 124.5 at the end of the second year. Trainees generally are concluding that training and experience has increased their skill attainment.

Table 9

FTSE Means by Period ANOVA

Family Therapy Skill Evaluation	First year trainees $\bar{x}$'s			Second year trainees $\bar{x}$'s			F-Ratio	Significance of F
	Pre	Mid	Post	Pre	Mid	Post		
FISE Total scale	93.1	99.4	105.0	106.0	114.05	124.8	8.62	.0001
FISE Subscales								
Engagement	26.4	27.4	29.0	28.1	30.1	32.9	5.03	.0001
Problem ID	27.7	29.4	32.3	32.9	34.5	37.8	7.639	.0001
Change	29.7	32.5	34.0	34.7	38.1	41.8	8.366	.0001
Termination	9.3	10.1	9.6	10.3	11.2	12.2	4.688	.0001

Alternative explanations for this finding include possible social desirability and effect of testing. These possible influences will be discussed later in greater detail.

It seems most likely that family therapy training and supervision does increase the family therapy trainee's skill attainment. The minimum result of family therapy training is the increased trainee's self-perception of skill attainment. Trainees seem to be gaining increased confidence in their ability to recognize and treat family difficulties. In the eyes of the trainee, family therapy training seems effective. Whether or not actual family therapy trainee's skill attainment is taking place will be discussed as supervisors's assessments of trainees are compared.

Hypothesis V

A significant increase will be reported from supervisor 1 to supervisor 2 on the FTSE and its subscales.

It is suspected that if family therapy training is effective that each successive supervisor will assess trainees at a higher level of skill attainment with each successive period of training. Supervisor mean

scores as they assess trainees on the FTSE and its subscales should each increase. If no recognizable change has taken place in the trainees as assessed by the supervisors, then no significance will be found or a possible decrease in skill will be reported.

The *t* Test was used to compare group means for each of the subscales and each period. While supervisors' assessment of trainees' skill level increased for the FTSE Total Scale in each subscale for each successive period, statistical significance was found only in first-year trainees on the Change subscale (see Table 10). The greatest change in one period of training appears to take place in the first year on the ability to bring about therapeutic change.

It may be that a trainee's ability to bring about change in a family system is one of the most noticable skills for a supervisor to assess. A trainee's ability to articulate a strategy for bringing about change is one of the more common foci of structural and strategic family therapy supervision (Liddle, 1980b). It is also possible that some supervisors may tend to assess trainees more critically while others are more positive. Another possible explanation for significance on this scale is that it is the subscale with the largest

Table 10

t Test of Supervisor Evaluations

Family Therapy Skill Evaluation	First Year Trainees						Second Year Trainees					
	Supervisor 1		Supervisor 2		t		Supervisor 1		Supervisor 2		t	
	$\bar{x}$	sd	$\bar{x}$	sd	value	p	$\bar{x}$	sd	$\bar{x}$	sd	Value	p
FTSE Total scale	88.6	24.7	98.8	26.0	-1.38	.175	99.0	29.5	107.3	30.8	- .89	.377
FTSE Subscales												
Engagement	25.5	7.0	26.8	5.8	- .7	.485	27.1	6.8	29.2	8.2	- .92	.365
Problem ID	25.6	8.9	28.2	8.7	-1.03	.309	30.0	9.8	32.1	9.6	- .74	.463
Change	27.7	7.5	32.8	9.3	-2.13	.039*	32.0	10.5	35.3	10.5	-1.02	.316
Termination	9.2	2.6	8.9	3.8	.29	.775	10.3	3.4	10.3	3.9	- .01	.995

number of items. The result of breaking each aspect of family therapy skill down into larger number of subscales may make it possible to more easily assess family therapy skill attainment. These findings are similar to the findings of Hypothesis IV. Change in a single period does not produce statistically significant increases in skill attainment. However, over a year's period of time and during the 2-year period of family therapy supervision significant increases are found.

Hypothesis VI

A significant difference will exist between trainee's and supervisor's evaluation scores on several subscales on the FTSE.

It is suspected that trainees and supervisors may have a different assessment at various periods of the training program. It may be that trainees have blind spots with regard to their lack of skill as assessed by the FTSE and its various subscales. The awareness of such discrepancies may be important to the training process.

The *t* Test at the .05 level of significance was utilized to compare trainees' and supervisors' means for midyear and year-end on both first-year and

second-year trainees. Consistently supervisors' evaluations of trainees throughout the training program were lower than trainees' evaluations of themselves. Statistical significance beyond .05 level for first-year trainees was only found at the midyear evaluation on the Change subscale (see Table 11). During the second year the midyear evaluation yielded significantly different scores between trainee and supervisor on both the Total Scale as well as the Change score (see Table 12). At year-end means for trainees and supervisors were significantly different on the Total Scale as well as the Problem-ID and Change subscales.

The trend toward trainees evaluating themselves higher than supervisors evaluations consistently holds true throughout the training program during both the first and second years. Consistently throughout the program trainees at each period of training evaluate themselves higher than the previous period. Supervisors also rate trainees as possessing greater skill progressively throughout the training program. Statistical significance is achieved fairly consistently only on the Change subscale which has the largest number of items and may be the most easily

Table 11

First Year Supervisor-Trainee FTSE *t* Test

Family Therapy Skill Evaluation	Midyear						Year-End					
	Trainee		Supervisor		*t*		Trainee		Supervisor		*t*	
	$\bar{x}$	*sd*	$\bar{x}$	*sd*	value	*p*	$\bar{x}$	*sd*	$\bar{x}$	*sd*	Value	*p*
FTSE Total scale	99.36	14.8	88.6	24.7	1.81	.078	105.0	16.3	98.8	26.0	.97	.337
FISE Subscales												
Engagement	27.36	4.4	25.5	7.0	1.09	.282	29.0	4.5	26.8	5.8	1.45	.155
Problem ID	29.45	5.7	25.6	8.9	1.79	.081	32.3	5.8	28.2	8.7	1.96	.057
Change	32.5	5.3	27.7	7.5	2.58	.013*	34.0	6.2	32.8	9.2	.53	.598
Termination	10.1	1.7	9.2	2.6	1.04	.328	9.6	2.6	8.9	3.8	.77	.445

*$p <$ .05

Table 12

Second Year Supervisor-Trainee FTSE *t* Test

Family Therapy Skill Evaluation	Midyear						Year-End					
	Trainee		Supervisor		*t*		Trainee		Supervisor		*t*	
	$\bar{x}$	*sd*	$\bar{x}$	*sd*	value	*p*	$\bar{x}$	*sd*	$\bar{x}$	*sd*	Value	*p*
FTSE Total scale	114.0	16.5	99.0	29.5	2.11	.043*	124.8	12.6	107.3	30.8	2.35	.028*
FTSE Subscales												
Engagement	30.1	4.5	27.1	6.8	1.75	.087	32.9	3.4	29.2	8.2	1.87	.076
Problem ID	34.5	5.6	30.0	9.8	1.90	.066	37.8	3.8	32.1	9.6	2.47	.023*
Change	38.1	6.7	32.1	10.5	2.28	.028*	41.8	5.9	35.3	10.5	2.39	.026*
Termination	11.2	2.4	10.3	3.4	.90	.385	12.2	2.0	10.3	3.9	1.84	.080

*$p \leq .05$

observable.

At the end of the second year of the training program trainees are rating themselves considerably higher with a greater jump in skill attainment than reported during any other period. Supervisors also rate trainees higher at this point, however without as significant a jump. This results in statistically significant differences between trainees' and supervisors' mean scores on the Total Scale as well as Problem-ID and Change subscales. The two remaining subscales approach statistical significance.

It would appear that at the very beginning of the first year of the training program trainees' perception of their own skill level is higher at the midyear than supervisors' perceptions of those trainees. The training program seems to give trainees a greater confidence in one's ability to change families than may actually be true. During the middle of the second year trainees once again see themselves as more skilled than their supervisor sees them on the total scale as well as their ability to change families. At the end of the entire program trainees see themselves as having acquired more skill than supervisors observed.

One factor which may partially account for these

significant differences between trainees' and supervisors' perceptions is the much larger standard deviation and standard error of the measurement reported on supervisor evaluations of trainees. Trainees' scores throughout the program are more tightly grouped than supervisors' scores on trainees. When the standard error of the measurement is considered, supervisors' assessments of trainees' skill attainment have greater variance. This may be accounted for by differences in philosophies and strictness of evaluation on the part of some supervisors.

Another alternative explanation is that trainees may be less able after a 2-year family therapy training program to understand their own limitations as a therapist. Supervisors who are more highly trained and have considerably more years of experience may be somewhat more skeptical of the power of family therapy to change families.

Hypothesis VII

Items on each of the FTSE subscales will be related to underlying single "factors" and will load with significant factor loadings.

Factor analysis was used to examine the items on the FTSE to determine whether the subscales were related

to underlying factors. The principle axis method of extraction with varimax rotation was chosen as the most appropriate technique for confirmatory factor analysis. First the entire scale was analyzed using this method and then each of the subscales was subsequently analyzed in a similar fashion. It was assumed that if actual underlying factors corresponded to each of the subscales, a sufficient Eigen Value would be found. It was also assumed that items would have sufficient factor loadings corresponding to these factors.

The factor matrix on the total scale yielded a six-factor solution with Eigen Values of 19.4, 1.4, 1.1, 1.0, .83, and .68 (see Table 13). It is relatively clear from these data that the FTSE is comprised of one major factor and perhaps three minor factors.

Factor one has an Eigen value of 19.4. This factor accounts for the largest amount of variance and includes items primarily from the Change subscale. The major items focus on the family problem and interventions designed to alter the problem. Factor two has an Eigen Value of 1.41. The items loading on this factor are primarily from the Engagement subscale and seem to have the common thread of being empathetic, warm, and joining with family members. Factor three has an Eigen Value of

Table 13

Factor Analysis of Family Therapy Skill Evaluation

Number	Item	Scale	Loading
	Factor 1 Eigen Value = 19.4		
13	Summarizes the essence of the presenting problem...	Problem ID	.740
11	Obtains a precise description of problem behaviors...	Problem ID	.680
26	Prescribes an individuals own problem behavior...	Change	.671
14	Explores the function that the presenting problem...	Problem ID	.644
25	Evaluates the potential of paradoxical...	Change	.644
28	Uses metaphors, similie, overstatement...	Change	.564
29	When possible, reframes preexisting negative concepts...	Change	.564
6	Formulates an explicit agreement regarding expectations...	Engagement	.507
	Factor 2 Eigen Value = 1.41		
3	Acknowledges each family member...	Engagement	.709
4	Responds with sensitivity and warmth...	Engagement	.657
8	Intensifies engagement with the family members...	Engagement	.562
12	Stimulates all family members to share...	Problem ID	.553
2	Is able to communicate a rationale...	Engagement	.544
7	Works toward including the whole executive subsystem...	Engagement	.496
	Factor 3 Eigen Value = 1.09		
39	Achieves formal closure...	Termination	.713
40	Reviews unresolved family problems and suggests changes...	Termination	.682
38	Initiates a review of family problems...	Termination	.670
37	Explores family members' rational for termination...	Termination	.588
	Factor 4 Eigen Value = 1.04		
31	Introduces adaptive changes...	Change	.707
20	Assesses the nature and intensity of boundaries...	Problem ID	.457
32	Facilitates negotiation and implements changes...	Change	.441
8	Intensifies engagement with family members...	Engagement	.421

1.09 and is comprised only of items from the Termination subscale. All of the items on the Termination subscale loaded heavily on this factor and thus the factor seems to be related to the subscale termination. Factor four has an Eigen Value of 1.04. Items loading on this scale seem to have a common element of focusing on the family structure and its boundaries and alliances.

The fifth and following factors had Eigen Values of less than 1.0 and thus were not significant for further evaluation.

Hypothesis VII is partially supported by factor analysis. The major factor on the FTSE was problem solving and accounted for 48.5% of all the variance. The remaining three factors were of minor significance and together with factor one accounted for 57.4% of the variants. It would seem that the underlying factor structure primarily relates to the problem-solving activity of family therapy.

These findings also add evidence of construct validity. Strong evidence for the validity of the full scale seems to exist. Moderate to strong support exists in support of the subscales. It would appear that not only is the FTSE reliable, it measures family therapy skills.

Summary

Descriptive statistics, *t* Test, analysis of variance, factor analysis, and estimates of reliability including Cronbach's Alpha, Split-half reliability, and Guttman reliability were applied to the data. All significance tests on the hypotheses were analyzed at the .05 level of significance for acceptance.

The findings presented in this chapter are based on the analysis of hypotheses I-VII on data obtained from the Family Therapy Skill Evaluation (FTSE) on family therapy trainees in a large midwestern family therapy training program. Twenty-five trainees in the first year and 25 trainees in the second year of that training program were evaluated over a 1-year training period and results of those evaluations from both trainees' as well as supervisors' perspectives were presented.

The FTSE was a new scale designed to assess family therapy trainees' skill attainment. Reliability estimates on the FTSE exceed those required for research purposes. Each of the items on the FTSE were of sufficient reliability to be retained in the instrument. Each of the subscales on the FTSE were also determined to be reliable.

Insufficient numbers of trainees presented video tapes and audio tapes in supervision to determine whether a significant difference exists on the FTSE based on the method of data presentation in supervision.

The hypothesis that a "deskilled phase" exits in the first year of family therapy training was not supported by data collected on the FTSE. In fact, trainees report higher levels of skill attainment at each phase of the training program throughout the 2-year period. Supervisors also report trainees change over time. In many cases a 1-semester training period was not long enough to yield significant statistical increases in family therapy skill acquisition. However, over a 1-year or 2-year period of time statistical significance was achieved.

Trainees perceive themselves as being more skillful in family therapy than the ratings of their supervisors justify. Supervisors also assess trainees as having changed over time, however at a lesser rate than trainees assessing themselves.

Finally, the FTSE seems to be related to one major underlying factor of problem solving and three minor factors related to empathy skills, termination skills, and realignment skills. These factors correspond

roughly to the subscales originally defined by Tomm and Wright (1979).

CHAPTER V

SUMMARY AND DISCUSSION OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS FOR FURTHER STUDY

Family therapy is a relatively new profession and is a rapidly growing treatment modality among mental mental-health professionals. Many claims are made about the effectiveness of family therapy as well as the effectiveness of various approaches to training marriage and family therapists.

A thorough review of the literature on marriage and family therapy supervision and training indicates that very little research has been done to demonstrate that family therapy training is effective (Kniskern & Gurman, 1979; Liddle & Halpin, 1978). At the time of the design of this research no instruments had been constructed to measure family therapy skill level. This research was undertaken to answer the questions as to whether family therapy training indeed produces results.

An instrument entitled "The Family Therapy Skill Evaluation" (FTSE) was constructed based on the various skills identified by Tomm and Wright (1979) required of a competent family therapist. This 40-item scale was used by both trainees and supervisors in a

2-year family therapy training program to measure both trainees' and supervisors' perceptions of family therapy skill attainment during the supervision and training process.

Trainees in a large midwestern family therapy training program were asked to rate their own family therapy skills at the beginning of each of the family therapy training years as well as during the middle of the program and at and the end of each year. Supervisors were asked to evaluate trainees at the midyear of the program and at the end of the year.

The training program inclued 25 trainees in the first year and 25 trainees in the second year of the training program. Approximately 30% of the trainees were male and 70% were female. Average age of trainees was 43 years with an average experience in the mental health field of 8.5 years. All trainees possessed a minimum of a Master's Degree and were currently employed in the mental-health field.

It was found that the FTSE was a reliable instrument exceeding minimum standards of reliability for purposes of research. Each of the subscales were also found to be adequately reliable.

Due to the small sample size and the relatively

small number of trainees bringing audio- and video tapes for supervision, it was impossible to determine whether a significant increase in skill attainment was achieved by those trainees being supervised by video tape or audio tape as compared to those trainees supervised only from case notes and recollection.

The hypothesis that trainees would report a lower level of skill at the midprogram than at the beginning of the first year of the training program was not substantiated. It appears that a "de-skilled phase" is not reflected in a trainee's self-report of actual skill acquisition. Trainees instead reported a gradual increase in their perception of their own skills at each phase of the training program throughout the 2-year period. Supervisors also assessed trainees at a higher level of skill at each of the periods during each period of supervision. Supervisors did, however, rate trainees lower than trainees rated themselves.

It was found that the underlying factor structure of the FTSE suggested that one main factor of family therapy skill accounted for the majority of variance within the scale. Three other less significant factors accounted for a smaller amount of variance. These four factors roughly corresponded to the skill subscales

identified by Tomm and Wright (1979).

Though the methodology of utilizing self-report has been called into question, it was found in this research project that correspondence existed between the ways trainees evaluated themselves and the way supervisors evaluated them. A consistent pattern of supervisors rating trainees lower than trainees rate themselves may suggest that trainees are not as aware of their own limitations or overestimate their own power to change families.

A number of factors may account for trainees continuing to report increased skill acquisition over time. The first hypothesis is that the actual experience of family therapy training increases a trainee's skill acquisition. Since actual in-therapy behavior and interaction between trainees and families in treatment were not measured, it is not known whether the actual in-therapy behavior changes. Trainees seem to be gaining in their own perceived acquisition of family therapy skill. Supervisors also share this perception. Whether trainees actually change their behavior in therapy was not within the focus of this study. It is significant and important to know that trainees do change their own perception of skill

acquisition as family therapy training proceeds.

There are many formats in which family therapy training may be offered. This particular training program format included both didactic presentations and supervision in small groups. Some have suggested that this method of training is inferior to trainees conducting family therapy with a supervisor viewing live from behind a one-way mirror. The question of superiority is still unanswered. This study found no significant difference in the sample available.

This study raises many interesting questions which are yet unanswered. To further understand the findings of this study it is suggested that the following projects be undertaken:

1. To determine more about the nature of the FTSE and its subscales it would be useful to take measurements both from family therapy trainee as well as supervisor and use trained observers to view the video tapes of actual in-therapy interaction between trainee and family in treatment. It could be determined whether a trained observer could detect changes in the therapy and determine whether a correlation between these changes exist and the trainee's self-perception as revealed by the FTSE.

2. It would be useful to know what role social desirability plays in both trainee's self-report as well as supervisor's report of trainees under their supervision. Does the desire to present oneself in a good light or for supervisors to present their own trainees in a good light influence the outcome data?

3. It would be useful to know whether a correlation between the FTSE and self-reported skill attainment and successful outcome in therapy are correlated. We do not know whether a trainee's increased self-perception actually produces a significantly better outcome in therapy.

4. It is still unknown whether supervision from case notes, video tapes, or live supervision from behind the one-way mirror actually produces different results. A study with a more balanced division of trainees being supervised by each of these methods could answer this question.

5. It would be useful to determine whether or not therapist's background characteristics and experience influence family therapy skill acquisition. We do not know whether certain academic backgrounds or interpersonal characteristics influence one's ability to conduct family therapy. It would be useful to

determine which academic background best prepares one to conduct family therapy.

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APPENDIXES

APPENDIX A

FAMILY THERAPY SUPERVISION ARTICLE CODING CRITERIA

FAMILY THERAPY SUPERVISION ARTICLE CODING CRITERION

1. Author _____ 2. 2nd Author _____ 3. 3rd Author _____

4. Year of Publication _____ 5. Ex _____

6. Professional Discipline Addressed
   - 10) Family therapy in general
   - 20) Psychology-Counseling
   - 30) Social Work
   - 40) Nursing
   - 50) Medicine
     - 51) Practicing Physicians
     - 52) Psychiatrists
     - 53) Residents
     - 54) Medical Students
   - 60) Other _____
     - 61) Psychotherapy in general
     - 62) Clergy
     - 63) Marriage Counselors
     - 64) Interdisciplinary
     - 65) Any
     - 66) General Mental Health
     - 67) Alcoholism in Counseling

7. Theory of Therapy Emphasized
   - 10) Structural
   - 20) Strategic
     - 21) Haley
     - 22) MRI
     - 23) Milan
   - 30) Psychodynamic
   - 40) Communications
   - 50) Bowen
   - 60) Behavioral
   - 70) Integration
   - 80) Other _____
     - 81) Social Casework
     - 82) Marriage Counseling
     - 83) Family Group Casework
     - 84) All
     - 85) Extended Family
     - 86) Multiple Family Marathon
     - 87) Boston Model
     - 88) Life Cycle
     - 89) Other
   - 90) Not specifically Family Therapy

8. Supervision Methods/Procedures Specified
   1 = Yes 0 = No

9. Theory of Supervision Proposed
   1 = Yes 0 = No

10. Outcome Data Empirical Research
    1 = Yes 0 = No

11. Training Format Presented
    (Lectures, Seminars, Bibliographies, etc.)
    1 = Yes 0 = No

12. Specific Objectives for Trainees Established
    1 = Yes 0 = No

13. Multiple Levels of Trainee Skill Accounted for
    1 = Yes 0 = No

Supervising Skills Presented: 1 = Yes, 0 = No
- 14) Family of origin work
- 15) Therapist personal growth
- 16) Live Supervision
  - 17) With Bug-in-the-ear
  - 18) With telephone call ins
  - 19) With team consultation
  - 20) With a co-therapist
- 21) Videotape
- 22) Case Notes

Usefulness to (on a scale of 1 to 5:)
- 23) Trainees _____
- 24) Supervisor _____
- 25) Therapists _____
- 26) Researchers _____
- 27) Theorists _____

APPENDIX B

CODED FAMILY THERAPY TRAINING LITERATURE

FIRST AUTHOR	SECOND AUTHOR	THID AUTHOR	YEAR	E	PROF DISC	THEORY TH	SUPER MET	THEORY SU	OUTCOME #	TRAIN FOR	OBJECTIVE	LEVEL SKL	FAM ORIG	PERS GROW	LIVE SUP	BUG INEAR	TELE CALL	TEAM CONS	CO THERAP	VIDEO TAP	CASE NOTE	USEFULNESS TRAINEE	USEFULNESS SUPERVIS	USEFULNESS THERAP	USEFULNESS RESEARCH	TO: THEORIST
AAMFT			1978		10	0	1	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3	5	3	3	3
AAMFT			1979		10	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	2	5	2	5	2
AAMFT			1979		10	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	3	2	2	2
AAMFT			1979		10	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	5	5	4	5	3
AAMFT			1979		10	84	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	2	5	2	2	2
ACKERMAN	BEATMAN	SHERMAN	1961		30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	2	2
ALLEN			1976		30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	3	2	1
AMATEA	MUNSON	ANDERSON	1980		30	81	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2	3	2	2	1
ANDERSON	AMATEA	MUNSON	1979		30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	2	1
ANDOLFI			1979		10	70	1	0	0	0	0	0	0	0	1	0	0	1	1	0	0	4	4	4	3	3
ANDOLFI	MENGHI		1980		10	70	1	1	0	1	1	0	0	0	1	0	0	0	0	0	0	2	3	1	1	1
ANDREWS			1974		10	70	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	4	5	4	3	3
APONTE	LYONS		1980		61	90	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	2	4	2	2	2
APONTE	VANDEUSEN		1981		10	10	1	1	1	1	1	1	0	0	1	0	0	0	0	0	0	5	5	4	3	3
APPEL	GOODWIN	WOOD	1961		50	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1
ARD			1973		63	82	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
BARDILL			1976		30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1
BARNARD	CORRALES		1979		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	2	2	2
BARTON	ALEXANDER		1981		10	60	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	4	4	4	4	4
BATESON			1972		60	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	1	2
BATESON			1972		60	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	2	1	1
BEAL			1976		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	1	1
BEATMAN			1964		30	83	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1
BEELS	FERBER		1969		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	3	2	2

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BERGER			1978		61	90	1	0	0	1	1	0	0	0	0	0	0	0	0	1	0	4	5	3	3	3
BERGER	DAMMANN		1982		10	70	1	1	0	1	1	1	0	0	1	0	1	1	0	0	0	4	5	3	3	3
BERMAN	DIXON-MURPHY		1979		10	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	2	2	2	2	1
BIRCHLER			1975		10	0	1	0	0	0	0	0	0	0	1	0	1	0	1	0	1	3	4	2	3	1
BLOCH	WEISS		1981		64	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	5	5	3	5	2
BOCKUS			1980		10	70	1	0	0	1	1	0	1	1	0	0	0	0	0	0	0	4	4	3	2	2
BODIN			1969		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	2	2
BODIN			1969		65	90	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	2	2	2	2
BOWEN			1972		10	50	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	4	4	4	3	3
BOWEN			1978		10	50	1	1	0	1	1	0	1	0	0	0	0	0	0	0	0	4	4	4	3	4
BREUNLIN	SCHWARTZ	KRAUSE	1983		10	70	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	3	5	3	5	3
BRODER	SLOMAN		1982		53	70	1	0	0	1	1	0	0	0	1	0	0	0	0	1	0	2	4	2	3	2
BRODKIN			1980		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	2	2
BYLES	BISHOP	HORN	1983		30	70	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	3	5	3	4	3
CAPLAN			1970		66	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3	1	1	1
CHODOFF			1972		52	90	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	1	1	1
CHURVEN			1979		10	70	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	1	1	1	1
CLEGHORN	LEVIN		1973		10	89	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	4	5	3	4	3
COHEN	GROSS	TURNER	1976		0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	1	1
COLAPINTO			1979		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	5	5
CONSTANTINE			1976		10	87	1	0	0	1	1	1	0	1	0	0	0	1	1	0	0	3	5	2	3	3
CROMWELL			1979		10	70	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	3	3	4	2
DELL	SHEELY	PULLIMAN	1977		10	70	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	3	2	2	2
DILLON			1976		30	70	1	0	0	1	0	0	0	1	1	0	0	0	0	0	0	3	2	2	1	1
DOEHRMAN			1976		61	90	1	1	1	1	1	0	0	0	0	0	0	0	0	1	0	2	4	2	3	3

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DUHL	DUHL		1979		0	87	1	0	0	1	0	1	0	1	1	0	0	0	0	0	0	2	3	2	1	1
DUHL	KANTOR	DUHL	1973		10	40	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	4	3	3	1	1
EKSTEIN	WALLERSTEIN		1972		61	90	1	0	0	1	1	1	0	1	0	0	0	0	0	0	1	2	5	2	2	3
EPSTEIN	BISHOP		1981		10	89	1	1	1	1	1	1	0	1	1	0	0	1	1	1	1	4	4	4	3	3
EPSTEIN	LEVIN		1973		50	70	0	0	0	1	1	1	0	0	1	0	0	0	0	1	0	2	3	2	1	1
EVERETT			1980		10	70	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	3	4	2	2	2
EVERETT			1979		10	70	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	3	3	2	1	1
EVERETT			1980		10	84	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	5	3	4	1
EVERETT			1975		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	5	2	3	2
EVERETT			1980		10	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	3	2
FALICOV	CONSTANTINE	BREUNLIN	1981		10	70	1	0	0	1	1	1	0	0	1	0	1	1	0	1	0	5	5	3	4	3
FERBER	MENDELSOHN		1969		10	70	1	0	0	1	1	1	0	0	1	0	0	0	0	0	0	3	5	3	2	2
FERBER	MENDELSOHN	NAPIER	1972		10	84	1	0	0	1	1	1	0	0	1	0	1	1	1	1	0	3	4	2	2	2
FERGUSON			1979		20	88	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	3	3	3	2	2
FIGLEY	SPRENKLE	DENTON	1976		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	3	2	2
FISHER			1982		10	70	1	0	1	0	1	0	0	0	1	0	0	0	0	1	0	2	4	2	4	2
FLINT	RIOCH		1963		10	70	1	0	0	1	1	1	0	0	0	0	0	0	0	1	0	2	3	2	2	1
FLOMENHAFT	CARTER		1977		10	10	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	2	4	2	5	2
FLOMENHAFT	CARTER		1974		10	10	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	2	3	2	4	2
FLOMENHAFT	CHRIST		1980		52	84	1	0	0	1	1	0	0	0	1	0	0	0	0	1	0	2	5	2	2	1
FLORES			1979		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	3	3
FRAMO			1976		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	1	1
FRAMO			1981		10	85	1	1	0	1	1	0	1	1	0	0	0	0	0	0	0	4	3	3	1	3
FRAMO			1975		10	70	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	3	2	2	1	1
FRAMO			1979		20	70	1	0	0	1	1	1	1	0	1	0	0	0	0	0	0	1	3	1	1	1

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FREEMAN			1980		10	70	0	0	0	1	1	1	1	0	0	0	0	0	0	1	0	2	3	2	1	1
GARFIELD			1979		10	70	0	0	0	1	1	1	1	1	1	0	0	0	0	0	0	2	2	2	1	1
GARFIELD			1980		10	70	1	0	0	1	1	1	0	0	1	0	0	0	0	1	1	2	4	1	1	1
GARFIELD			1977		61	90	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	4	2	4	4
GARRIGAN	BAMBRICK		1977		10	0	1	0	1	1	1	1	0	0	0	0	0	0	0	0	0	3	4	3	3	3
GERSHENSON	COHEN		1978		10	70	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	5	5	2	2	2
GOLDENBERG	PRESTON		1975		10	86	1	0	0	1	1	1	0	1	1	0	0	1	1	0	0	4	4	3	2	2
GREEN	FERGUSON	FRAMO	1979		20	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4	1	3	1
GROUP ADV.PSYCH			1970		10	84	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	3	2
GUERIN			1976		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	3	3	3
GULDNER			1978		10	70	1	0	0	1	1	1	0	1	0	0	0	0	0	0	0	5	4	2	1	1
GURMAN			1981		10	70	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	5	4	4	3	2
GURMAN	KNISKERN		1978		10	89	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	4	5	4	5	5
GURMAN	KNISKERN		1981		10	84	1	1	1	1	1	1	1	1	1	0	0	0	0	1	1	5	5	5	4	4
GURMAN	RAZIN		1977		61	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	5	5
HALEY			1972		10	21	1	0	0	1	1	1	0	0	1	0	0	0	0	0	0	3	4	2	1	1
HALEY			1980		10	21	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	4	4	3	1	1
HALEY			1974		10	21	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	3	5	3	1	1
HALEY			1975		10	21	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	1	1
HALEY			1969		61	20	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	5	5	4	3	3
HALEY			1977		61	20	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	5	5	4	3	3
HALEY			1976		10	21	1	1	0	1	1	1	0	0	1	0	1	1	0	1	0	5	5	4	3	3
HALEY			1980		10	21	1	0	0	1	1	1	0	0	1	0	1	1	0	0	1	4	5	4	4	3
HALEY	HOFFMAN		1967		10	84	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	3	2	2	2
HARE-MUSTIN			1976		61	90	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	2	1	1	1

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HARVEY			1980		10	70	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	3	3	2	1	1
HEATH			1982		10	0	1	0	0	1	0	1	0	0	0	0	0	1	0	0	0	3	4	3	3	2
HEILVEIL			1983		61	90	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	2	5	2	2	2
HENDRICKSON	KRAUSE		1972		20	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	1	1	2
HESS			1980		61	90	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	5	3	4	4
HOFFMAN			1981		10	84	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	4	4	3	5
JACKSON			1980		10	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2	3	1	1
JACOBSON			1981		10	60	1	1	0	1	1	0	0	0	0	0	0	0	1	0	1	4	4	4	3	3
JESSEE	L'ABATE		1981		0	70	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	2	3	1	1	1
KADUSHIN			1976		30	90	1	1	1	1	1	1	0	1	0	0	0	1	0	1	1	2	5	3	4	3
KAHN			1979		10	70	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	3	1	1
KASLOW			1972		30	90	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	3	2	1	1
KASLOW			1977		10	70	1	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3	4	2	1	1
KEMPSTER	SAVITSKY		1967		10	70	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2	1	1	1
KNISKERN	GURMAN		1980		10	70	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	4	4	4	4	4
KNISKERN	GURMAN		1979		10	70	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	4	3	5	3
KNOX			1976		10	60	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
KRAFT			1966		10	89	1	0	0	1	1	1	0	0	0	0	0	1	0	0	0	2	3	1	1	1
KRAMER			1980		10	70	1	0	0	1	1	1	1	1	1	1	1	1	1	1	0	4	4	3	2	3
KRAMER	REITZ		1980		10	0	1	0	1	1	1	1	0	1	0	0	0	0	0	1	0	3	4	2	3	1
L'ABATE	BERGER	WRIGHT	1979		20	70	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	2	4	2	2	2
L'ABATE	O'CALLAGHAN		1977		10	89	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	2	2	2	1	1
LANGS			1979		61	30	1	1	0	1	1	1	1	1	0	0	0	0	0	1	1	4	2	2	2	2
LANSKY	MCVEY	WENDAHL	1978		40	70	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	2	3	1	1	1
LAPERRIERE			1979		10	70	1	0	0	1	1	1	1	1	1	0	1	1	0	1	0	3	5	2	2	1

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LAPERRIERE			1979		20	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	4	1	1	1
LIDDLE			1982		0	70	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	5	3	3	4
LIDDLE			1978		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	2	1	1
LIDDLE			1980		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	2	2
LIDDLE			1980		10	70	1	1	0	1	1	1	0	0	1	0	1	1	0	1	0	4	5	3	3	3
LIDDLE			1982		10	70	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	3	4	5
LIDDLE			1982		10	20	1	0	0	1	1	0	0	0	0	0	0	0	0	0	1	3	5	3	3	2
LIDDLE	HALPIN		1978		10	70	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	3	5	3	4	4
LIDDLE	SABA		1983		10	70	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	4	5	4	3	5
LIDDLE	SABA		1982		10	70	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	3	5	3	3	3
LIDDLE	SCHWARTZ	BRUEMLIN	1984		10	70	1	1	0	1	1	1	0	1	1	0	0	1	0	1	1	4	5	3	3	4
LIDDLE	VANCE	PASTUSHAK	1979		20	70	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	4	2	4	2
LUTHMAN	KIRCHENBAUM		1974		10	70	0	0	0	1	0	1	0	1	0	0	0	1	1	1	0	4	3	3	2	3
MADANES			1981		10	20	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	4	5	3	2	2
MALONE			1974		50	70	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
MARTIN			1979		50	70	1	0	1	1	1	1	0	0	1	0	0	0	1	1	0	3	4	2	1	1
MARTIN			1976		10	30	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	3	3	3	3	3
MARTIN	LIEF		1973		52	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	1	1	1
MATARAZZO			1978		60	90	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3	1	1	1
MATTER			1980		10	70	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2	3	1	3	1
MEAD	CRANE		1978		10	70	1	1	0	1	1	1	0	0	1	0	0	0	0	0	0	4	5	2	4	4
MELTZER			1973		30	70	1	0	0	1	0	0	0	0	1	0	0	0	0	1	0	2	2	1	1	1
MENDELSOHN	FERBER		1972		10	70	1	1	0	1	1	1	0	0	1	0	0	0	0	0	0	4	5	3	2	1
MENDELSOHN	FERBER		1972		10	70	1	1	0	1	1	1	0	0	1	0	0	1	0	1	0	2	3	2	1	1
MERENESS			1968		40	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1

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MESSNER	SCHMIDT		1974		54	70	1	0	0	1	1	1	0	0	1	0	0	0	0	1	0	1	4	1	1	1
MEYERSTEIN			1979		10	70	0	0	0	1	1	1	0	0	0	0	0	0	0	0	1	5	5	4	4	3
MEYERSTEIN			1977		10	70	1	0	0	1	1	1	0	0	1	0	0	1	0	1	0	3	4	2	1	1
MEZYDLO	WAUCK	FOLEY	1973		62	70	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	2	2	1	3	1
MINUCHIN			1974		10	10	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	5	4	4	3	4
MINUCHIN	FISHMAN		1981		10	10	1	0	0	1	1	1	0	0	1	0	1	1	0	1	0	5	5	5	3	3
MIYOSHI	LIEBMAN		1969		53	70	0	0	0	1	1	1	0	0	0	0	0	0	1	0	0	1	3	1	2	1
MODLIN			1976		52	70	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3	3	3	1	1
MONTALVO			1973		10	70	1	1	0	0	1	1	0	0	1	1	1	1	1	0	0	5	5	4	4	4
MUDD	FOWLER		1976		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4	4	2	2
MUELLER	KELL		1972		61	90	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	3	2	1	1
MUNSON			1980		30	70	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	2	1	1	1
NAPIER			1976		10	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2	3	2	1	1
NAPIER	WHITAKER		1973		10	70	0	0	0	1	1	1	0	0	0	0	0	0	1	0	0	5	4	3	1	1
NAPIER	WHITAKER		1978		10	89	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	4	3	3	3	3
NICHOLS			1979		10	70	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3	3	2	1	1
NICHOLS			1979		10	70	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3	3	2	1	1
NICHOLS			1973		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2	1	1
NICHOLS			1968		10	30	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	2	2	1	1
NOVAK	BUSKO		1974		10	70	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	1	2	1	1	1
O'HARE	HEINRICH	KIRSCHNER	1975		10	70	1	0	0	1	1	1	0	0	1	0	0	1	0	1	0	3	3	2	1	1
OLSON			1970		10	70	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	3	3	2	3	3
OLSON	PEGG		1979		10	70	1	0	0	1	1	0	0	0	1	0	0	1	1	0	0	3	5	2	2	2
OLSON	RUSSELL	SPRENKLE	1980		10	70	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3	3	3	3	3
ORMONT			1974		10	70	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	2	2	1	1	1

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PAPP			1980		10	20	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	3	5	0	2	2
PAPP			1977		10	20	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	4	4	4	3	3
PERLMUTTER	LOEB	GUMPERT	1967		10	70	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	3	3	3	2	2
PHILLIPS			1975		10	70	1	0	0	1	1	0	0	0	0	0	0	0	1	1	0	2	3	1	1	1
PIERCY	LAIRD	MOHAMMED	1983		10	70	0	0	1	1	1	1	0	0	1	0	0	0	0	1	0	5	5	4	5	4
POWELL			1980		67	90	1	0	0	1	1	1	0	1	0	0	0	0	0	0	0	2	4	2	2	2
RAASOCH	LANGUEUR		1979		10	89	1	0	0	1	1	1	0	0	0	0	0	0	0	0	0	2	2	1	1	1
REISS			1960		61	90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
RESNIKOFF			1981		53	70	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3	3	2	1	1
RICKERT	TURNER		1978		10	70	1	0	0	1	1	0	0	0	1	0	1	1	0	0	0	3	4	2	1	1
RITTERMAN			1977		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	3	2	3
ROBERTS			1982		10	20	1	0	1	1	1	0	0	0	1	0	0	0	0	0	0	2	4	2	5	3
ROBERTS			1982		10	70	1	0	0	1	1	1	0	0	1	0	0	0	0	1	0	3	4	3	3	2
ROSENBAUM	SERRANO		1979		0	70	1	0	0	1	1	1	0	0	1	0	0	1	1	0	0	3	3	2	1	1
RUBINSTEIN			1964		52	70	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	2	1	1	1
RUSSELL			1976		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	4	1
SANDER	BEELS		1970		10	70	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	3	1	1	1
SATIR			1963		10	40	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
SCHNEIDERMAN	PAKES		1976		61	70	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	2	1	1	1
SCHOPLER	FOX	COCHRANE	1967		54	70	0	0	1	1	1	0	0	0	0	0	0	1	0	0	0	3	4	3	4	2
SHALETT			1979		10	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	3	3	2	2
SHAPIRO			1975		40	70	0	0	0	1	0	1	0	0	0	0	0	0	1	0	0	2	2	1	1	1
SHAPIRO			1975		20	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1	0	2	2	1	1	1
SHAPIRO			1979		20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	2	1	1
SHERMAN			1966		30	30	1	0	0	1	0	0	0	0	1	0	0	0	1	1	0	1	1	1	1	1

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SIGAL	GUTTMAN	CHAGOGA	1973		10	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	0	1	3	1	4	1
SIPORIN			1980		30	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	1	1	1
SKYNNER			1976		10	70	1	0	0	1	0	0	0	1	0	0	0	0	1	0	0	3	3	3	2	3
SKYNNER	SKYNNER		1979		10	30	0	0	0	1	1	0	1	1	0	0	0	0	0	0	0	3	3	2	1	1
SLUZKI			1974		53	89	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	2	2	4
SMITH	NICHOLS		1979		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	1	1
SPRENKLE	KEENEY	SUTTON	1982		10	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3	5	2	5	5
STANTON			1980		10	70	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4	4	2	5
STANTON			1975		20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	2	1	1
STANTON			1975		20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	1	1
STANTON			1981		10	20	1	1	0	1	1	0	0	0	1	0	1	1	0	0	0	4	4	4	3	3
STEDMAN	GAINES		1978		10	40	0	0	1	1	0	1	0	0	0	0	0	1	1	0	0	2	4	2	4	2
STIER	GOLDENBERG		1975		10	89	0	0	1	1	1	1	0	0	1	0	0	1	1	1	0	2	3	2	4	3
TALMADGE			1975		50	70	1	0	0	1	0	1	1	0	0	0	0	1	0	0	1	3	4	2	1	1
TOMM	LEAHEY		1980		54	70	1	0	1	1	1	1	0	0	0	0	0	0	0	1	0	3	5	3	5	2
TOMM	WRIGHT		1979		10	70	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	5	5	4	5	3
TOMM	WRIGHT		1982		10	70	1	1	1	1	1	1	0	0	1	0	1	1	1	1	1	4	5	3	3	3
TOOLEY			1975		10	70	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	3	3	3	2	2
TUCKER	HART	LIDDLE	1976		10	70	1	0	0	1	1	1	0	1	1	0	0	1	1	0	0	3	4	2	1	1
TUCKER	LIDDLE		1978		10	70	1	0	0	1	1	1	0	1	1	0	0	0	0	0	0	3	4	2	1	1
WALTERS			1977		10	20	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	4	3	3	2	2
WATZLAWICK	WEAKLAND	FISCH	1974		10	20	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	4	4	4	3	4
WENDORF			1984		10	10	1	1	0	1	1	1	0	0	1	0	0	1	1	1	0	3	5	2	3	3
WERTHEIMER			1978		30	70	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	2	3	1	1	1
WHITAKER	ABROMS		1974		50	90	0	0	0	1	0	0	0	0	0	0	0	1	0	0	1	1	2	1	1	1

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WHITAKER	KEITH		1981		10	89	1	0	0	1	1	1	0	0	1	0	0	1	1	0	0	4	4	3	3	3
WILLIAMSON			1973		10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	2	1
WINKLE	PIERCY	HOVESTADT	1981		10	70	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	3	5	2	5	2
WOODWARD	SANTA-BARBARA	LEVIN	1980		10	70	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	4	4	4	4	2
ZUK			1975		53	89	1	1	0	1	0	0	0	0	0	0	0	0	0	0	1	2	3	1	1	3

APPENDIX C

TRAINING PROGRAM BROCHURE

Family Therapy Training Program for Community Practitioners

Two-year Program

Format and curriculum

This program is designed to offer the practitioner an eclectic frame of reference, based on the belief that different families require different approaches and that while one approach may be useful for brief therapy, more ambitious treatment goals demand a broader and deeper base of knowledge and expertise. An effort is made to familiarize students with approaches offered by all of the major schools of thought in family and marriage therapy.

The first-year curriculum emphasizes social system concepts and techniques of structural and strategic approaches. The second-year curriculum is designed to assist the student's struggle to integrate the various approaches into a flexible, functional frame of reference.

The first session of each meeting day (9:30-11:00 a.m.) will be devoted to a seminar focusing on the above topics and related assigned readings. The second session (11:00-12:30 p.m.) is spent in small group supervision with three students in each group. Focus is on the students' ongoing caseload. Students are expected to videotape their work for supervision or audiotape if videotape facilities are not available.

Tuition and application

Tuition is $1,050 per student for the training year 1981-1982. Deadline for receiving the attached application and your tuition deposit of $225 is Wednesday, July 1, 1981. Please make checks payable to The [redacted] Foundation.

Location

Continuing education credit

The director of Social Work Licensing for the State of [redacted] has approved this program for fifty (50) hours of continuing education credit per year for social workers.

As an organization accredited for continuing medical education, The [redacted] Foundation designates this continuing medical education activity as meeting the criteria for fifty (50) hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

In addition, a certificate from The [redacted] Foundation Department of Education is offered to participants who complete the Two-year Program.

Requirements for admission

Applicants must have a graduate degree in a mental health profession and at least two years of clinical experience; be currently employed in a mental health agency or clinic with an ongoing caseload of at least five family and marital cases; and have a willingness to audio or videotape cases for supervision. Second-year students must complete the first-year program.

Time

First-year students will meet on the second and fourth Fridays of each month, excepting holidays, from 9:30 a.m. to 12:30 p.m. Dates for the first-year class in 1981-82 will be as follows: September 11 and 25, October 9 and 23, November 13, December 11, 1981 and January 8 and 22, February 12 and 26, March 12 and 26, April 9 and 23, May 14 and 28, and June 11 and 25, 1982.

Second-year classes will meet on the first and third Fridays, excepting holidays, from 9:30 a.m. to 12:30 p.m. Dates for the second year class in 1981-82 will be as follows: September 4 and 18, October 2 and 16, November 6 and 20, December 4 and 18, 1981 and January 15, February 5 and 19, March 5 and 19, April 2 and 16, May 7 and 21, and June 4, 1982.

Classes will not meet during the summer except for make-up sessions for holidays. Also, there are no class meetings on fifth Fridays.

APPENDIX D

FAMILY THERAPY SKILL EVALUATION

(FTSE)

FAMILY THERAY SKILL EVALUATION

Name of Trainee _____ Supervisor _____

Completed By: ____Trainee, or ____Supervisor

Period covered by supervision _____

Number of supervision sessions _____ Length of each session _____

Was supervision: ____individual, or ____group(how many trainees?_____)

How many cases were presented for supervision? _____

What methods of presentation were used (rank): _____case notes
_____audio tape
_____video tape
_____live, co-therapy
_____live, one-way

How well prepared for supervision was trainee?
1 2 3 4 5
Poor Excellent

How well does trainee incorporate learning from supervisor?
1 2 3 4 5
Poor Excellent

Overall rating of trainees' skill.
1 2 3 4 5
Poor Excellent

EVALUATE EACH OF THE FOLLOWING SKILLS:	Needs Much Improvement	Sometimes Effective	Often Effective	Extremely Effective	Do Not Know	Not Needed
Understands the basic axioms of systems theory as applied to a family unit.	___	___	___	___	___	___
Is able to communicate a rationale for treating the whole family.	___	___	___	___	___	___
Acknowledges each family member, thus engaging the whole family system.	___	___	___	___	___	___
Responds with sensitivity and warmth toward all family members.	___	___	___	___	___	___

	Needs Much Improvement	Sometimes Effective	Often Effective	Extremely Effective	Do Not Know	Not Needed
Respects appropriate interpersonal boundaries by exploring particular issues within appropriate subsystems.	___	___	___	___	___	___
Formulates an explicit agreement regarding expectations and goals of treatment.	___	___	___	___	___	___
Works toward including the whole executive subsystem in the therapy process.	___	___	___	___	___	___
Intensifies engagement with the family members least committed to therapy.	___	___	___	___	___	___
Initiates contact directly with clients to resume therapy or to clarify reasons for unexpected failure to return.	___	___	___	___	___	___
Provides support before and after confrontation.	___	___	___	___	___	___
Obtains a precise description of problematic behaviors and the sequence of events relevant to the problem.	___	___	___	___	___	___
Stimulates all family members to share their knowledge and experience of the presenting problem.	___	___	___	___	___	___
Summarizes the essence of the presenting problem for validation by the family.	___	___	___	___	___	___
Explores the function that the presenting problem may be serving in the system.	___	___	___	___	___	___
Recognizes discrepancies between verbal content and other channels of communication.	___	___	___	___	___	___
Recognizes the moment-to-moment impact the therapist has on the family.	___	___	___	___	___	___
Refocuses the discussion when family members confuse the issues.	___	___	___	___	___	___
Resists pressures to be taken in by problematic rules and beliefs that constrict the therapeutic process.	___	___	___	___	___	___

	Needs Much Improvement	Sometimes Effective	Often Effective	Extremely Effective	Do Not Know	Not Needed
Stimulates interaction between family members so as to observe and assess family functioning.	___	___	___	___	___	___
Assesses the nature and intensity of family boundaries, alignments, coalitions, and maladaptive family rules.	___	___	___	___	___	___
Explores potential factors at the physical, psychological, and interpersonal levels which may relate to the problem.	___	___	___	___	___	___
Involves the family in selecting a target problem or problems, in setting goals, and in elaborating a plan of management.	___	___	___	___	___	___
Estimates realistically the family's capacity for change.	___	___	___	___	___	___
Intervenes to control maladaptive patterns by restructuring family interaction verbally or physically.	___	___	___	___	___	___
Evaluates the potential of paradoxical instruction in overcoming resistance.	___	___	___	___	___	___
Prescribes an individual's own problematic behavior to gain paradoxical control of maladaptive interaction.	___	___	___	___	___	___
Mobilizes family members to provide validation and support for one another.	___	___	___	___	___	___
Uses metaphor, simile, overstatement, paradoxical statement, etc., to clarify, distill, and emphasize concepts with adaptive potential.	___	___	___	___	___	___
When possible, reframes preexisting negative concepts that are problematic in more positive and constructive terms.	___	___	___	___	___	___
Encourages client exposure to relevant new experiences outside therapy in addition to trying new behaviors in the session.	___	___	___	___	___	___

	Needs Much Improvement	Sometimes Effective	Often Effective	Extremely Effective	Do Not Know	Not Needed
Introduces adaptive changes by redirecting interactions and altering spatial arrangements of various subsystems.	___	___	___	___	___	___
Facilitates negotiation and implements changes by directing family members to try new behaviors in the session.	___	___	___	___	___	___
Achieves optimal anxiety levels experienced by different family members thru use of confrontation and support.	___	___	___	___	___	___
Relinquishes control of the interaction and avoids interrupting when adaptive patterns of family interaction emerge.	___	___	___	___	___	___
Assigns realistic and clearly stated behavioral tasks for homework and seeks commitments to comply from the family.	___	___	___	___	___	___
Initiates and maintains contact with other professionals who are involved in the case.	___	___	___	___	___	___
Explores family members' rationale for termination to differentiate reasonable from inappropriate motives.	___	___	___	___	___	___
Initiates a review of family problems and offers to renegotiate the therapy contract when indicated.	___	___	___	___	___	___
Achieves formal closure as part of the fulfillment of the therapeutic contract.	___	___	___	___	___	___
Reviews unresolved family problems and suggests possible changes for consideration while striving to end treatment on a positive note.	___	___	___	___	___	___

APPENDIX E

BACKGROUND INFORMATION FORM

BACKGROUND INFORMATION

CONFIDENTIAL

PLEASE REMOVE LABEL WITH YOUR NAME TO INSURE CONFIDENTIALITY

ID.....

Your Professional Title:_____

FORMAL EDUCATION:

SCHOOL/INSTITUTION	DEGREE	YEAR GRANTED	MAJOR FIELD OR SPECIALIZATION

POSTGRADUATE CLINICAL TRAINING (Include Workshops):

SPONSORING INSTITUTION	MODE OF THERAPY TAUGHT	LENGTH OF TRAINING

SUPERVISION RECEIVED:

SUPERVISORS QUALIFICATIONS and/or ORIENTATION	PROVIDED BY: 1=Employer 2=Consultant	MODE OF THERAPY TAUGHT	NUMBER OF HOURS

PRESENT WORK SETTING:

____ Social Service Agency
____ School
____ College/University
____ Mental Health Center
____ Inpatient
____ Out-patient
____ Hospital
____ Private Practice
____ Religious Organization
____ Criminal Justice Agency
____ Other_____

PROFESSIONAL MEMBERSHIPS:

How Many Years?

_____ American Association For Marriage and Family Therapy

_____ American Association of Pastoral Counselors

_____ American Family Therapy Association

_____ American Group Psychotherapy Association

_____ American Medical Association

_____ American Orthopsychiatric Association

How Many Years?

_____ American Personnel & Guidance Association

_____ American Psychological Association

_____ National Alliance For Family Life

_____ National Association of Social Workers

_____ National Council of Family Relations

_____ Other_____

_____ Other _____

PROFESSIONAL LICENSES/CERTIFICATIONS:

___ Physician

___ R.N.

___ Psychologist

___ Social Worker

___ Marriage/Family Counselor

___ Other_____

LIST ANY BOARD CERTIFICATIONS:

1. _____

2. _____

3. _____

PROFESSIONAL EXPERIENCE:	YEARS OF EXPERIENCE	AVERAGE NUMBER OF HOURS PER WEEK	HOURS OF SUPERVISION RECEIVED	RATE YOUR EFFECTIVENESS: 0 = Totally Ineffective 10= Extremely Effective
INDIVIDUAL COUNSELING/PSYCHOTHERAPY				
PRE-MARITAL COUNSELING				
MARITAL THERAPY				
FAMILY THERAPY				
MARRIAGE/FAMILY ENRICHMENT				
GROUP THERAPY				
SUPERVISION OF PSYCHOTHERAPISTS				
AGENCY ADMINISTRATION				
COLLEGE/UNIVERSITY TEACHING				
CONSULTING				
RESEARCH				

FAMILIARITY WITH FAMILY THERAPY MODELS:

RATE EACH OF THE FOLLOWING:

1 Low 2 3 MEDIUM 4 5 HIGH

FAMILY THERAPY MODELS	FAMILIARITY WITH MODEL	LEVEL OF YOUR SKILL	FREQUENCY OF YOUR USE	AMOUNT OF TRAINING RECEIVED	RANK ORDER FROM 1 to 13 ACCORDING TO YOUR PREFERENCE (1= Highest)
1. STRUCTURAL - Minuchin					
2. STRATEGIC - Haley					
3. STRATEGIC - Watzlawick					
4. STRATEGIC - Palazzoli					
5. STRATEGIC - Hoffman,Papp					
6. BOWEN					
7. COMMUNICATION-Satir,Bandler					
8. PSYCHODYNAMIC - Dicks,Stierlin					
9. INTERGENERAGIONAL - Nagy,Spark					
10. EXPERIENTIAL - Whitaker					
11. BEHAVIORAL					
12. Other_____					
13. Other_____					

How long have you been interested in family therapy? _____

How long have you practiced family therapy? _____

Is family therapy your primary approach? ___Yes ___No

Do you ever use the title "Family Therapist?" ___Yes ___No

Select the statement which best describes your position on family therapy:

___ I am skeptical about the effectiveness and usefulness of family therapy

___ Family therapy is one of the techniques or approaches I use

___ Family therapy is my primary orientation

How long have you been doing professional counseling/psychotherapy? _____

YOUR DATE OF BIRTH: ___/___/___
Month Day Year

NUMBER OF CHILDREN: _____

Ages	Sex	Living at Home?
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

YOUR MARITAL STATUS:

___ Single (Never Married)
___ Single (Widowed)
___ Single (Divorced)
___ Married (First Marriage)
___ Married (Separated)
___ Remarried (Circle: 1st, 2nd, 3rd, 4th)

YOUR PARENTS CURRENT STATUS:

___ Married and living together
___ Separated
___ Divorced and both single
___ Divorced, one single, one remarried
___ Divorced, both remarried
___ Single, partner deceased
___ Remarried, partner deceased
___ Both parents deceased

	1st	2nd
If your parents were divorced, how old were you?	___	___
If your parents separated, how old were you?	___	___
If your parent(s) remarried, how old were you?	___	___
If your parent(s) are deceased, how old were you?	___	___

NUMBER OF SIBLINGS (Include self): _____

CIRCLE SELF	OLDEST	2nd	3rd	4th	5th	6th	7th	8th
AGE								
SEX	M F	M F	M F	M F	M F	M F	M F	M F

Some Therapy models emphisize the importance of the therapists family experiences.

PLEASE RANK YOUR FAMILY ON THE FOLLOWING ITEMS:

Low		Medium		High
1	2	3	4	5
Poor				Excellent

Family of Origin

1. Your family of origin's overall mental health _____
2. Your mother's overall mental health _____
3. Your fathers overall mental health _____
4. Your parents overall marital satisfaction _____
5. Your family of origin's overall stability _____
6. The overall quality of relationships between siblings while growing up _____
7. The overall quality of relationships between siblings now _____
8. The overall quality of relationship with parents while growing up _____
9. The overall quality of relationship with parents now _____
10. The overall mental health of your weakest sibling _____

Family of Orientation

11. Your own overall mental health _____
12. Your overall marital satisfaction _____
13. Your spouses overall mental health _____
14. The overall mental health of your children _____
15. The overall quality of your relationship with your children _____
16. The overall mental health of your weakest child _____

Has any event influenced you to pursue a career in family therapy?

_____ Yes _____ No

Please explain:_____

_____

_____

APPENDIX F

ADDITIONAL RESEARCH INSTRUMENTS

CONFIDENTIAL ID NUMBER:_____

SUPERVISION TECHNIQUES

FAMILY THERAPY SUPERVISION	Recognizing that it is not always possible or necessary to use all skills with all trainees, which techniques are used with two-year trainees:			Which, in your opinion, are the most beneficial to facilitate trainees learning:		
	USED WITH ALL	USED WITH MOST	RARELY USED	MOST USEFUL	USEFUL	NOT VERY USEFUL
Establishing a Supervision Contract	1	2	3	1	2	3
Identifying Specific Skill Weaknesses	1	2	3	1	2	3
Setting Learning Objectives	1	2	3	1	2	3
Giving Homework in Supervision	1	2	3	1	2	3
Directly Observing Via Audio Tape	1	2	3	1	2	3
Directly Observing Via Video Tape	1	2	3	1	2	3
Directly Observing Via One-way Mirror	1	2	3	1	2	3
Advise-Giving in Supervision	1	2	3	1	2	3
Giving Trainee Directives	1	2	3	1	2	3
Understanding the interface between ones family experience and therapy	1	2	3	1	2	3
Focusing on the Supervisor-Trainee Transference (parallel process)	1	2	3	1	2	3

PLEASE RATE EACH OF THE FOLLOWING SKILLS ACCORDING TO YOUR VIEW OF ITS IMPORTANCE AS A FOCUS OF TRAINING FOR TWO YEAR FAMILY THERAPY TRAINEES:

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Understand the basic axioms of systems theory as applied to a family unit.	___	___	___	___
Is able to communicate a rationale for treating the whole family.	___	___	___	___
Acknowledges each family member, thus engagementing the whole family system.	___	___	___	___
Responds with sensitivity and warmth toward all family members.	___	___	___	___
Respect appropriate interpersonal boundaries by exploring particular issues within appropriate subsystems.	___	___	___	___
Formulates an explicit agreement regarding expectations and goals of treatment.	___	___	___	___
Works toward including the whole executive subsystem in the therapy process.	___	___	___	___
Intensifies engagement with the family members least committed to therapy.	___	___	___	___
In order to resume therapy (when appropriate) or to clarify unexpected failure to return, initiates contact directly by phone, mail, or visit.	___	___	___	___
Provides support before and after confrontation.	___	___	___	___
Obtains a precise description of problematic behaviors and the sequence of events relevant to the problem.	___	___	___	___
Stimulates all family members to share their knowledge and experience of the presenting problem.	___	___	___	___
Summarizes the essence of the presenting problem for validation by the family.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Explores the function that the presenting problem may be serving in the system.	___	___	___	___
Recognizes discrepancies between verbal content and other channels of communication.	___	___	___	___
Recognizes the moment-to-moment impact the therapist has on the family.	___	___	___	___
Refocuses the discussion when family members confuse the issues.	___	___	___	___
Resists pressures to be taken in by problematic rules and beliefs that would constrict the therapeutic process.	___	___	___	___
Stimulates interaction between family members so as to observe and assess family functioning.	___	___	___	___
Assesses the nature and intensity of family boundaries, alignments, coalitions, and maladaptive family rules.	___	___	___	___
Explores multiple factors at the physical, psychological, and interpersonal levels which may be involved in the problem.	___	___	___	___
Involves the family in selecting a target problem or problems, in setting goals, and in elaborating a plan of management.	___	___	___	___
Estimates realistically the family's capacity for change.	___	___	___	___
Intervenes to control maladaptive patterns by restructuring family interaction verbally or physically.	___	___	___	___
Evaluates the potential of paradoxical instruction in overcoming resistance.	___	___	___	___
When appropriate, prescribes an individual's own problematic behavior in order to gain paradoxical control of maladaptive interaction.	___	___	___	___
Mobilizes family members to provide validation and support to one another.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Uses metaphor, similie, overstatement, paradoxical statement, etc., to clarify, distill, and emphasize concepts with adaptive potential.	___	___	___	___
When possible, reframes preexisting negative concepts that are problematic in more positive and constructive terms.	___	___	___	___
Encourages family members to expose themselves to relevant types of new experiences outside therapy or direct them to try new behaviors in the session.	___	___	___	___
Introduces adaptive changes in behavior during the interview by redirecting interaction patterns and altering spatial and seating arrangements to rearrange subsystems.	___	___	___	___
Helps family members negotiate and implement simultaneous changes and when appropriate, direct them to initiate the new behaviors in the session.	___	___	___	___
Intensifies or diminishes the degree of emotion experienced by specific individuals through confrontation and support, respectively to achieve optimal anxiety levels.	___	___	___	___
Relinquishes control of the interaction and avoids interrupting when adaptive patterns of family interaction emerge.	___	___	___	___
Assigns realistic and concrete behavioral tasks as homework. Seeks explicit commitments to carry them out within a specific time period.	___	___	___	___
Initiates and maintains contact with other professionals who are involved in the case.	___	___	___	___
Explores family members' rationale for termination to differentiate reasonable from inappropriate motives.	___	___	___	___
Initiates a review of family problems and offer to renegotiate the therapy contract when indicated.	___	___	___	___
Achieves formal closure as part of the fulfillment of the therapeutic contract.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Reviews unresolved family problems by suggesting direction for future change and strives to conclude treatment on a positive note.	____	____	____	____

PLEASE RATE THE USEFULNESS OF THIS RATING SCALE IN THE SUPERVISION PROCESS:

1	2	3	4
USELESS	NOT VERY HELPFUL	HELPFUL	VERY HELPFUL

PLEASE LIST ANY SKILLS YOU BELIEVE SHOULD HAVE BEEN INCLUDED IN THIS EVALUATION:

_____

_____

_____

PLEASE MAKE COMMENTS ON YOUR EXPERIENCE IN PARTICIPATING IN THIS RESEARCH PROJECT:

_____

_____

_____

_____

_____

FINAL EVALUATION OF THE PROGRAM

FAMILY THERAPY MODELS	As a result of your training, how fimiliar are you with each of the following models: LOW 1 2 3 4 5 HIGH	Rank Order Five Preferred Models 1= Most Preferred
1. STRUCTURAL - Minuchin	1 2 3 4 5	
2. STRATEGIC - Haley	1 2 3 4 5	
3. STRATEGIC - Watzlawick	1 2 3 4 5	
4. STRATEGIC - Palazzoli	1 2 3 4 5	
5. STRATEGIC - Hoffman, Papp	1 2 3 4 5	
6. BOWEN	1 2 3 4 5	
7. COMMUNICATION - Satir,Bandler	1 2 3 4 5	
8. PSYCHODYNAMIC - Dicks,Stierlin	1 2 3 4 5	
9. INTERGENERATIONAL -Nagy,Spark	1 2 3 4 5	
10. EXPERIENTIAL - Whitaker	1 2 3 4 5	
11. BEHAVIORAL	1 2 3 4 5	
12. OTHER_____	1 2 3 4 5	
13. OTHER_____	1 2 3 4 5	

Is family therapy your primary approach? ____Yes ____No

Do you ever use the title "Family Therapist?" ____Yes ____No

Select the statement which best describes your position on family therapy:

____ I am skeptical about the effectiveness and usefulness of family therapy

____ Family therapy is one of the techniques or approaches I use

____ Family therapy is my primary orientation

Have you experienced a change in work setting or position since beginning training?

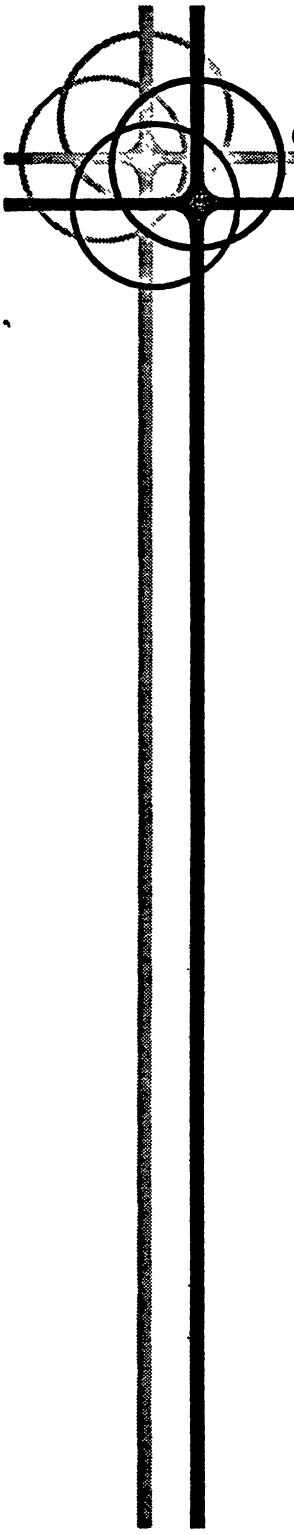
____ Yes ____ No If yes, please explain_____

_____

PLEASE RATE EACH SUPERVISOR ON THE USE OF THESE SUPERVISION TECHNIQUES	SUPERVISOR FOR SEPTEMBER THRU JANUARY:_____ Very Helpful	Helpful	Not Very Helpful	Did Not Use	SUPERVISOR FOR JANUARY THRU JUNE:_____ Very Helpful	Helpful	Not Very Helpful	Did Not Use
Establishing a Supervision Contract	1	2	3	9	1	2	3	9
Identifying Specific Skill Weaknesses	1	2	3	9	1	2	3	9
Setting Learning Objectives	1	2	3	9	1	2	3	9
Giving Homework in Supervision	1	2	3	9	1	2	3	9
Directly Observing Via Audio Tape	1	2	3	9	1	2	3	9
Directly Observing Via Video Tape	1	2	3	9	1	2	3	9
Directly Observing Via One-way Mirror	1	2	3	9	1	2	3	9
Advise-Giving in Supervision	1	2	3	9	1	2	3	9
Giving Trainee Directives	1	2	3	9	1	2	3	9
Understanding the interface between ones family experience and therapy	1	2	3	9	1	2	3	9
Focusing on the Supervisor-Trainee Transference (parallel process)	1	2	3	9	1	2	3	9
If you had the opportunity, would you seek further supervision from this supervisor?	(Circle One) YES NO				(Circle One) YES NO			
Please rate your overall supervision experience with each supervisor.	1 2 3 4 5 6 7 8 9 10 Not at all Helpful Helpful Extremely Helpful				1 2 3 4 5 6 7 8 9 10 Not at all Helpful Helpful Extremely Helpful			
Please make comments which will help us understand the above evaluation:	Comments:				Comments:			

APPENDIX G

CORRESPONDENCE WITH TRAINING PROGRAM



CHRISTIAN FAMILY INSTITUTE
6717 S. Yale, Suite 105/Tulsa, Oklahoma 74177/(918) 496-3090

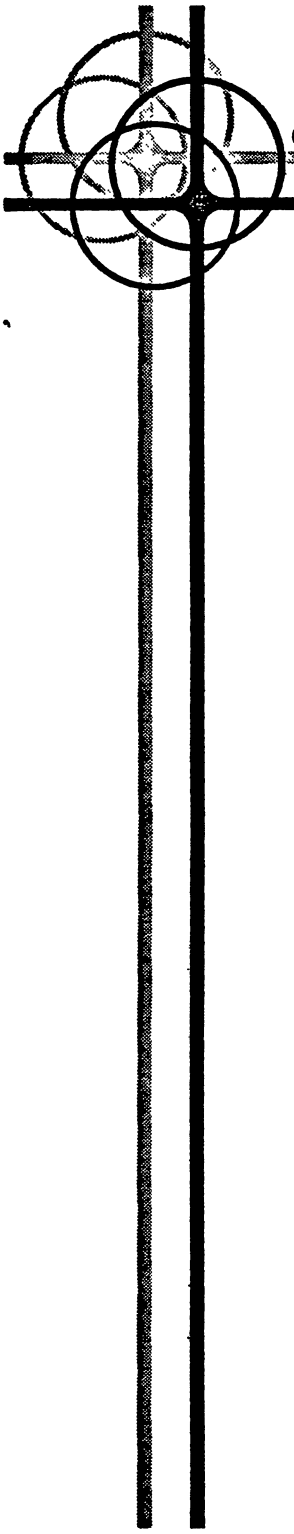
May 4, 1981

Stephen A. Jones, Director
Family Therapy Training Program

Dear Steve:

Enclosed please find a description of the design of our family therapy training research. It includes information on how the actual research will take place over the coming year. I would just like to call your attention to some high points. The measurements will be taken prior to the beginning of the year or as close to the beginning of the year as possible. Supervisors will complete a questionnaire on their approach to supervision as well as their own professional background and trainees will also fill out a detailed background questionnaire. Trainees will also at the beginning of the year evaluate in self-report form their own family therapy competence. At the point at which trainees change supervisors, at mid-year, both supervisors as well as trainees, will evaluate their performance. Trainees will evaluate by self-report and supervisors will evaluate from their observations during the supervision process each trainee. At the end of the year, again, trainees will evaluate themselves on a questionnaire as well as the supervisors for the second half of the year will also evaluate them. This will give us multisystem level responses within our research design so as to answer some of the criticisms raised by systems-oriented people to empirical research.

One additional note I would like to call your attention to. The actual time involved in the preparation of the research instruments and the design of the research, the data collection, analysis, and write-up are being donated to The Foundation. It is estimated that the cost of such research will be between $15,000 and $20,000. This is offered to The Foundation at no charge. What is expected of The



CHRISTIAN FAMILY INSTITUTE
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One additional note I would like to call your attention to. The actual time involved in the preparation of the research instruments and the design of the research, the data collection, analysis, and write-up are being donated to The Foundation. It is estimated that the cost of such research will be between $15,000 and $20,000. This is offered to The Foundation at no charge. What is expected of The

5. A policy decision needs to be made about what stationery will be used in circulating memos or letters to both trainees and supervisors within this program. Can such correspondence be written by myself on Foundation stationery as I assume we have official sanction by The Family Therapy Training Program to conduct such research? Can you advise me as to a policy decision on the stationery that is to be used for all correspondence related to this research?

6. I have also included a model letter which I would recommend that you send with whatever revisions you believe are necessary to all of the supervisors and training staff of The Family Therapy Training Program. This letter simply introduces myself and the subject of the research to the staff and gives them an opportunity to give feedback to me and to you about their feelings of participating in such research.

Steve, I trust that this will a productive year, both for The Foundation as well as for the field of family therapy. It is our hope and dream that this research will yield valuable information on the teaching and learning of family therapy skills. I believe that that research will be directly valuable to The Foundation and hopefully will be valuable to many others who are seeking to provide quality training and learning in family therapy. If you have any other questions about this design or if there are any other necessary steps which we must take in order to insure that this project is successful, please let me know. I will cooperate in any way possible.

Thank you very much.

Sincerely,

Dale R. Doty, M.S.W.
Director

DRD:ms

July 20, 1981

Mr. Dale R. Doty
Director
Christian Family Institute
6717 S. Yale, Suite 105
Tulsa, OK 74177

Dear Dale:

In addition to trying to answer some specific detailed questions, this letter also is to serve as the formal agreement between the family therapy training program and yourself regarding this next year's research project which you want to pursue. The model letter which you constructed for me to send to the supervisors and faculty was very nice and has been forwarded to them for their reading and then we'll be talking further with them as you are able to come here to or some staff meetings. In regards to a possible time for our staff meeting, we will have to clarify that later and see what time might work best for everyone, however, we should definitely plan now for your proceeding to be here on the opening days of both the first and second year programs which will be September 4 and 11, 1981. I also will talk further with to see fully about the options of your pursuing the research there also,which I think would be helpful. In regards to meeting with his groups also on the first day, I think it would work best for you to be here in first and then drive to and catch his groups probably just before they complete the training at 12:30 o'clock on those first mornings when they arrive. In regards to the stationery, we will be happy to supply Foundation stationery since it seems only appropriate to do so and I will talk further with you about that on the telephone. The other point you raised was about any publications and I will have to talk with the staff further,but in the specific area of training and supervision, I do not believe that we have written anything particularly on those areas.

I believe that answers most of the questions you raised around which we needed formal clarification. I had best also mention in regards to my schedule that I will be leaving for some teaching and vacation on Friday, July 24, and will not return to the office until Tuesday, August 18. I think you will receive this letter before I leave and possibly we should talk on the telephone before my departure to finalize any other details so that you can keep moving with things until we can talk further when I return in August. At any rate, I think we can move ahead and hope that we can assist you fully so that your project can be successful.

Sincerely,

Stephen

VITA

Dale Robert Doty, Jr.

Candidate for the Degree of

Doctor of Philosophy

Thesis: FAMILY THERAPY SUPERVISION: ASSESSMENT OF SKILL ATTAINMENT BY TRAINEE AND SUPERVISOR

Major Field: Home Economics-Family Relations and Child Development

Biographical:

Personal Data: Born in Joplin, Missouri, January 15, 1953, the son of Dale R. and Joan Doty.

Education: Graduated from Memorial High School, Joplin, Missouri, in May 1971; received Bachelor of Science degree in Social Work from Oral Roberts University in 1976; received the Master of Social Work from the University of Kansas in 1977; received a two-year post graduate certificate in Family Therapy from the Menninger Foundation in 1980, and completed requirements for the Doctor of Philosophy degree in Family Relations and Child Development at Oklahoma State University in May, 1985.

Professional Experience: Director and Marriage and Family Therapist, Christian Family Institute, 1977 to present; Clinical Professor of Psychiatry, Medical School, Oral Roberts University, 1980 to present; Adjunct Professor of Marriage and Family Counseling, Covenant Theological Seminary, St. Louis, Missouri 1980; Marriage and Family Life Counselor, Counseling Center, Oral Roberts University 1978-1979; Adjunct Professor, Behavioral Science Department, Oral Roberts University, 1977-1979; Marriage and Family Counselor,

Family and Children's Service, Tulsa, 1979; Marriage and Family Counselor Internship, Catholic Family and Community Service, Kansas City, Missouri, 1976-1977; Marriage and Family Counselor, Internship, Family and Children's Service, Tulsa, 1975-1976; and a Records and Warrants Clerk, Tulsa Police Department, 1971-1976.

Professional Organizations: National Council on Family Relations, Christian Association for Psychological Studies, National Association of Christians in Social Work, Clinical Member and Approved Supervisor for American Association for Marriage and Family Therapy, Christian Medical Society, and American Association of Sex Educators, Counselors, and Therapists.

APPENDIX E

BACKGROUND INFORMATION FORM

BACKGROUND INFORMATION

CONFIDENTIAL

PLEASE REMOVE LABEL WITH YOUR NAME TO INSURE CONFIDENTIALITY

ID.....

Your Professional Title:_____

FORMAL EDUCATION:

SCHOOL/INSTITUTION	DEGREE	YEAR GRANTED	MAJOR FIELD OR SPECIALIZATION

POSTGRADUATE CLINICAL TRAINING (Include Workshops):

SPONSORING INSTITUTION	MODE OF THERAPY TAUGHT	LENGTH OF TRAINING

SUPERVISION RECEIVED:

SUPERVISORS QUALIFICATIONS and/or ORIENTATION	PROVIDED BY: 1=Employer 2=Consultant	MODE OF THERAPY TAUGHT	NUMBER OF HOURS

PRESENT WORK SETTING:

____ Social Service Agency
____ School
____ College/University
____ Mental Health Center
____ Inpatient
____ Out-patient
____ Hospital
____ Private Practice
____ Religious Organization
____ Criminal Justice Agency
____ Other_____

PROFESSIONAL MEMBERSHIPS:

How Many Years?

_____ American Association For Marriage and Family Therapy

_____ American Association of Pastoral Counselors

_____ American Family Therapy Association

_____ American Group Psychotherapy Association

_____ American Medical Association

_____ American Orthopsychiatric Association

How Many Years?

_____ American Personnel & Guidance Association

_____ American Psychological Association

_____ National Alliance For Family Life

_____ National Association of Social Workers

_____ National Council of Family Relations

_____ Other_____

_____ Other _____

PROFESSIONAL LICENSES/CERTIFICATIONS:

___ Physician

___ R.N.

___ Psychologist

___ Social Worker

___ Marriage/Family Counselor

___ Other_____

LIST ANY BOARD CERTIFICATIONS:

1. _____

2. _____

3. _____

PROFESSIONAL EXPERIENCE:

	YEARS OF EXPERIENCE	AVERAGE NUMBER OF HOURS PER WEEK	HOURS OF SUPERVISION RECEIVED	RATE YOUR EFFECTIVENESS: 0 = Totally Ineffective 10= Extremely Effective
INDIVIDUAL COUNSELING/PSYCHOTHERAPY				
PRE-MARITAL COUNSELING				
MARITAL THERAPY/				
FAMILY THERAPY				
MARRIAGE/FAMILY ENRICHMENT				
GROUP THERAPY				
SUPERVISION OF PSYCHOTHERAPISTS				
AGENCY ADMINISTRATION				
COLLEGE/UNIVERSITY TEACHING				
CONSULTING				
RESEARCH				

FAMILIARITY WITH FAMILY THERAPY MODELS:	RATE EACH OF THE FOLLOWING: 1 Low 2 3 MEDIUM 4 5 HIGH				
FAMILY THERAPY MODELS	FAMILIARITY WITH MODEL	LEVEL OF YOUR SKILL	FREQUENCY OF YOUR USE	AMOUNT OF TRAINING RECEIVED	RANK ORDER FROM 1 to 13 ACCORDING TO YOUR PREFERENCE (1= Highest)
1. STRUCTURAL - Minuchin					
2. STRATEGIC - Haley					
3. STRATEGIC - Watzlawick					
4. STRATEGIC - Palazzoli					
5. STRATEGIC - Hoffman,Papp					
6. BOWEN					
7. COMMUNICATION-Satir,Bandler					
8. PSYCHODYNAMIC - Dicks,Stierlin					
9. INTERGENERAGIONAL - Nagy,Spark					
10. EXPERIENTIAL - Whitaker					
11. BEHAVIORAL					
12. Other_____					
13. Other_____					

How long have you been interested in family therapy? _____

How long have you practiced family therapy? _____

Is family therapy your primary approach? ___Yes ___No

Do you ever use the title "Family Therapist?" ___Yes ___No

Select the statement which best describes your position on family therapy:

___ I am skeptical about the effectiveness and usefulness of family therapy

___ Family therapy is one of the techniques or approaches I use

___ Family therapy is my primary orientation

How long have you been doing professional counseling/psychotherapy? _____

YOUR DATE OF BIRTH: ____/____/____
Month Day Year

NUMBER OF CHILDREN: _____

Ages	Sex	Living at Home?
___	___	_____
___	___	_____
___	___	_____
___	___	_____
___	___	_____
___	___	_____
___	___	_____

YOUR MARITAL STATUS:

____ Single (Never Married)
____ Single (Widowed)
____ Single (Divorced)
____ Married (First Marriage)
____ Married (Separated)
____ Remarried (Circle: 1st, 2nd, 3rd, 4th)

YOUR PARENTS CURRENT STATUS:

____ Married and living together
____ Separated
____ Divorced and both single
____ Divorced, one single, one remarried
____ Divorced, both remarried
____ Single, partner deceased
____ Remarried, partner deceased
____ Both parents deceased

	1st	2nd
If your parents were divorced, how old were you?	____	____
If your parents separated, how old were you?	____	____
If your parent(s) remarried, how old were you?	____	____
If your parent(s) are deceased, how old were you?	____	____

NUMBER OF SIBLINGS (Include self): _____

CIRCLE SELF	OLDEST	2nd	3rd	4th	5th	6th	7th	8th
AGE								
SEX	M F	M F	M F	M F	M F	M F	M F	M F

Some Therapy models emphisize the importance of the therapists family experiences.

PLEASE RANK YOUR FAMILY ON THE FOLLOWING ITEMS:

Low		Medium		High
1	2	3	4	5
Poor				Excellent

Family of Origin

1. Your family of origin's overall mental health _____
2. Your mother's overall mental health _____
3. Your fathers overall mental health _____
4. Your parents overall marital satisfaction _____
5. Your family of origin's overall stability _____
6. The overall quality of relationships between siblings while growing up _____
7. The overall quality of relationships between siblings now _____
8. The overall quality of relationship with parents while growing up _____
9. The overall quality of relationship with parents now _____
10. The overall mental health of your weakest sibling _____

Family of Orientation

11. Your own overall mental health _____
12. Your overall marital satisfaction _____
13. Your spouses overall mental health _____
14. The overall mental health of your children _____
15. The overall quality of your relationship with your children _____
16. The overall mental health of your weakest child _____

Has any event influenced you to pursue a career in family therapy?

_____ Yes _____ No

Please explain: _____

_____

_____

APPENDIX F

ADDITIONAL RESEARCH INSTRUMENTS

CONFIDENTIAL ID NUMBER:_____

SUPERVISION TECHNIQUES

FAMILY THERAPY SUPERVISION	Recognizing that it is not always possible or necessary to use all skills with all trainees, which techniques are used with two-year trainees:			Which, in your opinion, are the most beneficial to facilitate trainees learning:		
	USED WITH ALL	USED WITH MOST	RARELY USED	MOST USEFUL	USEFUL	NOT VERY USEFUL
Establishing a Supervision Contract	1	2	3	1	2	3
Identifying Specific Skill Weaknesses	1	2	3	1	2	3
Setting Learning Objectives	1	2	3	1	2	3
Giving Homework in Supervision	1	2	3	1	2	3
Directly Observing Via Audio Tape	1	2	3	1	2	3
Directly Observing Via Video Tape	1	2	3	1	2	3
Directly Observing Via One-way Mirror	1	2	3	1	2	3
Advise-Giving in Supervision	1	2	3	1	2	3
Giving Trainee Directives	1	2	3	1	2	3
Understanding the interface between ones family experience and therapy	1	2	3	1	2	3
Focusing on the Supervisor-Trainee Transference (parallel process)	1	2	3	1	2	3

PLEASE RATE EACH OF THE FOLLOWING SKILLS ACCORDING TO YOUR VIEW OF ITS IMPORTANCE AS A FOCUS OF TRAINING FOR TWO YEAR FAMILY THERAPY TRAINEES:

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Understand the basic axioms of systems theory as applied to a family unit.	___	___	___	___
Is able to communicate a rationale for treating the whole family.	___	___	___	___
Acknowledges each family member, thus engagementing the whole family system.	___	___	___	___
Responds with sensitivity and warmth toward all family members.	___	___	___	___
Respect appropriate interpersonal boundaries by exploring particular issues within appropriate subsystems.	___	___	___	___
Formulates an explicit agreement regarding expectations and goals of treatment.	___	___	___	___
Works toward including the whole executive subsystem in the therapy process.	___	___	___	___
Intensifies engagement with the family members least committed to therapy.	___	___	___	___
In order to resume therapy (when appropriate) or to clarify unexpected failure to return, initiates contact directly by phone, mail, or visit.	___	___	___	___
Provides support before and after confrontation.	___	___	___	___
Obtains a precise description of problematic behaviors and the sequence of events relevant to the problem.	___	___	___	___
Stimulates all family members to share their knowledge and experience of the presenting problem.	___	___	___	___
Summarizes the essence of the presenting problem for validation by the family.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Explores the function that the presenting problem may be serving in the system.	___	___	___	___
Recognizes discrepancies between verbal content and other channels of communication.	___	___	___	___
Recognizes the moment-to-moment impact the therapist has on the family.	___	___	___	___
Refocuses the discussion when family members confuse the issues.	___	___	___	___
Resists pressures to be taken in by problematic rules and beliefs that would constrict the therapeutic process.	___	___	___	___
Stimulates interaction between family members so as to observe and assess family functioning.	___	___	___	___
Assesses the nature and intensity of family boundaries, alignments, coalitions, and maladaptive family rules.	___	___	___	___
Explores multiple factors at the physical, psychological, and interpersonal levels which may be involved in the problem.	___	___	___	___
Involves the family in selecting a target problem or problems, in setting goals, and in elaborating a plan of management.	___	___	___	___
Estimates realistically the family's capacity for change.	___	___	___	___
Intervenes to control maladaptive patterns by restructuring family interaction verbally or physically.	___	___	___	___
Evaluates the potential of paradoxical instruction in overcoming resistance.	___	___	___	___
When appropriate, prescribes an individual's own problematic behavior in order to gain paradoxical control of maladaptive interaction.	___	___	___	___
Mobilizes family members to provide validation and support to one another.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Uses metaphor, similie, overstatement, paradoxical statement, etc., to clarify, distill, and emphasize concepts with adaptive potential.	___	___	___	___
When possible, reframes preexisting negative concepts that are problematic in more positive and constructive terms.	___	___	___	___
Encourages family members to expose themselves to relevant types of new experiences outside therapy or direct them to try new behaviors in the session.	___	___	___	___
Introduces adaptive changes in behavior during the interview by redirecting interaction patterns and altering spatial and seating arrangements to rearrange subsystems.	___	___	___	___
Helps family members negotiate and implement simultaneous changes and when appropriate, direct them to initiate the new behaviors in the session.	___	___	___	___
Intensifies or diminishes the degree of emotion experienced by specific individuals through confrontation and support, respectively to achieve optimal anxiety levels.	___	___	___	___
Relinquishes control of the interaction and avoids interrupting when adaptive patterns of family interaction emerge.	___	___	___	___
Assigns realistic and concrete behavioral tasks as homework. Seeks explicit commitments to carry them out within a specific time period.	___	___	___	___
Initiates and maintains contact with other professionals who are involved in the case.	___	___	___	___
Explores family members' rationale for termination to differentiate reasonable from inappropriate motives.	___	___	___	___
Initiates a review of family problems and offer to renegotiate the therapy contract when indicated.	___	___	___	___
Achieves formal closure as part of the fulfillment of the therapeutic contract.	___	___	___	___

	NOT IMPORTANT	SOMEWHAT UNIMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Reviews unresolved family problems by suggesting direction for future change and strives to conclude treatment on a positive note.	____	____	____	____

PLEASE RATE THE USEFULNESS OF THIS RATING SCALE IN THE SUPERVISION PROCESS:

1	2	3	4
USELESS	NOT VERY HELPFUL	HELPFUL	VERY HELPFUL

PLEASE LIST ANY SKILLS YOU BELIEVE SHOULD HAVE BEEN INCLUDED IN THIS EVALUATION:

_____

_____

_____

PLEASE MAKE COMMENTS ON YOUR EXPERIENCE IN PARTICIPATING IN THIS RESEARCH PROJECT:

_____

_____

_____

_____

_____

FINAL EVALUATION OF THE PROGRAM

FAMILY THERAPY MODELS	As a result of your training, how fimiliar are you with each of the following models: LOW MEDIUM HIGH					Rank Order Five Preferred Models 1= Most Preferred
1. STRUCTURAL - Minuchin	1	2	3	4	5	
2. STRATEGIC - Haley	1	2	3	4	5	
3. STRATEGIC - Watzlawick	1	2	3	4	5	
4. STRATEGIC - Palazzoli	1	2	3	4	5	
5. STRATEGIC - Hoffman, Papp	1	2	3	4	5	
6. BOWEN	1	2	3	4	5	
7. COMMUNICATION - Satir,Bandler	1	2	3	4	5	
8. PSYCHODYNAMIC - Dicks,Stierlin	1	2	3	4	5	
9. INTERGENERATIONAL -Nagy,Spark	1	2	3	4	5	
10. EXPERIENTIAL - Whitaker	1	2	3	4	5	
11. BEHAVIORAL	1	2	3	4	5	
12. OTHER_____	1	2	3	4	5	
13. OTHER_____	1	2	3	4	5	

Is family therapy your primary approach? ____Yes ____No

Do you ever use the title "Family Therapist?" ____Yes ____No

Select the statement which best describes your position on family therapy:

____ I am skeptical about the effectiveness and usefulness of family therapy

____ Family therapy is one of the techniques or approaches I use

____ Family therapy is my primary orientation

Have you experienced a change in work setting or position since beginning training?

____ Yes ____ No If yes, please explain_____

_____

PLEASE RATE EACH SUPERVISOR ON THE USE OF THESE SUPERVISION TECHNIQUES	SUPERVISOR FOR SEPTEMBER THRU JANUARY:_____ Very Helpful	Helpful	Not Very Helpful	Did Not Use	SUPERVISOR FOR JANUARY THRU JUNE:_____ Very Helpful	Helpful	Not Very Helpful	Did Not Use
Establishing a Supervision Contract	1	2	3	9	1	2	3	9
Identifying Specific Skill Weaknesses	1	2	3	9	1	2	3	9
Setting Learning Objectives	1	2	3	9	1	2	3	9
Giving Homework in Supervision	1	2	3	9	1	2	3	9
Directly Observing Via Audio Tape	1	2	3	9	1	2	3	9
Directly Observing Via Video Tape	1	2	3	9	1	2	3	9
Directly Observing Via One-way Mirror	1	2	3	9	1	2	3	9
Advise-Giving in Supervision	1	2	3	9	1	2	3	9
Giving Trainee Directives	1	2	3	9	1	2	3	9
Understanding the interface between ones family experience and therapy	1	2	3	9	1	2	3	9
Focusing on the Supervisor-Trainee Transference (parallel process)	1	2	3	9	1	2	3	9
If you had the opportunity, would you seek further supervision from this supervisor?	(Circle One) YES		NO		(Circle One) YES		NO	
Please rate your overall supervision experience with each supervisor.	1 2 3 4 5 6 7 8 9 10 Not at all Helpful Helpful Extremely Helpful				1 2 3 4 5 6 7 8 9 10 Not at all Helpful Helpful Extremely Helpful			
Please make comments which will help us understand the above evaluation:	Comments:				Comments:			

APPENDIX G

CORRESPONDENCE WITH TRAINING PROGRAM

CHRISTIAN FAMILY INSTITUTE
6717 S. Yale, Suite 105/Tulsa, Oklahoma 74177/(918) 496-3090

May 4, 1981

Stephen A. Jones, Director
Family Therapy Training Program

Dear Steve:

Enclosed please find a description of the design of our family therapy training research. It includes information on how the actual research will take place over the coming year. I would just like to call your attention to some high points. The measurements will be taken prior to the beginning of the year or as close to the beginning of the year as possible. Supervisors will complete a questionnaire on their approach to supervision as well as their own professional background and trainees will also fill out a detailed background questionnaire. Trainees will also at the beginning of the year evaluate in self-report form their own family therapy competence. At the point at which trainees change supervisors, at mid-year, both supervisors as well as trainees, will evaluate their performance. Trainees will evaluate by self-report and supervisors will evaluate from their observations during the supervision process each trainee. At the end of the year, again, trainees will evaluate themselves on a questionnaire as well as the supervisors for the second half of the year will also evaluate them. This will give us multisystem level responses within our research design so as to answer some of the criticisms raised by systems-oriented people to empirical research.

One additional note I would like to call your attention to. The actual time involved in the preparation of the research instruments and the design of the research, the data collection, analysis, and write-up are being donated to The Foundation. It is estimated that the cost of such research will be between $15,000 and $20,000. This is offered to The Foundation at no charge. What is expected of The

Foundation is somewhat less than 7 hours on the part of each supervisor over the one year period of time. This time will allow the supervisors to complete the evaluations on each of their trainees as well as the necessary background information prior to the beginning of the program. I will also wish to get together with each supervisor for a one-hour interview sometime during the year. It is estimated that the actual length of time it will take will be 5 hours or less. In order to be realistic, we will estimate 7 hours time. I realize that this by itself, is costly to the Foundation. However, since these 5 to 7 hours will be spread out over a one year period of time, it is not likely that that cost will be observed directly. In light of the research time being devoted by the researchers, myself as well as the backup at Oklahoma State University, it is still cost advantangeous for The Foundation to continue to participate in this project.

Since you can see that a great deal of time, energy, and money are being invested in this research, I would like to ask a few things of you:

1. I would like a letter back from you stating that you understand the research design and that you are willing to ask the supervisors within the program to participate in filling out the evaluation forms.

2. I would like to have an opportunity to come to a staff meeting of the Family Therapy Training supervisors prior to the training year, if possible, to explain the research that we will be doing and to establish rapport with the supervisors. I would also be happy to answer any questions that may be raised. This is to promote cooperation between the staff and myself.

3. I would also like to have approximately 3 to 5 minutes on the first day of each of the three years of training during the didactic seminar. During this 3 to 5 minute period of time I would also like to briefly describe the research that we are conducting to each of the three years involved in the training project. This again is for the purpose of establishing rapport and promoting cooperation during this research year.

4. I would like to have any publications in however rough form they may be, that may have been produced by The Family Therapy Training Program, giving guidelines to supervisors involved in the program or stating the goals of the treatment or training program. This inhouse correspondence will be useful to me in understanding the specific goals that supervisors within the program are aware of. This is only in the case that such documents actually exist.

5. A policy decision needs to be made about what stationery will be used in circulating memos or letters to both trainees and supervisors within this program. Can such correspondence be written by myself on Foundation stationery as I assume we have official sanction by The Family Therapy Training Program to conduct such research? Can you advise me as to a policy decision on the stationery that is to be used for all correspondence related to this research?

6. I have also included a model letter which I would recommend that you send with whatever revisions you believe are necessary to all of the supervisors and training staff of The Family Therapy Training Program. This letter simply introduces myself and the subject of the research to the staff and gives them an opportunity to give feedback to me and to you about their feelings of participating in such research.

Steve, I trust that this will a productive year, both for The Foundation as well as for the field of family therapy. It is our hope and dream that this research will yield valuable information on the teaching and learning of family therapy skills. I believe that that research will be directly valuable to The Foundation and hopefully will be valuable to many others who are seeking to provide quality training and learning in family therapy. If you have any other questions about this design or if there are any other necessary steps which we must take in order to insure that this project is successful, please let me know. I will cooperate in any way possible.

Thank you very much.

Sincerely,

Dale R. Doty, M.S.W.
Director

DRD:ms

July 20, 1981

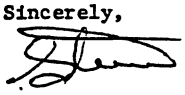
Mr. Dale R. Doty
Director
Christian Family Institute
6717 S. Yale, Suite 105
Tulsa, OK 74177

Dear Dale:

In addition to trying to answer some specific detailed questions, this letter also is to serve as the formal agreement between the family therapy training program and yourself regarding this next year's research project which you want to pursue. The model letter which you constructed for me to send to the supervisors and faculty was very nice and has been forwarded to them for their reading and then we'll be talking further with them as you are able to come here to or some staff meetings. In regards to a possible time for our staff meeting, we will have to clarify that later and see what time might work best for everyone, however, we should definitely plan now for your proceeding to be here on the opening days of both the first and second year programs which will be September 4 and 11, 1981. I also will talk further with to see fully about the options of your pursuing the research there also,which I think would be helpful. In regards to meeting with his groups also on the first day, I think it would work best for you to be here in first and then drive to and catch his groups probably just before they complete the training at 12:30 o'clock on those first mornings when they arrive. In regards to the stationery, we will be happy to supply Foundation stationery since it seems only appropriate to do so and I will talk further with you about that on the telephone. The other point you raised was about any publications and I will have to talk with the staff further,but in the specific area of training and supervision, I do not believe that we have written anything particularly on those areas.

I believe that answers most of the questions you raised around which we needed formal clarification. I had best also mention in regards to my schedule that I will be leaving for some teaching and vacation on Friday, July 24, and will not return to the office until Tuesday, August 18. I think you will receive this letter before I leave and possibly we should talk on the telephone before my departure to finalize any other details so that you can keep moving with things until we can talk further when I return in August. At any rate, I think we can move ahead and hope that we can assist you fully so that your project can be successful.

Sincerely,



Stephen

VITA 2

Dale Robert Doty, Jr.

Candidate for the Degree of

Doctor of Philosophy

Thesis: FAMILY THERAPY SUPERVISION: ASSESSMENT OF SKILL ATTAINMENT BY TRAINEE AND SUPERVISOR

Major Field: Home Economics-Family Relations and Child Development

Biographical:

Personal Data: Born in Joplin, Missouri, January 15, 1953, the son of Dale R. and Joan Doty.

Education: Graduated from Memorial High School, Joplin, Missouri, in May 1971; received Bachelor of Science degree in Social Work from Oral Roberts University in 1976; received the Master of Social Work from the University of Kansas in 1977; received a two-year post graduate certificate in Family Therapy from the Menninger Foundation in 1980, and completed requirements for the Doctor of Philosophy degree in Family Relations and Child Development at Oklahoma State University in May, 1985.

Professional Experience: Director and Marriage and Family Therapist, Christian Family Institute, 1977 to present; Clinical Professor of Psychiatry, Medical School, Oral Roberts University, 1980 to present; Adjunct Professor of Marriage and Family Counseling, Covenant Theological Seminary, St. Louis, Missouri 1980; Marriage and Family Life Counselor, Counseling Center, Oral Roberts University 1978-1979; Adjunct Professor, Behavioral Science Department, Oral Roberts University, 1977-1979; Marriage and Family Counselor,

Family and Children's Service, Tulsa, 1979; Marriage and Family Counselor Internship, Catholic Family and Community Service, Kansas City, Missouri, 1976-1977; Marriage and Family Counselor, Internship, Family and Children's Service, Tulsa, 1975-1976; and a Records and Warrants Clerk, Tulsa Police Department, 1971-1976.

Professional Organizations: National Council on Family Relations, Christian Association for Psychological Studies, National Association of Christians in Social Work, Clinical Member and Approved Supervisor for American Association for Marriage and Family Therapy, Christian Medical Society, and American Association of Sex Educators, Counselors, and Therapists.