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Factors Associated with Family Counseling Practices: The Effects of Training, Experience, and Multicultural Counseling Competence

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**FACTORS ASSOCIATED WITH FAMILY COUNSELING PRACTICES: THE
EFFECTS OF TRAINING, EXPERIENCE, AND MULTICULTURAL
COUNSELING COMPETENCE**

by

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Abstract**FACTORS ASSOCIATED WITH FAMILY COUNSELING PRACTICES: THE EFFECTS OF TRAINING, EXPERIENCE, AND COUNSELING COMPETENCE**

Amanda A. Brookshear
Old Dominion University, 2015
Chair: Dr. Jeffry Moe

The ACA code of ethics encourages the inclusion of family in the therapeutic process when doing so can be considered positive (ACA, 2014). Additionally, family dynamics are an important component of counseling for clients from diverse cultural backgrounds. A critical review of the literature reveals that there are differences between conceptual and physical inclusions of families in counseling. Counselors can use a family systems theoretical lens and/or incorporate family-based interventions. The purpose of this study was to investigate how counselors include families in counseling and what factors are associated with family counseling practice. Variables assessed include training and coursework, experience, and multicultural competence. A MANOVA showed that there is a significant difference between family counseling practice groups (High, Low, Inconsistent) and the multivariate dependent variables. Post Hoc analysis further described these differences as being focused on training in family counseling and also in reported multicultural counseling competence (as measured by the MCKAS). Limitations, implications for training and practices, and future directions for research are discussed.

Keywords: Family-Based Counseling, Family Systems Counseling, Multicultural Counseling

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Chapter One: Introduction

The inclusion of families in counseling has a rich history dating back to Freud (Freud, 1909). Despite its rich history, there is little research on how exactly family is currently being integrated in counseling practices today. The term *family counseling* is often synonymous with the use of family systems concepts; these concepts are a theoretical framework in which the counselor views the family as the cause of dysfunctions and/or the focus of interventions (Bitter, 2013). However, there is an area of literature that describes and discusses interventions that involve family members in counseling; these interventions are called family-based interventions (Berg, 1994). The use of family systems concepts is conceptual whereas the use of family-based interventions is concrete. The literature that addresses family counseling is vague, especially as it relates to the conceptual framework or concrete interventions used in counselors' work with families.

Evidence shows that the inclusion of family in counseling can be beneficial to therapeutic outcomes (Loeber & Stouthamer-Loeber, 1986; Northey, 2002; Stanton & Shadish, 1997). Both family-based interventions and family systems concepts have a body of literature that provide insight as well as support their use with specific populations and presenting problems. It is not until the family counseling literature gets critically reviewed that these two distinct practices emerge from what is often viewed as the singular practice of family counseling.

This study is seeking to understand the family counseling practices of licensed counselors and the factors associated with specific family counseling practices. The goal of this chapter is to provide a brief overview of the proposed study while expanding on the background of the research topic and terminology.

Background

In order to explicate an individual's pathology or to help remedy the individual's struggle, the founders of the counseling field integrated an individual's family in the counseling process (Walsh & McGraw, 2002). Those early founding practices contained aspects of family-systems counseling and family-based interventions, whether it be Freud's Oedipal or Electra complex or Berg's Solution Focused book entitled *Family-Based Services*. As the mental health field has evolved, a dichotomy has developed; some counselors and therapists have become focused on the individual, while others, often called marriage and family therapists (MFT), have become focused on family units. This dichotomy is evident in professional identity but not necessarily in practice. Approximately half of the treatment provided by marriage and family therapists is individual in nature with mood disorders and behavioral problems being two of the top presenting problems seen (Doherty & Simmons, 1990).

Family counseling or therapy is often focused on systemic theories; these theories have evolved over the last 80 years since Adler's and Ackerman's introduction of families in counseling and the initial family systems theories were developed by Adler, Satir, and Bowen (Bitter, 2013). Systemic theories tend to view problems from a perspective of circular causation of individual dysfunctions. The term circular causation postulates that problems are not linear, or as simple as cause and effect, but more complex and circular.

This is distinctly different from the majority of counselors who are trained in psychodynamic, person centered, and cognitive-behavioral theories developed by Freud, Rogers, and Beck (to name a few). These theories have a range of paradigms from Freud's focus on subconscious motivations to Beck's linear causality and most recently to symptom alleviation such as de Shazer and Berg's Solution focused theory (Bitter, 2013). The manner in which family systems and individual counseling approaches view pathology and best practices are very different from one another; with family system counseling looking toward systemic influences and individuals counseling concepts looking at inward behaviors, feelings, and thoughts

There are two premiere professional associations and training standards in the field of counseling and therapy; together they can illustrate the dichotomy between the two schools of thought and professional identities. The American Counseling Association (ACA) is the professional association for counselors; this association has a distinct set of ethical codes and numerous specialty divisions (ACA, 2014; Neukrug, 2016). The ACA works closely with the Council of Accreditation of Counseling and Related Educational Programs (CACREP) to establish counseling program standards (Bobby, 2013). Within the ACA, there is the International Associations of Marriage and Family Counselors (IAMFC) division, which has its own ethical codes. Within CACREP, there is a specialty or concentration in Marriage, Couple, and Family Counseling (CACREP, 2009).

The American Association of Marriage and Family Therapy (AAMFT) is a distinctly separate professional association, whose members often prefer to be called therapists. The AAMFT has its own set of ethical codes and has established the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) that trains family therapists (AAMFT, 2014). All of COAMFTE's programs and the CACREP accredited marriage, couple, and family specialty programs train counselors or therapists to use family systems concepts.

It is clear that marriage and family therapists are trained in family-systems concepts and counselors are most often trained in individual counseling concepts, the exception being MFTs trained in CACREP accredited programs. These two fields are unique in training, theory, and sometimes associations. It is unclear how exactly these fields intertwine in practice. As previously stated, MFTs spend approximately half of their time working with individuals (Doherty & Simmons, 1990). We also know that psychologists (another mental health profession) spend between 19 and 38% of their time working with families (Norcross, Hedges, & Castle, 2002). It is unknown how much time counselors spend working with families and it is likewise unknown what exactly counselors are doing when working with families (family-based interventions and/or family systems concepts).

Limitations of Past Research

While research has validated the efficacy of family counseling, the literature that validates family counseling often lacks specificity regarding the practices being used (Sprenkle, 2002). When analyzing the use of family in counseling, there are two evidence-based family counseling practices that arise from the literature.

The first is family counseling that involves an individual's family in the treatment without adhering to a family systems' conceptualization per se (Kendell, 1994; Kendell & Sugarman, 1997). This mode of family involvement will be referred to as family-based counseling. Family-based interventions have proven to be cost-effective and provide strong therapeutic outcomes (Baldwin & Huggins, 1997; Shadish, Ragsdale, Glaser, & Montgomery, 1995).

Second, treatment provided by MFTs, most often trained in family-systems concepts, have shown to be efficacious in treating various populations or presenting problems including childhood disorders, addictions, and schizophrenics (Mari & Streiner, 1994; Montgomery, 1991; Shadish, 1993). Family-systems based interventions may, but do not always, include interaction between other members of the identified client's family unit and the counselor or therapist.

To reiterate, family-based counseling involves the intentional literal involvement of family members in the counseling process regardless of the counselor or therapist's theoretical orientation. Family-systems counseling involves counseling from an explicit family-systems theoretical framework with or without the literal involvement of the identified client's family members. In summary a counseling relationship can be both family-based and family-systems, one or the other, or neither. It is clear that both of the two family counseling practices are supported in the literature, but it is unclear how much counselors are using either of these practices.

A review of the literature reveals numerous studies that identify the importance of the family in counseling diverse populations. Unfortunately, research done in this area is limited to obscure populations and presenting problems, which lead to small sample sizes and limited

generalizability (Dupree, Bhakta, Patel & Dupree, 2013; Krieger, 2010). Although the research is limited, there are numerous studies that underscore the multicultural counseling implications of family inclusion in counseling. One study even found that counselors view different families as more or less symptomatic based on ethnicity alone (Gushue, Constatine, & Sciarra, 2008). Given this literature and the understood value of multicultural counseling, a possible link to family counseling practices seems appropriate to explore (Ponterro, Cases, Suzuki, & Alexander, 2001).

Rationale

The ACA code of ethics states that counselors are expected to “recognize that support networks hold various meanings in the lives of clients and consider enlisting the support, understanding and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent (ACA, 2014, A.1.d.).” This section of the ethical code makes a point of encouraging the inclusion of family (or other systems) when it can be considered positive. The positive aspects of including family in counseling is important, especially when considering the importance of family to various populations from collectivist cultures. The code of ethics also states that the counselor must identify who is considered the client, whether it is an individual within the couple, or family, or the couple or family itself (a systemic concept) (ACA, 2014, B.4.b). Both these codes make it clear that family is and can be an important component of ethical counseling. It is for this reason that it is critical to understand how counselors are including families in their counseling practices.

Since the early 1980’s when the multicultural counseling competencies were first introduced, they have become a prominent component of counselor education and competence (Ponterro, Cases, Suzuki, & Alexander, 2001). Given the cultural importance of families for many of the collectivist cultures around the world, which is a stark contrast to America’s individualistic culture, multicultural counseling and family counseling becomes a natural coupling (Daneshpour, 1998). This is further emphasized because of the increasing diversification

of the world; the likelihood of counselors working with individuals from a collectivist culture has and will continue to increase (Pew research Center, 2008; U.S. Census Bureau, 2010).

As previously discussed, there is evidence to support the use of both family-systems concepts and family-based interventions. Family inclusion is ethically encouraged when beneficial, especially when considering different cultural groups. The inclusion of family in counseling can be valuable, but the counseling field's current family counseling practices are not fully understood. It is for this reason that this study is being proposed; it is imperative that the counseling field has a better understanding of how family is being integrated in counseling practices and what factors, including a counselor's multicultural counseling competence, may determine a counselor's family counseling practices.

Purpose Statement

There is limited current research in the area of family counseling, especially as it relates to counseling practices. The purpose of this quantitative analysis is twofold; first to understand the current practices of counselors as they relate to family inclusion in counseling, and second to inquire as to what factors are associated with specific family counseling practices.

Research Questions

The following research questions will be addressed in this study:

1. To what extent are counselors including family in their counseling practices?
2. How are counselors including families in their counseling practice?
3. What factors (education, skill, and attitude) influence a counselor's family counseling practice?

Study Specific Definition of the Terms

Counseling, as defined by the ACA's 20/20 vision, "is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Galddings, 2014, p. 368). Those who practice counseling and

who are engaged in this empowering relationship are called counselors. For the purposes of this study participants must be fully licensed as counselors by their state.

Family Counseling is keeping in accordance with the use of ACA's 20/20 vision. This study will view any empowering relationship that includes family as a part of counseling as family counseling. This inclusion can occur either physically (i.e. the presence of family in counseling sessions), or conceptually (i.e. the use of family systems concepts). Literature in family counseling often identifies two forms of family counseling, family-based counseling and family-systems counseling.

Family-Based counseling is when a counselor literally includes family member(s) in the counseling process.

Family Systems counseling is a form of family counseling in which a counselor uses a theoretical framework that views the family unit as the focus of treatment and relational problems as the root of individuals' dysfunction.

Multicultural Counseling is a form of counseling that seeks to establish a counseling relationship that is sensitive to the diversity that exists within each individual's lived experience. This diversity can be across culture, ethnicity, religion, or sexual orientation.

Conclusion

The following two chapters will discuss and introduce the history and literature regarding family counseling while helping to expand on the two variations of family counseling practices. The current measures within the family counseling field will be discussed along with the multicultural implications of family counseling. The methodology will then introduce the manner in which the study was conducted, including information about my participants, instrumentation, and data analysis.

Chapter Two: Literature Review

In order to clarify the current dichotomy of family counseling practice, this chapter will define family-based counseling and family systems counseling. The history and current literature pertaining to family counseling practices will be introduced. Multicultural counseling competence (MCC) will be discussed, along with examination of the relationship between MCC and family counseling. The chapter will conclude with a review of the current training standards and assessments in family counseling and MCC.

Family Systems Therapy Defined

Family systems therapy is comprised of numerous theories and theorists. In order to define such a vast field, there are four main family systems concepts identified in several texts the systemic counselor is likely to focus on 1) family process and patterns, 2) the various systems within an individual's life 3) identifying relational problems, and 4) changing relational interactions (Bitter, 2014; Nichols & Schwartz, 2005; Walsh & McGraw, 2002). Each of these four concepts are in stark contrast to what is typically taught and practiced by counselors trained with a more individual or intrapsychic focus.

The first concept identified is the family systems counselor's desire to understand the family process and related patterns of interaction, as opposed to solely focusing on diagnosing pathology. Second is the systemic counselor's desire to embrace and understand the client's family and other influential systems, rather than seeing the client as an autonomous individual. The third concept is the systemic counselor's desire to understand the relational roots of problems rather than the individual's perceived struggles. Fourth is the systemic counselor's desire to focus treatment on relational interactions as opposed to focusing on alleviating the client's individual symptoms. All four characteristics focus on the pivotal role family plays in an individual's life, which is the underlying key concept of family system therapy.

The History of Family Systems Counseling

The history of family systems counseling and its concurrent theoretical development can be divided into three generations. Each of these generations are built off of one another and provided a unique and new perspective to family systems therapy. The term generation is used to denote the underlying kinship of each of these theoretical phases with an emphasis that theorists from newer generations often developed concepts from the work of theorists in the previous generation, while also being distinct. The first generation is represented by Adler, Bowen, and Satir beginning in early 1900's through the mid to late 1950's. The second generation is represented by Haley, Minuchin, and the Milan group picking up in the 1960's through the 1970's, and the third generation during the 1980's lasting into the present.

The first generation of family systems counseling can be traced back to Sigmund Freud and his theory of psychoanalysis (Walsh & McGraw, 2002). After splitting from Freud and developing his own theory, Alfred Adler opened a clinic in Vienna that was among the first known to treat couples. In 1937, Rudolph Dreikurs, a student of Adler's, came to the United States and began to promote and provide Adlerian Family therapy. On the other hand, Object Relations theory also used Freud's theory in its attempt to conceptualize child-parent attachment as a determinate to an individual's relationships later in life (Walsh & McGraw, 2002).

Nathan Ackerman is another initial contributor that is especially important to America's family systems foundations. He was a practicing psychoanalyst when he combined family systems and psychoanalysis (Bitter, 2014). He was one of the first persons to publish an article about family therapy and later started the first family therapy journal, titled *Family Process*.

Murray Bowen, another first generation theorist, developed his framework of Family Systems theory based on the general system theories seen in nature and originally hypothesized by von Bertalanffy (Bowen, 1978). General Systems theory postulated that various systems in nature are run by a self-regulating homeostasis, and that various parts of a system maintain

homeostasis through different forms of feedback (von Bertalanffy, 1968). Bowen developed his theory, which focused on the complex functions of a family system over multiple generations. (Bowen, 1978).

The final first generation theorist was Virginia Satir, a social worker, who developed a theory rooted in similar systemic foundations, which sought to help people heal through self-directed restoration (Satir, Banmen, Gerber & Gomori, 1991). Satir's warm and welcoming demeanor with her clients was distinct (Satir, et. al, 1991). She was a proponent of the depathologizing people while possessing a more hopeful humanistic perspective (Satir, et. al, 1991).

The second generation of family systems theories began with Gregory Bateson. Bateson was not a family systems practitioner, but conceptualized a family communication system theory, which became a springboard for several family systems theories (Bitter, 2014). Bateson's theory explained interpersonal communication using cybernetics (Rambo & Hibel, 2013). Bateson's original theoretical concept asserted that the family is a complex system that does not communicate or interact in a linear fashion, but rather in a circular or reciprocal fashion (Bateson, 1979; Bowen, 1978). This transition, from linear to circular communication, is an underpinning to family systems therapy that made it distinctively separate from counseling. The relational or interactional focus is part of all family system theories. This generation's theories further explained concepts from the first generation by enriching the initial key concepts and bringing depth to family systems (Bowen, 1978; Palazzoli, 1981).

The Milan Model of Family Therapy, Jay Haley's Strategic family therapy, and Salvador Minuchin's Structural Therapy are each considered second-generation theories, in which Bateson was seminal. Each theory focuses on the intricate nature of family and human interactions. Minuchin developed Structural Family Therapy that was founded on the present and future (as opposed to the past, like Bowen's theory). Structural family therapy is used to help clinicians and clients understand the invisible web of family structures that exists within each family (Minuchin

& Nichols, 1993). Haley's theory postulates that families often have a set of established rules that are part of the complex system of functioning that the family inherently ascribes to. These rules can cause dysfunction or maintain presenting problems (Haley, 1961). Jay Haley, who worked with Bateson in Palo Alto, also worked closely with Minuchin in Philadelphia. Milan family therapy is a unique combination of Ackerman's psychoanalysis and numerous other family systems theories in which the family is composed of a complex web system of interactions and patterns in which each behavior serves a purpose (Palazzoli, Boscolo, Cecchin, & Prata, 1978).

The final or third phase of family systems theories are used effectively with both families and individuals (Walsh & McGraw, 2002). Narrative therapy and Solution-focused therapy are both antideterministic and focus on the here-and-now (White & Epston, 1990; de Shazer, 1985). The underlying principle of these theories is applicable to any counselor who desires to understand his or her client's subjective reality and individual experiences and allows that to inform the client's treatment without a need to be the established expert (White & Epston, 1990; de Shazer, 1985). These theories built on a postmodern philosophy that seeks to critically examine assumptions that are held as truths within society and that reality is objective.

Efficacy of Family Systems Counseling

When reviewing the efficacy of family system interventions, the majority of literature is conducted by clinicians whom identify as marriage and family therapists (MFTs) (Sprenkle, 2002). These clinicians have a higher likelihood to have been trained solely or partially in family systems therapy (Neukrug, 2016). It seems that the research conducted in this field of study is typically done with the purpose of informing and validating the work done by MFTs (Sprenkle, 2002).

Marriage and family therapy has a comparable effect size as individual therapy approaches regardless of the therapeutic model being used (Shadish, Ragsdale, Glaser, & Montgomery, 1995). A number of meta-analyses have expanded on the efficacy of family

systems counseling. Shadish (1993) completed an expansive meta-analysis of $n = 163$ trials that validated therapeutic interventions using the family. His findings indicated that family therapy (behavioral, systemic, eclectic, and general) was found to be effective. In 1997, Stanton and Shadish conducted another meta-analysis of $n = 1,571$ cases involving 3,500 patients and family members. This meta-analysis indicated statistical support for family therapy over individual counseling, peer group counseling, and family psychoeducation, with family therapy resulting in higher treatment retention rates and a better prognosis.

Family systems treatment has been researched with various presenting problems. In two meta-analyses, family therapy was found to be efficacious for treating schizophrenic adults (Mari & Streiner 1994; Pitschel-Walz et al. 2001). Montgomery (1991) also found that child-identified psychopathologies were effectively addressed with family-systems counseling interventions. Law and Crane (2000) also found that counselors utilizing marital and family therapy reduced their use of healthcare services by 21.5%, which validates the offset effect of marriage and family interventions.

Family systems counseling approaches have also proven to be effective for treating various addictions. Edwards and Steinglass' (1995) meta-analysis supported family behavioral therapy for the treatment of alcoholism, while O'Farrell and Fals-Stewart (2002) found family systems therapy to be an empirically supported treatment for families with a member who was diagnosed with an alcohol use disorder.

The research conducted in this area tends to be isolated to surveying and studying marriage and family therapists who are often trained in MFT programs. It provides a picture of the importance and effectiveness of providing family counseling to various populations while not specifically addressing the training. The purpose of these studies are often to validate the practices being done by MFTs rather than understanding the role specific interventions may or may not play in the efficacy of their interventions. This literature lacks specific descriptions of the interventions being used, which leaves much unknown regarding specific interventions and their

efficacy. This lack of explanation could mean that the literature may very well be discussing individual or family-based interventions.

Family-Based Counseling Defined

The practice of family-based counseling is simply defined by physically including family in the counseling process (Sprenkle, 2002). This type of counseling may involve parents in the treatment of their child or spouses or partners in the treatment of their spouse or partner. The key component of family-based counseling is physical involvement of the family (Berg, 1994). It is not possible to have only one person in the counseling room at all times and consider the counseling to be family-based counseling, because it is the involvement of at least one additional family member that defines family-based counseling (Berg, 1994).

History of Family-Based Counseling

Adler was one of the first individual counselors to include family members in the counseling process (Bitter, 2013; Walsh & McGraw, 2002). Later Bowen hypothesized the role mothers played in their children's schizophrenia while Minuchin credited the family structure for an individual's dysfunctions (Bowen, 1978; Minuchin, 1974). Each of these original theorists sought to include the family in counseling with the intention of increasing the family's and individual's wellness. The goal of family-based interventions is to increase successful therapeutic outcomes in counseling. Family-based interventions have consistently been seen in the social work field because of the pragmatic implications of involving family in interventions (National Organization of Social Work, 2014).

Efficacy of Family-Based Counseling

There has been extensive research in the treatment of various populations and presenting problems through what is being identified as family-based counseling. Children and their families are the most researched and supported population for the use of family-based counseling. Henggeler and Sheidow (2012) analyzed the effects of specific therapeutic models that have been

shown to reduce deviant adolescent behavior for at least one year. The therapeutic underpinnings in these theories or models were each an eclectic blend of intra-psychoic interventions with strong family-based origins. Childhood anxiety and mood disorders have shown to be effectively treated with family-based interventions in several small studies (Northey, 2002). Oppositional defiant disorder (ODD) has been identified as being precipitated by relational interactions, specifically within the family (Loeber & Stouthamer-Loeber, 1986; Northey, 2002). Parent training is a validated treatment for ODD. Additionally, there is significant evidence to support the use of parenting training and family-based interventions with children whom have an Attention Deficient Disorder (Klein & Abikoff, 1997). Stupak, Hook and Hall (2007) found that clients whom had more family-based sessions or interactions tended to not prematurely terminate. This finding further underscores the importance of family-based intervention in counseling.

With the consistency of literature supporting the use of family-based interventions with children, the Surgeon General of the United States of America advocated for an increase in these family-based interventions in his conference on Children's Mental Health in 2000 (U.S. Public Health, 2000). This report emphasized the crucial role family plays in addressing the nation's children. This is especially true for underserved families and children, who tend to be racial/ethnic minorities and/or economically despondent (Snells-Johns, Smith & Mendez, 2004). When addressing this concern and possible solutions, it is noted that a majority of the strategies to support marginalized populations are family-based interventions (Snells-Johns, Smith & Mendez, 2004). There is additional evidence to suggest that family-based interventions can be more cost-effective and/or provide better therapeutic outcomes for specific groups or presenting problems (Baldwin & Huggins, 1997; Stanton & Shadish, 1997).

The importance of family-based interventions is observed in the promotion of health and wellness in individuals. Family-based interventions have been helpful in the fight against childhood obesity and other related health problems (Davison, Lawson, Coatsworth, 2012). The importance of family has also been found in the family-based weight management program

outlined by Avery, Pallister, Allan, Stubbs, and Lavin (2012). The importance of wellness and family-based interventions is supported in the treatment of anorexia nervosa and other eating disorders (Downs & Blow, 2013; Hurst, Read, & Wallis, 2012; Treasure, Claudino and Zucker, 2010).

There has been an emphasis in the development of community partnership and integrative treatment considerations that seek to understand and advocate for children through the community, family, and school (Bryan & Henry, 2012). This type of partnership model is becoming more important for counselors regardless of the setting as observed in the increased focus on advocacy in the counseling program accreditation standards (CACREP, 2009). Family-based interventions can be viewed as a form of advocacy.

In conclusion the studies cited above present clear evidence to support the use of family-based services. The research conducted in this field addresses various measures of successful outcomes, populations, and presenting problems; each of these studies identifies physical family inclusion as an important component. This emphasizes the importance of what are identified, as family-based counseling services that include the family, but do not prescribe to a specific therapeutic modality. This means that when family based counseling is being practiced, there is no way to know if family systems concepts are being used. This practice of family-based counseling is even seen clearly in the operationalization of the multicultural counseling competencies (Arredondo, et al, 1996).

Multicultural Counseling Competence, Defined

The hypotheses in this study relate to the factors that may influence counselors' family counseling practices. One of the factors that will be studied is multicultural counseling competence (MCC). Multicultural counseling is defined by Hays and Erford as "the integration of cultural identities within the counseling process" (p. 5). These cultural identities are directly related to how each individual identifies with various cultures, groups, or categories (Hays & Erford, 2014).

Specific concrete aspects of multicultural counseling are identified in the multicultural counseling competencies. The multicultural counseling competencies identify three areas of competence, including (a) the counselor's awareness of own cultural values and biases, (b) the counselor's awareness of the client's worldview, and (c) the counselor's ability to use appropriate intervention strategies (Sue et al, 2012). Multicultural competence is not limited to ethnic or cultural groups; it also includes sexual orientation, socioeconomic status, disability, gender, generational status, spirituality, privilege and oppression, and worldview (Hays & Erford, 2014). The history of multicultural counseling competencies will be discussed further, later in this chapter.

Efficacy of Multicultural Counseling

The current United States population is experiencing a shift toward an increasingly more diverse society (U.S. Census Bureau, 2010). It is estimated that by 2050, the United States population will be composed of a majority of minorities, while individuals of European descent will make up less than 50 percent of the population (Pew Research Center, 2008). The current and future transition in population greatly affects the people counselors will serve.

The general importance of competent multicultural counseling practices has been demonstrated by many researchers. Many ethnically diverse populations underuse counseling services (Ancis, 2004; Constantine, 2002). The reason for this underuse has been hypothesized to be directly related to multicultural competence. Pack-Brown (1999) identified that culturally diverse clients tend to mistrust counselors. Researchers have found that counselors often misdiagnose culturally diverse clients, and it has also been identified that counselors conceptualize client experiences using their own Western norms and values (Ancis, 2004; Eriksen & Kress, 2004).

Relationship Between Family Counseling and Culturally Competent Counselors

Khodayarifard and McClenon (2011) postulate that cultural groups whose origin is grounded in collectivist cultural values benefit greatly from family counseling. Hays and Erford (2014) define collectivism as “the idea that decisions are...based on the betterment of others. Others might include community or family members. Collectivist values may include cooperation, “saving face,” and interdependence” (p. 7). When reviewing the leading counseling journals, MCC and diversity were major components of a majority of articles related to family counseling. The articles reviewed below are all related to family counseling and culture.

Krieger (2010) went into depth explaining the importance family plays in the Jewish culture, describing it as the “central social structure of Jewish life” (p. 154), and further identified ways this value of family affects counseling. This type of familial importance is also found in Asian Indian Americans. Counseling considerations related to this population stress (a) the importance of extended family relationships, (b) the influence of gender roles within the family (especially in parental considerations and acculturation) and (c) the unique role privacy and boundaries play in families (Dupree, Bhakta, Patel & Dupree, 2013). Khodayarifard and McClenon (2011) detail their adaptation of the Western Cognitive behavior models to the collectivist Islamic culture of Iran, including integrating the family into the treatment of a child with obsessive compulsive disorder (OCD). This is further emphasized by Daneshpour’s (1998) explanation of Muslims’ perspectives on inter-dependence and the emphasis placed on family over the self or individual, a concept that is atypical in the United States. Khodayarifard and McClenon (2011) discuss this by stating “western therapist are thought to overemphasize individual change, self concern, assertiveness, self-growth, ego strengthening, and self-actualization, depending on the their therapy orientation” (pg. 79). Familial importance is also observed in the Native American culture. Limb and Hodge (2011) detail a unique treatment approach in working with Native American families and children by acknowledging the unique

role family and spirituality plays in this culture. This therapeutic approach is very systemically based and helps couple family and spirituality for this specific oppressed population.

Gonzalez, Borders, Hines, and Villalba (2013) stressed the importance family plays in Latino immigrants and their children's success. The family-based integrative model described emphasizes the role of the family and details the ways to use the family as a strength to further student success. Yeh, Borrero and Tito (2013) found that adolescent Samoan-American students with depression tended to have high levels of conflict and low levels of collective self-esteem. This demonstrates the importance family can have on an adolescent's mood, specifically for Samoan-Americans. This type of familial influence is also seen in the racial identity development of African-American college students (Brown et al., 2013). Positive parental attachment and an individual's positive racial identity are directly correlated. Students with strong attachments tended to be further along in their racial identity development.

Partner conflict was the strongest predictor of postpartum depression (PPD) in Latina women. It was found that the more conflict in the woman's relationships, the more PPD symptoms she presented with (Hassert & Kurpis, 2011). This is congruent with various other studies that acknowledge the role family conflict or discord plays in depression and/or depression play in family discord (Beach 2002; Cano & O'Leary, 2000; Whisman, 2001). Individuals with mood disorders from collectivist cultures are highly correlated to overall family functioning. Each of the examples already listed present a body of literature about the value of family and counseling outcomes, there is another set of literature that identifies the role of the counselor in effective interventions across cultures.

Gushue, Constantine, and Sciarra (2008) found that when participants read a summary of two families (one White family and one Latino family), White Counselors perceived the Latino family behavior as normal while the White family was perceived as more symptomatic. Counselors who stated that families had marked differences in functioning were less aware of their own cultural competence, often reporting a higher level of multicultural competence. When

compared to a previous study by Gushe and Constantine (2007), it can be concluded that counselors perceive families differently than individuals. There is no other research that was found to expand on this important finding.

Professionals that work with specific cultural groups and populations and presenting problems have driven this field of research. This has provided a depth of knowledge for counselors seeking interventions with specific populations and presenting problems, but the literature related to cultural competency with a particular group or populations often lacks generalizability to other communities. The research conducted in this area has provided a good introduction to the implications of MCC and the importance of family to various populations likely seen in counseling.

It is important to understand that when researching family in counseling journals that vast majority of literature is directly related to populations from unique cultural or ethnic backgrounds. The multicultural counseling competencies address the importance of knowing family structures and understanding each person's uniqueness. The literature makes a strong case for the therapeutic value of family. Patricia Arredondo and her colleagues (1996) discussed the use of family in counseling when discussing the operationalization of the multicultural counseling competencies. This operationalization alludes but does not directly address what family in counseling specifically means; it seems to either be by acknowledging the importance of a client's family (use of family systems counseling) or by including the family (use of family-based counseling). This lack of specificity has left the connection of MCC and family counseling loosely defined.

There are several limitations relating to the bulk of the research currently presented. First, conceptual articles have become commonplace, these articles often introduce new ways to work with families from different cultures. This type of information, though valuable does not validate the conceptual hypothesis that families are imperative to therapeutic success. Second, the research conducted often has small sample sizes, which may be because these unique populations cannot

be readily assessed. Counselor competence has been assessed in a limited way especially as it relates to family counseling, and these studies are typically assessing competence with specific populations or presenting problems rather than overall MCC and family interventions.

Although multicultural competence is understood to be important, it has not been researched in relation to families and their affect on counseling outcomes. As demonstrated there is substantial evidence to show that for many ethnic and cultural populations, the inclusion of family in the session or even the acknowledgment of the role family plays in a person's life and choices can be of benefit. It is imperative that the counseling field does due diligence to assess the connection between MCC and family counseling, as this could provide greater understanding of multicultural counseling.

Counselor Training: Family Systems Counselor, Family Based Counseling, Cultural Competence

In the past, counseling programs typically trained counselors in linear, individual, or intra-psychoic counseling traditions (Sexton, 1994). Linear counseling focuses on the individual (personality and traits) of the client, seeking a Newtonian truth from a linear cause, and promotes the belief that actions can be understood with the use of objective reasoning (Smith, Carlson, Steven-Smith & Dennison, 1995). Today, counseling programs help train counselors in symptom identification and alleviation (Bitter, 2013). This type of training can often involve diagnosis of disorders and the introduction of ways to reduce or manage dysfunction. This type of counseling has become implicitly focused on individual experience rather than context (Bitter, 2013). Family systems counselors see the family as the client, and the focus is on the relational patterns and interactions within which clients experience, define, and create their subjective mode of existence (Bowen 1978; Haley, 1961). They tend to believe that there is a complex set of multiple truths that can be understood only with systemic exploration from multiple perspectives (Minuchin & Nichols, 1993). The original family systems theorists promoted the view that there is rarely a linear (or causal) reason for an individual's actions; circularity is inevitable (Bateson,

1979). Family systems counselors see that actions are to always be considered within numerous contexts. There is a deep web of interconnectedness that guides actions, that is often unknown or unrealized (Bowen, 1978; Haley, 1976).

The Role of Professional Identity and its affects on Training

As has been demonstrated, there are distinct similarities and differences in theoretical development and implementation of intra-psychic/individual counseling and family counseling. These differences and similarities can also be seen in the professional identity of these two schools of counseling thought. To truly understand these perspectives, understanding professional identity and self-identification is essential.

The primary association for counselors is the American Counseling Association (ACA), whose distant forerunner, in 1913, was the National Vocational Guidance Association (NVGA). In the 1950s, it renamed itself the American Personnel and Guidance Association (APGA). In 1983, it became the American Association for Counseling and Development (AACD), and then again in 1992, the name used today, the American Counseling Association (Neukrug, 2016). The ACA created a division called the International Association of Marriage and Family Counselors in 1989. This addition created a subgroup of counselors who identified as family, couples, and marriage counselors (or therapist). The American Association of Marriage and Family Therapy (AAMFT) was founded in 1942.

Currently, ACA has 55,000 members and AAMFT has 24,000 members (Neukrug, 2016). The leadership of ACA is currently seeking to establish a vision for the counseling field to be a unified, coherent profession across specialties (Kaplan & Gladding, 2011). The membership of AAMFT identify as Marriage and Family therapists, and today the leadership of the AAMFT seeks to establish a standard of practice across the marriage and family counseling field (AAMFT, 2014; Stratton, Reibstein, Lask, Singh, & Asen, 2011). This standard of practice is

supported through the creation of the Commission on Accreditation for Marital and Family Therapy Education (COAAMFTE) that accredits marriage and family therapy programs.

The ACA collaborates closely with the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (Sweeney, 1995). CACREP established standards that programs which are accredited or seeking accreditation must meet. CACREP (2014) has become the standard for counseling program accreditation, encompassing 301 schools. CACREP accredits two-thirds of institutions that offer counseling programs (Neukrug, 2016). Lastly, CACREP has a marriage, couples, and family counseling specialty that will be discussed later; this specialty corresponds closely in name and credentialing to AAMFT's accredited MFT programs.

ACA, CACREP, AAMFT, and COAAMFTE are diligently working toward licensure and program recognition. CACREP and ACA lobby to have CACREP program graduates achieve licensure through their vision, while AAMFT and COAAMFTE likewise lobby to have COAAMFTE program graduates achieve licensure following their separate and somewhat different vision and standards (Neukrug, 2016). Both bodies have been helpful in the goal of all 50 states having some form of licensure for marriage and family therapists, often designated as LMFT. These two distinct identities have created a dichotomy in the family counseling field; the theoretical premise of both schools are similar but diverge in their loyalties and self-identification.

Marriage and Family Therapists have a distinct professional identity, but often engage in professional activities that look very similar to counselors. Doherty and Simmons (1990) found that MFTs primarily treat depression, marital problems, anxiety, behavioral problems, parent-child interactions, and various other psychological problems. MFTs have a median number of 12 sessions, and tend to see families (9 sessions) for shorter duration than couples (11.5 sessions) and individuals (13 sessions). Approximately one-half of the treatment provided by MFTs is individual counseling. A similar study of psychologists conducting psychotherapy found that 38% were involved in family counseling and 78% were involved in marital/couples counseling,

though that takes up only 19% of their therapy time (Norcross, Hedges, & Castle 2002). Like MFTs, psychologists spend the bulk of their counseling time working with individuals. The percentage of time working with families and couples has decreased since 1981 (possibly with the increase of MFTs and counselors). These studies shed light on the probable practice of counselors regarding families and couples. Although the work that counselors and therapists likely do look very similar, these two distinctly separate schools are greatly influenced by how they label themselves.

The polarity of self-identification has created a false dichotomy of those who work with family and those who do not. The problem with this dichotomy is that it is not true. Counselors may graduate from a counseling program with little family counseling training, but still likely to see families. Therefore, it is imperative that we understand how and to what extent counselors are working with families. This understanding will help guide future education of counselors.

Family Systems Counseling in Counselor Training: History and Standards

The ACA code of ethics requires a person to have “education, training, supervision, credentials and appropriate professional experience” in order to practice within the boundaries of their competence (2014, C.2.a). This ethical code, as well as each State’s laws, essentially requires that anyone who calls him or herself a licensed marriage and family therapist (LMFT) must have credentials and appropriate training. This training is likely to come from marriage and family training programs (such as COAMFTE or CACREP); however, there are states that credential without consideration of accreditation and look at the number of courses in marriage and family counseling, professional experience, and/or supervision. LMFTs trained in marriage and family counseling tend to use family systems counseling theories (AAMFT, 2014).

The AAMFT created the Commission on Accreditation for Marital and Family Therapy Education (COAAMFTE) through several steps in the 1970’s (COAMFTE, 2014). In 2014, 93 institutions in the United States and Canada had a COAMFTE accredited program. COAMFTE

accredits three types of programs: masters, post-graduate, and doctoral. Each specializes in a particular facet of marriage and family counseling.

The International Association of Marriage and Family Counselors (IAMFC), a division of the ACA, sought to have a marriage and family counseling specialty added in the CACREP's standards in 1990; this came to fruition in 1992 (Bobby, 2013). Today, there are 42 programs with the CACREP-accredited marriage and family-counseling (or marriage and family counseling/therapy) specialty within the United States (CACREP, 2014). Like students that graduate from COAMFTE programs, graduates of Family Counseling Specialty CACREP programs will likely be eligible for their LMFT and practice using systemic theoretical concepts.

In the CACREP standards, for all specialties there are eight common core curricular areas that all counselors who graduate from an accredited program must possess knowledge and understanding in (CACREP, 2009). Within these core curricular areas, there are four standards that address families (not necessarily family counseling). As CACREP is the main counseling program accreditation, it is important to use its standards to measure family counseling educational background in counselors.

There are four CACREP standards that mention family. The first standard to mention family is within the multicultural core curricular and is related to the understanding and knowledge of strategies: "individual, couple, family, and community strategies for working with and advocating for diverse populations, including multicultural competencies (II.2.d)." This standard is related to the research question in this study regarding the possible connection between family counseling and MCC.

The human growth and development core includes the other two statements that mention family within the CACREP standards. The first standard is related to understanding "theories of individual and family development and transitions across the life span (II.3.a)". This standard is not directly related to family counseling (in either form), but rather how a family develops which is likely important to family counseling but not necessarily a family counseling competency. The

next standard states that students must understand “theories and models of . . . family . . . resilience (II.3.d)”. The following standard is part of the career development core and states “interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development (II.4.d).” This final standard once again places importance on family related to MCC. As noted, half (two of four) of the CACREP standards that mention family also cite multiculturalism, an important factor in this study. It is important to note that in addition to these core competencies there is an entire family counseling specialization within CACREP which does educate and train counselors in family systems concepts, and there are 42 programs nationally.

Despite evidence of efficacy, family-based or family system knowledge is not a CACREP core curriculum course and are addressed sporadically and poorly in the standards (Sprenkle, 2002). Within the other various specialties (addictions, careers, clinical mental health, school, student affairs, and college) there are varying degrees of family mentioned. Highly trained counselors across the nation could feasibly (or even likely) graduate without substantial knowledge of working with families in counseling (whether it be family systems or family-based).

Family Based Counseling in Counselor Training: History and Standards

The history of family-based interventions in counseling is murky because it is not something that has been readily discussed in literature. This researcher hypothesizes that this type of intervention is often done but not necessarily discussed and trained for. Fields similar to counseling have a richer explanation of services that engage family members. For example the National Organization of Social Work (2014) discusses the role of social workers with families, and 28% of social workers work in family or child services. In the description of the work they do with children, it is identified that social workers use family interventions. By the nature of their training, social workers have a wide array of tools to help these children and families. It is also

identified that they use a “systems and family-oriented approach in helping families.”

Within the counseling field, Insoo Kim Berg, a developer of Solution Focused counseling, wrote a book in 1994 entitled *Family Based Services*. This work by Berg is rich with detail on involving families with children in the counseling process using a solution-focused perspective. In her book Berg discusses specific therapeutic rationales for family-based services. Many of these rationales are family systems based, but do not reference specific systemic terminology such as homeostasis and systems. Berg identifies the philosophical basis for family-based services in stating “the best way to provide services to a child is through strengthening and empowering the family as a unit (pg. 1).” Berg later states that “by involving the family as a partner in the decision making and goal-setting process and using the family’s existing resources...the family members feel an increased sense of competency in conducting their lives...(pg. 2).”

The training standards associated with family-based services are the same as family systems training standards, which simply infer that families can be beneficial to the therapist process. This lack of distinction emphasizes the need to understand what is currently being done in the field in order to help that be reflected in future training standards.

The Training of Culturally Competent Counselors: History and Standards

First introduced by Sue and Sue in 1977 as cross-cultural counseling, this type of counseling sought to minimize how counselors’ values affect clients from other cultural groups (Ridley & Kleiner, 2003). This article contributed to the initial conversation about the role culture plays in counseling, and it was the starting point for what has become a cornerstone of competence. Then, in 1982, Sue and his colleagues introduced the cross-cultural counseling competencies based on three foundations: beliefs and attitudes, knowledge, and skills. Each of these components still serves as cornerstones in the MCC competencies used today. These competencies were expanded a decade later to ultimately become the Multicultural Counseling

Competencies, which are still used today (Sue et al., 1992). It was during the early 1990's that literature about MCC became more common and the dialogue became increasingly more salient (Ridley & Kleiner, 2003).

The 2014 ACA code of ethics emphasizes the importance of MCC by stating: "multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (C.2.a). Also within the Multicultural counseling competencies, described previously, it states: "Culturally skilled counselors have knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about the community characteristics and the resources in the community as well as the family" (Sue et al., 1992). The MCC competences are used as a guide to direct counselors and counselor education programs.

The 2016 CACREP standards address multicultural training as one of the essential core content areas under the umbrella of cultural and social diversity, within this core it is made clear that counselors must be ready and willing to work with clients from diverse backgrounds using the multicultural counseling competencies. Multiculturalism and diversity are mentioned consistently throughout the other content areas of human growth and development, group work, helping relationships, career development, and assessment. Only two of the core areas do not mention diversity or multiculturalism (research and professional identity/ethics). It is ardently clear that multiculturalism is an essential component of the counseling field, which is congruent with the 2001 Delphi poll conducted Neimeyer & Diamond, which identified issues of diversity as the single greatest core of the profession through 2010.

Assessment of Counseling Competence

Within the counseling and family therapy field, there has been an overwhelming emphasis on competency being measured through basic skills assessment. This type of skill assessment and measurement is seen clearly over the course of the last 40 years in the counseling

field (Young, 1998). Figley and Nelson published four “Basic family therapy skills” articles from 1989 to 1993, which covered various family therapy models/theories. These types of skill assessments are common in both counseling and family therapy. The counseling skills scale (CSS) developed in 2003 by Eriksen and McAuliffe is commonly used as the reference skills assessment and is used extensively in the marriage and family therapy training programs (Perosa & Perosa, 2010). Perosa and Perosa identify it as being “limited to skills learned early in MFT skills courses involving role-play simulations” (2010). This demonstrates that both the counseling and family counseling fields tend to rely on basic skills-based assessments rather than conceptual-based assessments, but ultimately, as previously demonstrated, the difference between the two fields is mostly conceptual. The field lacks advanced skills or conceptually based measures, which leaves researchers and educators without a way to measure these constructs.

Assessment of Family Counseling Competence

With the goal of defining competence explicitly and clearly, in January 2003, the AAMFT board of directors called for the development of core competencies in the MFT field (AAMFT, 2004). This call was a reaction to the need to regulate the MFT field and standardize the services offered by MFT (Miller, Todahl, & Platt, 2010). The competencies established by AAMFT, such as attending behaviors and ethical practices, are therapeutically based. This is in stark contrast to the CACREP standards, which are much more knowledge-based. Neither AAMFT nor CACREP have established a theoretical counseling orientation requirement. Even psychologists are seeking standardized family counseling competence especially given the number of psychologists seeing families. The American Board of Family Psychology also has recently sought to develop competencies for family-based services provided (Kaslow, Celano & Staton, 2005).

There is a struggle within the MFT field to fully accept a standardized competency list. Fruggeri (2012) wrote a conceptual article detailing her perspective of MFT competence not

being behavioral or skills-based, but rather relationally focused, “training therapist to enrich their relational competence...in the development of the interactive process in which they are engaged with clients” (2011, p 104). She identifies that the competency shift that focuses on manuals development cannot fully describe the art of counseling and the “dance that occurs between therapist and family” (p. 91). This emphasizes the underlying struggle between the need to regulate the field while keeping the field authentic and flexible.

The MFT field, in addition to following a set of competencies, is seeking to have a better way to measure MFT competence. Perosa and Perosa, key voices in the MFT field regarding competence, detailed the various competency assessments (2010). According to these experts, there are 12 competency measures, five to measure individual counseling skills and seven to measure family counseling skills. Of the seven family measures, two are not published or cannot be found. Of the remaining five measures, three have not been tested for reliability or validity, and the remaining two measures are supervisor-rated measures. The two measures that are not published were discussed at length by Perosa and Perosa (2010) but were either cited as a future publication or presented at past conferences; when I attempted to inquire Perosa about the measurements, I received no reply. There are no family counseling skills measures that are published, with established reliability and validity, which are self-reported. For practical purposes, this means that only supervisors can assess a counselor’s competence in family sessions, which is simply not feasible for a majority of post-graduating counselors in training. This is explained by saying that “measures to assess student clinical competence with couples and families are only beginning to be formulated and empirically tested by family therapy educators (p. 126).” Perosa and Perosa make a “call to the profession...to draw upon the developments made in all of these related clinical fields and adopt, adapt, and review some of these instruments in the pursuit of creating a viable MFT clinical competencies evaluation system (p126).” Simply stated, there is no viable family counseling competency scale or measure to help assess a counselor’s competence in this area, especially without a supervisor or expert observer.

The family therapist rating scale, published in 1983 by Piercy, Laird, and Mohammed, is a 50-question scale that is deeply behavioral and focuses solely on a counselor's actions rather than his or her conceptual thoughts or perceptions. This scale is divided into five categories (structuring, relationship, historical, structural/process, and experiential) with questions such as "Lays down ground rules for the therapeutic process, engenders hope, uses family sculpting, and rearranges the physical seating of family members" (p. 57-59). The first two categories are considered basic counseling skills across orientations, while the remaining three are specific to theoretical orientations. The expert observer would rate the 50 items with a six-point scale ranging from not present as a 0 to maximally effective as a 6. The authors and creators of this scale seem to describe it as relatively simple because "the rater must attend to only a limited number of family therapist skills...and simply observes another's family therapy and rates the relative effectiveness of the skills on the scale (p. 53)." This scale has been tested for reliability and validity, but lacks recent theoretical orientations and the newly established competencies (Perosa & Perosa, 2010).

The basic skills evaluation device, published in 1999, is a compilation of the basic skills projects completed in 1989, 1990, and 1993. These basic skills articles go into great depth measuring and rating various skills related to various theories. For this reason, the skills placed in the evaluation device are empirically derived. They are also more connected to the clinical competencies and much more abstract to rate. The observer rates a concept like "knowledge base" on a Likert scale ranging from "inadequate information to exceptional skills." This device is not detailed enough for a person to easily orientate to and use quickly and it is not detailed enough to establish criterion or content validity (Perosa & Perosa, 2010).

The two assessments explained are the two assessments for family counseling skills that have some form of empirical validation; the remaining assessments cannot be found or have not been validated. Of the non-validated devices, the postgraduate competency document is only 31 questions, and addresses general case management skills, a few very basic family system skills,

and the counselor's ability to connect interventions to theory (Storm, York, Vincent, McDowell & Lewis, 1997). This was created for self-report and supervisor evaluation. Perosa and Perosa's only critique is that there is not a (numerical) rating system (2010).

It is clear that there is a lack of competency assessments in the MFT field, which further translates into a lack of competence assessments in the counseling field. The need has been established in the last 10 years and it has been inadequately addressed. This predicament leaves counselors with an inability to understand and assess their skills and conceptualizations related to family counseling.

Assessment of Multicultural Counseling Competence

The importance and value of MCC has been established, but just as in the MFT field, the desire to measure competence has been prioritized. Unlike MFT measures, there are a number of reliable and valid measures that can be used to assess MCC. There are numerous measures; a few specific instruments have become commonplace in MCC research.

The first notable MCC competency assessment was developed as the Cross-Cultural Counseling Inventory (CCCI) in 1985. It was later revised to the Cross-Cultural Counseling Inventory-Revised (CCCI-R) in 1991 (Hernandez & Lambroise, 1985; Lambroise, Coleman, & Hernandez, 1991). In the early 1990's three new competency measures were researched and introduced: the Multicultural Counseling Inventory (MCI), the Multicultural Counseling Awareness Scale (MCAS), and the Multicultural Awareness/Knowledge/Skills survey (MAKSS) (D'Andrea, Daniels, & Heck, 1991, Ponterro et al., 1991, Sadowsky, Taffe, Gutkin, & Wise, 1994). Each of these measures relied upon the Multicultural Counseling Competencies introduced earlier.

Currently, there are two main scales that are often used in the literature: the Multicultural Counseling Inventory (MCI), developed and validated by Sadowsky, Taffe, Gutkin and Wise in 1994, and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), developed

and validated by Ponterro, Gretchen, Utsey, Riger and Austin in 2002. The MCI is a 40-item self-report questionnaire that uses a Likert scale ranging from 1-4. Scores on each item are added in order to develop a total score. The higher the total score, the higher the counselor's MCC. The validity and reliability have been established with an alpha of .86. Additional studies done since the original validation have further supported the validation and reliability (Hays, 2008; Ivers 2012).

The MCKAS is an updated version of the MCAS from 1991. It was extensively revised in 2002 using two separate studies. Unlike other MCC measures, the MCKAS measure is controlled for socially desirable responding. This measure consists of 32 questions in which participants self-report responses on a 1-7 Likert-type scale. Higher scores indicate higher MCC in two sub-scales. The alphas are between .75 to .95, which demonstrates the measure's reliability (Choa 2012; Choa, 2013; Neville, Spanierman & Doan, 2006; Ponterro et al., 2002). The use of the MCI and Multigroup Ethnic identity measure (MEIM) helped establish the construct and convergent validity of the MCKAS through correlations and high alpha coefficients (Ponterro et al., 2002).

Family Counseling in Counselor Education

There is very little research in the area of family counseling in counselor education. In the *journal, Counselor Education and Supervision*, the two articles published since 2005 that are family counseling focused are discussed below. In 2005, Stinchfield published a qualitative study where participants discussed the competencies required for their position of in-home counseling with at-risk families. The ultimate findings identified two main areas of importance for the counselor education field: first, the importance of joining with the family and community; and second, how under-prepared counselors were in their training. Participants reported that they felt as though their professors would have no idea how to do the work they were required to do within their counseling role. It is also unclear to what extent family system and/or family based interventions are discussed and learned or even needed.

The following year Murray, Lampinen and Kelley-Soderholm (2006) detailed the way in which a family-counseling introduction course was taught through service learning. A service learning assignment gave students the opportunity to learn several identified objectives through observing family systems. Students learned how stress affects a family by practicing basic family counseling skills with people and offering skills to support children and families. These observations and practice opportunities were all components of a Family Counseling course and its service-learning requirement. It is a unique way to teach family counseling and would mitigate the previous study's participants' concerns by learning about families prior to graduation. It is not clear why this knowledge would be helpful to future graduates and how the service project experience or overall course would increase competence. It is difficult to know what exactly was being learned in the services project because specifics of the other course material were not discussed. Once again it is unclear to what extent family system and/or family based interventions are discussed and learned.

There are some counseling programs that have implemented advanced family therapy training standards. The College of William & Mary has an established reputation in training family counseling using CACREP standards. Its program has developed a family counseling center that has implemented a deliberate psychological education model in its family counselor practicum (Kaiser & Ancellotti, 2003). This practicum is taught prior to a student's yearlong family counseling internship. This model of family-counseling education is enviable and exceptionally detailed, but is developed solely for students whom aspire to family counseling practitioners or MFTs. It is focused on family-counseling and is impractical to use in programs that do not specialize in family counseling, which ultimately brings us to the present, with counselors who are either solely trained in intra-psychic counseling or who specialize in family counseling.

Summary

In order to fully understand family counseling, one must understand its two perspectives: family systems counseling, in which the counselor uses a theoretical framework that sees the family as the focus of intervention or family based-counseling which involves the family in the therapeutic process while still focusing on the individual. The field of family counseling includes self-identified marriage and family therapists and marriage, couples, and family counselors who have distinctly different professional associations and training standards. This struggle is further deepened by the lack of standardized family counseling conceptual assessment that has marred the field with unmeasured and unknown competence and practices. Finally, while awareness of family dynamics appears to be an important part of MCC, the relationship between adherence to a family systems model of counseling, the use of family-based interventions, and multicultural competence has not been assessed directly.

Chapter Three: Methodology

This chapter reviews the methodology this researcher used to study family counseling practices in the counseling field. The researcher identifies the research questions, variables, and hypotheses. The researcher will then describe the sampling method and participant criteria as well as the manner in which participants were elicited while confidentiality and consent were ensured. The researcher will describe the instruments and protocols used in this study and details regarding the analysis of the data collected. The chapter will conclude with information regarding the limitations and delimitations of the study.

Overview of the Method

The purpose of this study was to identify the manner in which counselors are working with clients and their families and what factors are associated with family counseling practices. The independent variable in this study are the participants' family counseling practices and the dependent variables are each participant's amount of training in family counselor, experience counseling families, and the participants' MCKAS scores.

Participants were recruited through several counseling LISTSERV email lists, clinical and counseling program directors, and state counseling organizations. After consenting to participation each participant completed an online survey and demographic questionnaire. Data analysis was completed once the survey responses were input into SPSS Statistics Software, version 22. The data was analyzed using a multivariate analysis of variance (MANOVA), which analyzed how multivariate dependent variables differentiated participants between three distinct groups (Lund Research Limited, 2013).

Research Questions and Hypotheses

There are two facets of hypotheses within the study. The first set of hypotheses are directly related to the measures developed for this study, the second set of hypotheses are developed in order to answer the research questions. As previously discussed the family systems

concept measure and family-based questionnaire have not been extensively validated. In order to establish concurrent and convergent validity the following hypotheses have been developed.

Family systems concepts are almost exclusively taught in family counseling textbooks and courses; counselors whom measure higher in family-systems concepts will have more training and coursework. While participants that measure higher in family-based usage, should report to have more experience counseling families. The research questions and related null and research hypotheses of the entire study are as follows:

Research Questions

1. To what extent are counselors including family in their counseling practices?
2. How are counselors including families in their counseling practice?
3. What factors (education, skill, and attitude) influence a counselor's family counseling practice?

Research Hypothesis

Null hypothesis. The amount of experience, education, and MCC does not significantly differ between each group that utilizes different levels of family counseling practices ($p > .05$).

Research hypothesis. The amount of experience, education, and MCC differs significantly between each group that utilizes different levels of family counseling practices ($p < .05$).

Variables

Independent Variable

There is one independent variable used in this study. The independent variable is represented by three groups. The first part of the independent variable is family systems conceptualizations; the second part of the independent variable is of family-based interventions. Participants were labeled as high or low based on their responses to the two measures; these high and low responses were used to place each participant into a group. Group One consisted of

participants that responded as high in their use of both family-based practices and family systems concepts. Group Two consisted of participants that responded as high in one family counseling practice and low in the other family counseling practice. Group three consisted of individuals who scored low on both family counseling practice measures. This type of grouping has been previously used in MANOVAs; Tsan and Day grouped independent variables in their study of online counseling in 2007 and Moe, Dupuy, and Laux in their study of LGBTQ identity development in 2008. Just as in this study, each of these study's groups were formed using each participant's measurement scores.

Dependent Variables

There are three dependent variables in this study. The first dependent variable is the amount of experience counseling families (specifically number of hours). This variable was calculated using three questions from the demographic questionnaire: total years of experience counseling, average number of hours spent counseling each week, and the percentage of total experience comprised of family counseling. The second dependent variable is the amount of training and coursework in family counseling. This variable was calculated using three questions from the demographic questionnaire: number of graduate courses in family counseling and hours of formal and informal training hours (formal being supervision and continuing education units while informal being consultation and personal reading). The third dependent variable is each participant's multicultural counseling competence as assessed by the MCKAS, which is discussed in detail later in this chapter.

Participants

Criteria

In order to get an accurate glimpse of the counseling field, each participant must be licensed as a counselor by his or her state board. The established purpose of the study is to understand the practices of counselors. By requiring participants to be licensed counselors, each

participant will have met specific minimum requirements of supervision, experience, and examination as established by her or his state. This sample will represent the counseling field from the perspective of experienced professionals. Each participant will have been engaged in the counseling field and practice of counseling for a minimum amount of time (as established by their state).

As of 2010, the American Counseling Association reported that all 50 states (as well as Puerto Rico and the District of Columbia) have counselor licensure laws. Licensure laws are established to protect the public and often establish minimum standards of education, experience, and examination. The education requirements for licensure can range from 42 to 60 graduate semester hours and a master's degree in counseling (or similar degree). All states require post-master's supervised counseling experience, which can range from 500 hours to 4,500 hours depending on the state. In addition to education and experience requirements, all states had an additional testing requirement; this often involves passing the National Counselor Examination for Licensure and Certification (NCE) or the National Clinical Mental Health Counseling Examination (NCMHCE). This varies significantly by state and can include additional requirements. Although the titles and tiers used to denote licensure vary, the minimum standard of post-master's experience is established by each state. With these considerations it was decided that fully licensed counselors would provide the most accurate glimpse of the counseling field.

Recruitment and Ethical Considerations

The sample was obtained using convenience sampling; participants were recruited through emails sent through state counseling associations and LISTSERV email lists. Graduate program directors and instructors in various counseling programs also received an e-mail requesting participants. For participating, each participant could be entered into a drawing for eight \$25 digital gift cards to Amazon. After completing the entire survey the participants were able to submit an e-mail address in order to be entered into the drawing. Once data collection was

complete, the researcher will have SPSS randomly select eight e-mail addresses to send the gift cards to. Once the gift cards were distributed the e-mail addresses were removed from the data.

The emails sent out included an initial description, purpose of the study and information related to consent and confidentiality. The researcher sent 557 e-mails to obtain participants. There were three LISTSERVES that an e-mail seeking participants was sent, each LISTSERVE received two participant requests. The researcher also sent a personalized e-mail to 60 CACREP liaison's from doctoral programs across the country. Of the 60 e-mails sent five liaison's replied with well wishes and stated that the e-mail was forward to the program's students and alumni. The researcher also used snowball sampling by e-mailing six personal contacts in Idaho, Colorado, Washington and Texas to elicit participants, these personal e-mails resulted in a few Facebook calls for participant postings in Washington, Texas, and Colorado. In Idaho the e-mail was forwarded to other licensed counselors.

The researcher also used the Washington counseling association's website. Within this website there is a listing of counselors, which appears to be purposed for people looking for a counselor. Each of the counselors' lists his or her license in this information. The researcher sent an e-mail to each counselor on the website whom identified as being a Licensed Mental Health Counselor (LMHC), this was 143 individuals.

The researcher also used the Texas Counseling Association website, this website appears to have a listing of every person whom has been a member using numbers between (0 and 14,000). The researcher then identified how many of these numbers are still active with an individual's name and e-mail address, which was 812 individuals. The researcher then cross checked the 812 names with the Texas LPC roster, this ultimately results in approximately 343 LPCs. A personalized e-mail was sent to each of those individuals. This listing did not appear to be purposed as a member directory database.

Within each of the emails sent there was a link to the consent form that will be signed electronically (found in Appendix B). Within the consent form, each participant will be informed

of the risks and benefits of participating and their right to refuse to participate or withdrawal from the study at any time. After completion of the consent form, each participant will begin the survey with the included instruments.

Instrumentation

In order to answer the research questions, there were two instruments and two family counseling practices grouping protocols utilized. A previously developed and validated 32-item multicultural counseling measure along with three measures or protocols developed by the researcher (one demographic questionnaire and two family counseling group protocols) will be utilized. These four instruments provided the researcher with information about the variables and participants being studied.

Demographic Questionnaire

The purpose of the questionnaire is twofold. First, the demographic questionnaire allowed the researcher to provide a description of the participants within the study such as participants' age, sex, and ethnicity. Second, the demographic questionnaire collected several of the dependent variables; questions about each participant's number of family counseling graduate courses, training hours and experience counseling families. The demographic questionnaire can be found in Appendix C. Additional questions that were asked were the participants licenses, perceived competence in family counseling (both family-based and family systems) and whether they attended a CACREP-accredited program.

Multicultural Counseling Knowledge and Awareness Scale

To assess each participant's perceived multicultural competence, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) will be used (see Appendix D). This measure was chosen for several reasons. First, using the MCKAS negates the need for an additional social desirability response measure. Social desirability is a concern when doing research because people can answer questions either consciously or subconsciously in a manner

that is more congruent with societal expectations rather than reality. This is especially true when doing research in the multicultural arena because of the strong societal beliefs in a topic with various hidden biases.

Second, the MCKAS was chosen because it is eight items shorter than the MCI (discussed in chapter two). The length of a measure can affect the reliability of the overall survey. The more succinct a survey, the more likely participants that start the survey will finish the survey. By minimizing dropout participants the researcher will be obtaining a wider swath of the intended population.

The third and final reason the MCKAS was chosen was for its proven reliability and validity. The initial validity and reliability measured at an alpha of .86, while later studies have the alphas being between .75 to .95, which even further demonstrates the measure's reliability (Choa 2012; Choa, 2013; Neville, Spanierman & Doan, 2006; Ponterro et al., 2002). Additional studies done since the original validation have further reinforced the validation and reliability (Hays, 2008; Ivers 2012). The MCKAS was developed in 2002 as a revised adaption of a Multicultural Counseling Awareness Scale in 1996 (Ponterro et al., 2002). When initially introduced and published it was tested and revised twice in order to prove strong validity. As it has continued to be used since 2002, it has shown to be reliable and valid.

The MCKAS has two subscales: one of knowledge and one of awareness, with 10 questions that are reverse scored for a negative case analysis. A sample question is: "I believe that all clients must view themselves as their number one responsibility" (Awareness subscale, negative case analysis) and "I am knowledgeable of acculturation models for various ethnic minority groups" (Knowledge subscale) (Ponterro et al., 2002).

Family Counseling Practice Group Protocols

As previously discussed there is one independent variable (family counseling practice). For the data analysis this independent variable is what distinguishes each of the groups from one

another. These groups were created using a group scheme that utilized two grouping protocols; the two protocols are introduced below.

Family Systems Concepts Grouping Protocol. There are no specific instruments currently developed to provide insight into a counselor's family system's orientation practices. In order to identify if counselors are using a family systems approach in counseling a conceptual grouping protocol was developed (see appendix E). This protocol was developed with four key family systems concepts, with a positive and negative case analysis for each of the four concepts. There are questions for each concept that allowed the researcher to ensure some internal consistency reliability.

Through reading texts that discuss the difference between individual counseling and family counseling, there were four main points identified by each text (Bitter, 2014; Nichols & Schwartz, 2005; Walsh & McGraw, 2002). These four main family systems concepts being assessed are as follows.

- The family systems counselor's desire to understand the family process and patterns rather than only trying to diagnose pathology.
- The systems counselor's desire to embrace the client's family and other influential systems rather than seeing the client as an autonomous individual.
- The system counselor's desire to understand the relational roots of problems rather than the individual's perceived struggles.
- The system counselor's desire focus on relational interactions as opposed to focusing on alleviating the client's individual symptoms.

Each of these four concepts were used in this protocol to provide questions for each concept as well as a negative case analysis. These four concepts are identified as underlying foundations of all family-systems counseling, especially when compared to individual counseling (Bitter, 2013; Walsh & McGraw, 2002).

Two strategies were used to establish construct validity of this protocol. After developing the questions using guidance from family counseling texts, the researcher met with four experts in both individual and family systems counseling. During this initial review, each expert critiqued the protocol and changes were made to each question. This process was evolutionary, with each expert's critique leading to a new revision. Four revisions were made, with each revision improving upon the previous one. Prior to the final dissemination, the protocol was piloted with twenty practicing counselors. These pilot participants were given a five-dollar Starbucks card (using an e-mail address again to ensure maximum anonymity). After the 20 pilot participants had completed the entire survey, the researcher worked with a research team to review the feedback provided by the pilot participants. This process led to minor changes in overall survey but no change was suggested to this particular grouping protocol measure.

Family Based Intervention Grouping Protocol. In order to understand the participant's family-based usage, there is no need to assess for concepts, goals, or objectives. The goal was to inquire about how often they include the family of a client in counseling. This protocol was a short questionnaire about the participant's practice of including families, the question used to identify a participant's level of family based counseling is "I include a client's family at least once during the duration of the counseling" with multiple choice percentage responses to choose from "When I include family I tend to do so" with number of session responses to choose from (see Appendix F). Similar to the previous protocol, two strategies were used to establish construct validity initial expert review and pilot with 20 participants. Once again no major changes were suggested to this measure.

Data Collection Procedure

The data was collected using an online survey. The initial email included information about the survey purpose, confidentiality, and researcher contact information. The email also contained a link to informed consent that then led to a survey containing the four instruments being used. This online survey contained 60 questions, excluding the consent form. Prior to data

collection, the Institutional Review Board at Old Dominion University approved this study (see appendix A).

MANOVA

A MANOVA was chosen because of the desire to determine the conditions or factors that could explain the differences that exists between each of the groups representing different levels of the independent variable. This is different from a regression, which helps describe linear relationships between two or more within-group variables. The MANOVA procedure is more powerful than the ANOVA, as more variables can be assessed with fewer tests decreasing the likelihood of a type one error. By only running one tests rather than several there is less chance to generate a false positive also called a type one error. Each dependent variable is conceptually linked to the domain of counseling competence and so analyzing them together as a multivariate dependent variable is warranted. A multivariate analysis of variance was chosen for this study because of the hypothesized relevance each of the three dependent variables play in the use of family counseling practices. It is hypothesized that the three dependent variables compound in a manner that can explain a counselor's family counseling practices.

There are seven assumptions that must be understood and followed when using a MANOVA. (1) An important assumption when using a MANOVA is that each participant will be assigned to only one group. This assumption will be seen in this study by each participant's score, allowing them to be placed in only one group relating to their family counseling practices. (2) An adequate sample size is important. At a minimum the study must have at least the same number of participants in each group as there are dependent variables. This would mean that each of the four groups must have at least 3 individuals assigned. The researcher will explain GPower's optimal sample size for this study later. (3) There can be no univariate or multivariate outliers in the data, which simply means that the data must have normality. This normality allows the researcher to present the results with relevant significance. (4) Just as before, multivariate normality is required. SPSS tests for normality of each group in each dependent variable. Once again this

normality allows the results to be represented accurately. (5) The relationships being assessed between the dependent and independent variables must be linear; there must be some correlation to the results. (6) Finally there must be homogeneity of variances; the variances of each group and the dependent variables must be homogenous. This allows the researcher to examine two or more dependent variables; homoscedasticity will be examined using SPSS. (7) It is important that dependent variables are not too closely correlated; this could cause multicollinearity, which is not useful in a MANOVA. Three distinctly different dependent variables were chosen for this reason.

Data Analysis.

As previously discussed, there were two instruments and two grouping protocols used for data collection: a demographic questionnaire, the MCKAS scale, the Family Systems Concept Grouping Protocol, and the Family Based Grouping Protocol. The responses from each of these was transferred to SPSS 22 to be analyzed. In order to study the family counseling practices of counselors, a multivariate analysis (MANOVA) will be used to initially analyze the data. A MANOVA is chosen because of the desire to determine which factorial groups are associated with training or education, experience, and multicultural competence (Tabachink & Fidell, 2013). The groups were arranged based on their responses to the two grouping protocols (family-based protocol) and family systems (protocol). The groups were then analyzed. The intent in analyzing the data in this manner was to determine what factors contribute to family counseling practice groups.

The researcher then sought to further understand the data through post hoc comparisons. These post hoc comparisons were done while “thinking multivariately” as instructed by Enders (2003). A Bonferroni procedure will be used in this process by making the significance level more stringent for post hoc analyses (by dividing the level of significant in half from .05 to .25 significance) (Aron, Coups, & Aron, 2013).

Power Analysis

In order to accept the research hypothesis, the analysis being done must be significant (often to a .05 significance level) (Aron, Coups, & Aron, 2013). In order to establish a meaningful result with moderate magnitude, the researcher desires a medium effect size of .0625, for a study addressing a novel topic in the counseling field is appropriate. Through the use of G*Power it was determined that the total sample size must be 113 participants. The power of the study will be .80, which is acceptable in social sciences research (Cohen, 1992).

Delimitations

The delimitations of this study are related to the participant exclusion and inclusion criteria. By requiring participants to self identify as counselors, we are likely to eliminate participants who identify as family therapists. This will allow the researcher to understand the practice patterns of counselors regarding family. By also requiring that participants in this study be licensed, the researcher is excluding participants who cannot speak to the counseling field. The researcher has chosen to focus on the current practices of counselors in their inclusion or exclusion of families in counseling; this does not examine family counseling competence.

Limitations

The generalizability of this study will be affected by several limitations. All the instruments or protocols used are self-reported measures, which can lead to socially desirable responding and further inhibit the ability to infer the findings to all counselors. The use of the group protocols (family-based intervention group protocol and family systems concepts grouping protocol), both of which possess limited validity, will affect the overall validity of the results. Although the length of the total survey is limited, the reliability will be affected because of the number of questions. Although the researcher will work closely with her committee to eliminate any bias from the data collection procedures and analysis of the results, it will be a possible impediment. The use of convenience sampling further reduces generalizability; it would be ideal to have obtained a random sample.

The counseling field has a rich history that has continued to deepen as time has passed. This sample obtained in this study will have a wide array of experiences and backgrounds. The intended goal of this study is to understand the practices of counselors when working with families. For this reason, this study and the sample will provide a sliver of understanding of counselors and family counseling practices. Depending upon the results of this study, further research can be done to understand other factors that could be studied, such as the affects age, gender, and ethnicity have on a counselor's theoretical orientations and counseling practices.

Chapter Four: Results

This chapter presents the results from the data collected and analysis described in the previous chapter. A detailed description of the participants is presented along with a description of how the assumptions were met for the MANOVA analysis. The chapter ends with the results of the MANOVA and post hoc discriminate function analysis. As specified in the previous chapter there is one independent variable being assessed using two instruments: family systems conceptualization and family based utilization. There are three dependent variables: experience counseling families, total family counseling training hours, and reported multicultural counseling competence.

The research questions from chapter three are as follows. 1) To what extent are counselors including family in their counseling practices? 2) How are counselors including families in their counseling practice? 3) How does experience counseling with families, training in family counseling, and multicultural counseling competence differentiate counselors by level of family systems conceptualization and level of family based inclusion? The first two research questions will be analyzed using descriptive statistics and correlations. The third and principle research question will be answered using MANOVA and a post-hoc discriminate function analysis. The following research hypotheses will be addressed using those analyses as well.

Research Hypotheses

Null hypothesis one. The amount of experience, education, and MCC does not significantly differ between each group that utilizes different levels of family counseling practices ($p > .05$).

Research hypothesis one. The amount of experience, education, and MCC differs significantly between each group that utilizes different levels of family counseling practices ($p < .05$).

Description of Participants

At the conclusion of the data collection 162 participants started the survey with an initial completion rate of 29.6%. Eight participants were eliminated for not meeting the criteria of being fully licensed counselors (one participant had a distance counselor credential, one was a certified mental health counselor, three were licensed clinical social workers, one was a licensed professional counselor-intern, one was a licensed marriage and family therapist and one was a dual-licensed clinical social worker and marriage and family therapist). Thirty-two of the participants did not finish the survey and were eliminated. The final number of fully completed surveys by participants whom met the research criteria was 122 with a final completion rate of 21.9%.

Within the survey there was a demographic questionnaire (seen in Appendix C). The demographic questionnaire inquired about ethnicity, age, and gender as well as asked questions related to their highest degree and whether they attended a CACREP-accredited program. Additional questions were asked in the demographic questionnaire, which were used to answer specific research questions either through descriptive statistics or analysis, which will be introduced later.

Participants were asked to identify their ethnicity. Of the 122 participants that responded, 105 (86.1%) identified as Euro-American or European, 8 (6.6%) participants identified as African American or African, 6 (4.9%) participants identified as Hispanic or Latino, 2 (1.6%) participants identified as Native American, and 1 (.8%) participant identified as biracial or multiracial. It is noted that no participants identified as Asian or Asian American. Participants were asked to identify their gender. Of the 122 participants, 89 (73%) identified as female, 32 (26.2%) identified male and 1 (.8%) did not respond. It is noted that no participants identified as transgender. Participants were asked to identify the highest degree they have earned. Seventy-five (61.5%) identified as having earned a Master's Degree, 5 (4.1%) identified as having earned an

Educational Specialist Degree, 41 (33.6%) identified as having earned a Doctorate, and 1 person did not respond.

Participants were then asked to identify if they graduated from a CACREP-accredited program. Of the 122 participants, 81 (66.4%) participants identified as having attended a CACREP-accredited program, 29 (23.8%) participants identified as not having attended a CACREP-accredited program, and 12 (9.8%) participants identified as being unsure as to whether they attended a CACREP-accredited program. Participants were asked to identify their age and 118 participants responded to the question. The mean age was 46.51 years old with a standard deviation of 14.9 years. The youngest participant was 26 years old and the oldest participant was 78 years old.

Table 1: Demographic characteristics

Status characteristics		Frequency	Percent	Cumulative Percent
Ethno-race	Euro-American/ European	105	86.1	86.1
	African- American/African	8	6.6	92.6
	Hispanic/Latino	6	4.9	97.5
	Native	2	1.6	99.1
	Bi or Multi-racial	1	.8	100.0
	Southwest-Asian	0	0	
	Total	122	100.0	
Gender	Female	89	73.0	73.0
	Male	32	26.2	99.2
	Transgender	0	0	99.2
	No response	1	.8	100.0
	Total	122		
Highest degree	Master's	75	61.5	61.5
	Ed. Specialist	5	4.1	65.6
	Ph.D.	41	33.6	99.2
	No Response	1	.8	100.0
	Total	122	100.0	
CACREP	Yes	81	66.4	66.4
	No	29	23.8	90.2
	Unsure	12	9.8	100.0
	No Response	0		
	Total	122		

Independent Variable

The independent variable in this study is specific family counseling practices. The Family Systems concepts measure was used to identify each participant's use of family systems concepts. The family-based questionnaire simply inquires about a participant's physical inclusion of family in their counseling practice. These practices were explained in detail in chapter two.

Family Systems Concepts

Each participant responded to the family systems concepts scale. Those with higher scores signified a high level of family systems conceptualization while lower scores signified lower levels of family systems conceptualization. The mean was 34.41, the median was 35, the mode was 37, and the standard deviation was 5.227. The scores ranged from 20 to 45, with 45 being the participant(s) with the highest family systems conceptualization. Based on their responses each participant was identified as being either high or low in their use of family systems concepts. Participants with a score of 35 or higher were identified as high and participants with 25 to 34 were scored as low family systems. The score of 35 was chosen because of its relation to the mean and median. This resulted in 55 participants being coded as low in family systems concepts while 67 were coded as high.

Family-Based Inclusion

This variable is the family-based inclusion score for each participant. This score was determined based on each participant's response to two questions in the family based questionnaire. Participants response to "1) I include a client's family at least once during the duration of the counseling:" and "When I include a client's family in counseling, I tend to do so:" Participants who responded to question 1 with *almost always* or *always* were coded as high family based usage, while participants who responded with *never* or *almost never* were coded as low family based usage. Participants who responded with less often than not were coded as high if they responded to question 2 with a tendency to include family every 4 session or more;

Conversely participants that responded with less often than not were coded as low if they responded to question 2 with a tendency to include family every 5 sessions or less. This grouping resulted in 68 participants coded as low and 54 participants coded as high.

Table 2: Descriptive statistics for the dependent variables by groups

Variable	Assigned Group	Mean	Std. Deviation	N
MCKAS	Low FS/FB	177.14	19.847	44
	Inconsistent FS/FB	172.06	21.230	35
	High FS/FB	186.53	19.834	43
	Total	178.99	20.942	122
Total Training	Low FS/FB	8.32	4.787	44
	Inconsistent FS/FB	11.77	5.012	35
	High FS/FB	12.07	4.677	43
	Total	10.63	5.081	122
Total Experience	Low FS/FB	3024.69	5302.230	44
	Inconsistent FS/FB	6278.00	10817.852	35
	High FS/FB	6266.51	6001.440	43
	Total	5100.63	7604.413	122

Family Counseling Practices Groups

At this stage each participant was identified as High or Low in family systems concepts and High or Low in family-based inclusion. Participants were then divided into three groups. One group had participants who were low in both family systems concepts and family-based inclusion, which will be called low family counseling practitioners (44 participants or 36.1%), The second group was high in both family systems concepts and family-based inclusion, which will be called high family counseling practitioners (43 participants or 35.2%), and a final group with a high and a low in one or the other family counseling practices, which will be referred to as inconsistent family counseling practitioners (35 participants or 28.7%).

Instrument Validity and Reliability

After developing the instruments used in their measure, the research developed a hypothesis for each of the family counseling practice measures to establish convergent validity. First, participants who had more training would score higher in the family systems concepts

measure. Second, participants who worked with families more would have higher family-based scores. In order to answer these two hypotheses a Pearson correlation was ran to compare the variables assessed. There was a small positive correlation between family systems concept scores and total training hours, $r(122) = .265, p < .003$. There was a strong positive correlation between the family based score and percentage of family counseling experience $r(122) = .568, p < .001$.

The researcher evaluated the internal consistency of participants' responses to the family systems concept questions so as to provide preliminary support for their use in the grouping scheme. Participants' responses to the family systems concept items, which consisted of 9 questions, demonstrated an acceptable level of internal consistency as determined by the calculated Cronbach's alpha of .712. While insufficient evidence was collected to determine if these 9 items could function as a distinct psychometric instrument, the stability of the participants' responses to these items does provide support for the grouping protocol used in this study. In this analysis it was also identified that there were no individual questions that if removed would alter the alpha level significantly. .

Dependent Variables

The dependent variables were collected using the demographic questionnaire and the Multicultural Counseling Knowledge and Awareness Scale. Each of these variables is essential to answering what factors (education, skill, and attitude) influence a counselor's family counseling practice. A description of each of these variables is presented below.

Experience

Three questions were used to calculate the total hours of family counseling experience: the years of experience, the average number of direct contact hours each week, and the percent of experience that involves counseling families. These three questions resulted in an equation used to calculate their total number of family counseling hours.

The years of counseling experience ranged from 1 to 49 years of counseling. The mean was 14.86 years, the median was 10, the mode was 5, and the standard deviation was 11.655. For the average number of direct contact hours, the mean was 21.87, the median was 20, the mode was 30, and the standard deviation was 8.591. The range was from 4 hours each week to 40 hours each week.

Each participant chose a percent of clinical hours spent counseling families. Six (4.9%) participants identified 0% of their experience is with families, 25 (20.5%) participants identified 5% of their experience is with families, 11 (9.0%) participants identified 10% of their experience is with families, 10 (8.2%) participants identified 15% of their experience is with families, 9 (7.4%) participants identified 20% of their experience is with families, 8 (6.6%) participants identified 25% of their experience is with families, 9 (7.4%) participants identified 30% of their experience is with families, 4 (3.3%) participants identified 35% of their experience is with families, 5 (4.1%) participants identified 40% of their experience is with families, 1 (.8%) participant identified 45% of their experience is with families, 8 (6.6%) participants identified 50% of their experience is with families, 3 (2.5%) participants identified 55% of their experience is with families, 3 (2.5%) participants identified 60% of their experience is with families, 1 (.8%) participant identified 65% of their experience is with families, 2 (1.6%) participants identified 70% of their experience is with families, 8 (6.6%) participants identified 75% of their experience is with families, 2 (1.6%) participants identified 80% of their experience is with families, 3 (2.5%) participants identified 85% of their experience is with families, 3 (2.5%) participants identified 90% of their experience is with families, 0 (0%) participants identified 95% of their experience is with families, 1 (.8%) participant identified 100% of their experience is with families.

In order to get an approximate total number of family counseling hours, the average number of direct contact hours each week was multiplied by 50 (to signify 50 weeks a year), which was then multiplied by the years of experience. This total was then multiplied by the

percentage of family counseling hours. The mean number of family counseling hours in our sample was 5,100.63 hours, with a median of 2,068.75, a standard deviation of 7,604.413, and a range between 0 and 47,600 hours. This dependent variable is a continuous response variable as is required with a MANOVA.

Training

The dependent variable related to training is the result of three questions found in the demographic questionnaire. The three questions inquire about the number of graduate courses in family counseling, number of formal training hours in family counseling, and number of informal training hours in family counseling. Using a Pearson correlation all of these questions were found to be highly correlated (at a .001 significance), with graduate courses to formal training hours at .597, graduate courses to informal training hours at .442, and formal training hours and informal training hours at .686.

The number of graduate courses in family counseling was bimodal with a mean of 2.96, median of 2. 9 participants reported taking 0 family counseling courses, 28 reported taking 1 family counseling course, 28 reported taking 2 family counseling courses, 14 reported taking 3 family counseling courses, 9 reported taking 4 family counseling courses, 5 reported taking 5 family counseling courses, and 29 reported taking more than 5 family counseling courses.

The number of formal training hours was a multiple-choice question with blocks of hours such as 0-10 hours and 51 or more hours. 29 participants identified receiving 0 to 10 hours of formal training, 20 participants identified receiving 11 to 20 hours of formal training, 15 participants identified receiving 21 to 30 hours of formal training, 8 participants identified receiving 31 to 40 hours of formal training, 9 participants identified receiving 41 to 50 hours of formal training, and 41 participants identified receiving more than 51 hours of formal training. This data is bi-modal with peaks being on opposite ends of the data.

The number of informal training hours was similarly blocked into multiple-choice questions with hours such as 0-10 hours and 51 or more hours. Fifteen participants identified

obtaining 0 to 10 hours of informal training, 18 participants identified obtaining 11 to 20 hours of informal training, 18 participants identified obtaining 21 to 30 hours of informal training, 12 participants identified obtaining 31 to 40 hours of informal training, 8 participants identified obtaining 41 to 50 hours of informal training, and 51 participants identified obtaining more than 51 hours of informal training. This data is also bi-modal with peaks on opposite ends of the data.

These three questions were then added together to create an overall total training hours category. These totals were added together to create a scaled variable that ranged from 2 to 18; 2 representing very little total training hours (answering the minimum on all three questions) and 18 representing numerous training hours (answering each question with the highest training option available). The mean number is 10.63, the median is 10.50, the standard deviation is 5.081, and the mode was 18 hours, which was the highest possible option. This dependent variable is also a continuous response variable, as is required with a MANOVA.

Multicultural Competence

The MCKAS was used to determine each person's level of multicultural counseling competence. The mean was 178.99, the median was 181, and the standard deviation was 20.942. The minimum score was 110 and the maximum score was 224 with a range of 110. This dependent variable is also a continuous response variable as is required with a MANOVA.

In order to see how each dependent variable varies within each of the three groups a table with this information has been developed. It can be seen that the means in the MCKAS and total training hours are different between each group, while the total experience mean is similar for two groups. It is also seen that MCKAS scores are lower in the inconsistent family counseling practice group than the other two groups. Both total training and MCKAS scores are higher for the high family counseling practice groups.

MANOVA

In order to run a MANOVA it is important to assess the data to ensure it is meeting the various assumptions required to provide a proper analysis. Each of these assumptions was addressed individually at different points in the data analysis. First, in regards to the assumption of independence, each participant was assigned to only one group representing the independent variable. The sample size was more than adequate; according G*Power, the minimum was exceeded. The assumption related to the outliers require that outliers be removed from each of the dependent variables in order to reduce the likelihood of making a type II error by failing to reject the null hypothesis. Within this data set and analysis there were no outliers in the dependent variable for the result that was not significant. For this reason the researcher chose not to remove the other outliers. The researcher tested for normality of each group in each dependent variable. This check revealed that the data was normally distributed, as assessed by the Shapiro-Wilk test ($p > .05$). Each variable was identified as normal. The researcher then analyzed the relationship between the dependent variables, finding each to be linearly correlated but not too strongly to have multicollinearity. Finally there must be some homogeneity of variances; the variances of each group and the dependent variables must be homogenous. There was homogeneity of variance-covariances matrices, as assessed by Box's test of equality of covariance matrices ($p = .338$). With all of the assumptions met the researcher proceeded in using SPSS to compute the MANOVA.

MANOVA

A one-way MANOVA was run to identify how experience, training, and multicultural counseling competence affect different levels of family counseling practices. As described earlier, participants were placed in groups based on their use of family systems concepts and family based counseling. The dependent variables are the MCKAS scores, total training hours, and overall family counseling experience of each of the participants.

There was a statistically significant difference between each of the family counseling practices groups on the combined dependent variables, $F(6, 234) = 4.539, p < .0001$; Wilks' $\lambda = .802$, partial $\eta^2 = .104$. Follow-up univariate ANOVAs showed that both the MCKAS scores $F(2, 119) = 5.222, p < .007$; partial $\eta^2 = .081$ and total training hours $F(2, 119) = 7.990, p < .001$; partial $\eta^2 = .118$ were statistically significantly different between the family counseling practices groups, using a Bonferroni adjusted α level of .025. While the total experience was statistically not significant between family counseling practice groups $F(2, 119) = 2.634, p > .025$; partial $\eta^2 = .042$. Scheffe post-hoc tests showed that for MCKAS scores, participants from high family counseling practices had statistically significantly higher mean scores than participants from the inconsistent family counseling practices group ($p < .005$). For total training hours, Scheffe post-hoc tests showed that low family counseling practice participants had statistically significant lower mean total training hours than participants from either the inconsistent family counseling practices participants ($p = .008$) or high family counseling practices participants ($p = .002$).

Discriminate Function Analysis

The MANOVA was followed up with a discriminate function analysis (using only the significant dependent variables), which revealed two discriminate functions. The first explained 71.4% of the variance, canonical $R^2 = .16$, whereas the second explained only 28.6%, canonical $R^2 = .07$. In combination these discriminate functions significantly differentiated the three family therapy practice groups, $\Lambda = 0.8, \chi^2(5) = 25.6, p < .0005$.

The correlations between outcomes and the discriminate functions revealed that total training hours loaded more highly on the first function ($r = .84$) than the second function ($r = -.55$), whereas the MCKAS score loaded more on the second function ($r = .88$) than on the first function ($r = .47$). The discriminate function plot showed that the first function (the training hours) discriminated the low family counseling practice group from the high family counseling

practice group, while the second function (the MCKAS scores function) differentiated the inconsistent family counseling practice group from the other groups.

This analysis identified that total training hours differentiated the low family counseling practice group from the high family counseling practice group, this accounted for a majority of the significance. While MCC differentiated the inconsistent family counseling practices group from the other groups, this accounted for a small amount of the significance. These functions help expand on the significant MANOVA results.

Correlations

In order to understand the potential relationships within the data the researcher conducted Pearson correlations between the demographic information and the dependent and independent variables. Significant correlations are discussed here, see Table 3 for all correlations computed. It is noted that some of the highest correlations are those of age and total family training as well as age and total family counseling experience are highly correlated, which would be easily hypothesized. It can also be seen that nothing is correlated with Gender. The other significant correlations are those between the independent variable and dependent variables, which are expounded on using the MANOVA and post hoc analysis. The only other significant correlation is the between age and gender. The researcher chose not to include ethnicity or minority status within the correlation matrix because of the subjective nature of minority status, the demographic information did not include religious affiliation, sex orientation, or self-identified minority status.

Table 3: Correlations between demographics and variables

	1	2	3	4	5	6	7
1. Age	-	.185*	.257**	.356**	-.293**	-.231*	-.105
2. Gender		-	.172	.105	-.149	.061	-.143
3. Total Training hours			-	.455**	-.053	.265**	.287**
4. Total Experience				-	-.085	.028	.214*
5. MCKAS Score					-	.148	.178*
6. FS Group						-	.424**
7. FB Group							-

**Correlation is significant at the .01 level

* Correlation is significant at the .05 level

There was a small, positive correlation between age and gender. There is a negative correlation between age and MCKAS and also age and family systems concepts usage. There is a small positive correlation between family based grouping and total training hours in family counseling as well as family based grouping and total experience and also between family based grouping and MCKAS scores. There is a moderate positive correlation between family systems grouping and family based grouping. There is a moderate positive correlation between experience and age and also between age and training.

Chapter Five: Discussion

In this final chapter the finding of the study will be discussed in detail. The chapter will begin with an overview of the data collection, participants and methodology. The research questions will be presented and answered along with discussion related to each question and corresponding hypotheses. The chapter will finally conclude with limitations and implications of this study.

Overview of Study

The researcher conducted this study in order to understand the family counseling practices of counselors. There are two forms of family counseling that were assessed in this study, first family system concepts usage which is the theoretical inclusion of family and systems concepts in counseling; second, family based counseling which is the physical involvement of a client's family in the counseling process. The researcher developed a protocol for grouping participants by levels of the two family counseling practices. Then the researcher placed participants in groups in order to understand what participant factors influence family counseling practices. The participants were divided into three groups: one group contained participants with reported high levels of family systems concepts usage and high level of family based usage, one group contained participants with a low level family systems concepts usage and low level family based usage, and another group that contained participants that reported one level of low and one level of high family counseling practice. The researcher then ran a MANOVA using each group as the independent variable; the dependent variables within the MANOVA were family counseling experience, training hours, and multicultural counseling competence as assessed by the MCKAS. To conclude the data analysis the dependent variables that contributed to the significant results were input into a discriminate function analysis to understand the extent to which each variable affected the results.

The participants in this study are licensed counselors throughout the United States, with a swath of experience, anywhere between 1 and 49 years. This sample was elicited through e-mails

sent to several counseling LISTSERVES, graduate program directors, and state counseling association listings. The surveys were completed using an online survey and the data was analyzed using SPSS software.

Findings and Research Question Responses

The first two research questions for this study are: 1) To what extent are counselors including family in their counseling practices? 2) How are counselors including families in their counseling practice? These questions can be answered with descriptive statistics within the study.

This study provided insight into research question one “to what extent are counselors including family in their counseling practices?” We know that the majority (56.6%) of participants spent 25% or less of their total direct counseling hours counseling families. 20.5% reported counseling families approximately 5% of their total direct hours, while 13.9% of the participants counseled families 75% or more of their total direct hours. The majority of participants (72.1%) counseled families less than 50% of their total counseling hours. This also means that 27.9% of the participants spend a majority of their time counseling families.

Although the percentages provide insight into each participant’s physical inclusion of families in the counseling process, this only addressed physical inclusion rather than theoretical or conceptual family inclusion. The family systems concept measure helps provide a glimpse into each participant’s figurative inclusion of family systems in the counseling process. The family systems concept measure asked each participant to agree or disagree on a Likert-type scale to questions related to the manner in which they support and perceived their clients and counseling interactions. In order for participants to be considered to have no family systems conceptualization, they would score between 9-24, essentially strongly to slightly disagreeing to each and every family systems concept question. In this sample only three participants (2.5%) scored within that range (20-22). Conversely in order for participants to have a slight to strong family systems conceptualization they would score between 32-48, essentially strongly to slightly agreeing to each and every family systems conceptualization. In this sample, 83 participants

(68%) scored within that range. This means that a vast majority of the sample had a slight to strong tendency to utilize family systems concepts when working with clients.

The study also answered the second research questions “How are counselors including families in their counseling practice?” We know that counselors are most often conceptually including families in their counseling very often (68%), while a very small percentage are rarely or not at all conceptually including family in their counseling sessions (2.5%). We also know that a majority of counselors are not physically involving family in counseling a majority of the time.

The underlying response to the first two research questions is that a few counselors are physically including family a lot, 26.1% of counselors include the family in the counseling at least once during their treatment of an individual at least 75% of the time. The majority of counselors are not physically including family in the counseling much they are however conceptually adhering to family systems concepts often.

This information allows us to understand that while the majority of the sample may not be counseling families a significant amount of time they are using family systems concepts. This also tells us that within the counseling field there are more than a quarter of counselors counseling families a majority of the time. It is clear that within the sample family counseling both conceptually and physically is taking place.

The final research question: What factors (education, skill, and attitude) influence a counselor’s family counseling practice? This final question was addressed using the following hypothesis and MANOVA results.

Null hypothesis. The amount of experience, education, and MCC does not significantly differ between each group that utilizes different levels of family counseling practices ($p > .05$).

Research hypothesis. The amount of experience, education, and MCC differs significantly between each group that utilizes different levels of family counseling practices ($p < .05$).

Hypothesis

A multivariate analysis of variance was used to determine whether the combination of the dependent variables differ by levels of family counseling practitioners. As previously stated the participants were divided into three groups (both high, both low, one high/one low). Using these three groups the dependent variables were analyzed. The three dependent variables were family counseling experience, multicultural counseling competence (as assessed by the MCKAS), and total family counseling training hours. The results of the MANOVA indicated a significant difference between each group and the combined dependent variables.

A Post Hoc discriminate function analysis showed that training differentiates counselors utilizing high levels of family counseling practices from other counselors. The MCKAS scores differentiated counselors with inconsistent family counseling practices from other counselors. Essentially emphasizing the importance of family counseling training and also multicultural competence.

To answer the final research question “What factors (education, skill, and attitude) influence a counselor’s family counseling practice?” the MANOVA, univariate anovas, and discriminate function analysis identified that MCC and training most influence a counselors family counseling practices. Total training in family counseling was the most salient factor while MCC was also a factor that help influence a counselor’s family counseling practices.

Correlations

In order to understand the moderate positive correlation between experience and age and also between age and training the researcher hypothesizes that older individuals have more overall clinical experience and overall training hours. The converse would be true for older individuals reporting lower MCKAS scores because of the newer emphasis placed on MCC in the recent past. The moderate positive correlations between age and gender and between age and family systems practice groups cannot be fully understood without additional investigation. The

correlations between dependent variables and independent variables are better known because of the MANOVA and post hoc results.

These correlations allow one to understand that within the sample, men who completed the survey were more likely to be younger and that younger participants scored higher on the MCKAS and family systems groupings. With age being negatively correlated with the family systems groups and MCKAS it can be supposed that older individuals are not as well equipped to counsel with MCC and families systems concepts, this further emphasizes the potential relationship between MCC and family systems concepts.

Previous Research

It is difficult to compare previous research with these findings because the specific questions asked in this study had not previously been investigated with counselors. However there is some research that provides insight into this study's findings. First the significant body of research that discusses family counseling using the terminology of family counseling and family-based counseling can now be solidified as one group with very similar practices (Sprenkle, 2002). This study can help add a small notation that a small group of people may not be utilizing consistent family counseling practices and further help shed light on the discrepancy and possible solutions to the inconsistency.

The link between multicultural counseling and family counseling has not been fully expanded. Most of the literature can be found in the *Journal of Multicultural Counseling and Development* and alluded to a possible connection between MCC and family counseling (Hassert & Kurprius, 2011; Khodayarifard & McClenon, 2001; Krieger, 2010; Yeh, Borrero, & Tito, 2013). Finally Gushue, Constantine and Sciarra's findings noted that counselors with lower levels of MCKAS scores identified Hispanic and white case study families as having distinctly different levels of functioning (2008). This study noted the difference in how counselors perceive a family's level of functioning is highly related to a counselor's level of reported MCC. This study similarly noted the importance of MCC and family counseling.

This research can also be compared to the research done with psychologist and MFTs. Psychologist work with families between 19 and 38% of the time and most MFT counsel families 50% of the time, it is now known that a higher percentage of counselors work with families significantly less often than most psychologist and MFTs (Doherty & Simmons, 1990; Norcross, Hedges, & Castle, 2002). However there is still a quarter of counselors that work with families a majority of the time (similarly to MFTs).

Limitations of the study

Within this study there are two initial limitations that must be acknowledged first the use of survey research and second a non-experimental design (Heppner, Wampold, & Kivlighan, 2007). With survey research there is no way of knowing the causal relationships between the variables and demographic items. For this reason this study can only present a small part of the knowledge and only conjecture at possible relationships. By design there is also limited internal validity because of the potential outside influences that were not taken into account, which could have been eliminated with an experimental design and use of control group (Heppner, Wampold, & Kivlighan, 2007).

Limitations of this study can be also found in the data collection process. Participants were recruited using an e-mail that stated the purpose of the study: "to understand the family counseling practices of counselors." It is likely that participants with more family counseling experience and/or interest chose to take this survey while participants who had little or no interest in counseling families decided not to participate. This may be a reason for the participants that did not complete the survey and were not included in the final data. The lead researcher did receive response e-mails from several individuals confirming this tendency. For this reason the data may have limited generalizability. The sample also includes a high number of mature counselors, with the average age of 46.5 years old, which may also limit the generalizability to more experienced counselors. The participant sample had slightly more European American and male participants than what is found in CACREP vital statistics for 2013. This ultimately means that the data may

be less generalizable to the younger generation of counselors, this is also observed in mean counselor age.

An additional limitation found in the data collection process is the limited generalizability. Since the primary data collection was online surveys to LISTSERVES and counselors located in two states the data will not be as easily generalized to a larger national population. For this reason further research and replication of this research would be beneficial.

Additional limitations can be found in the instrumentation used. Both of the family counseling practices grouping protocols were developed for this specific study, which is a significant limitation of this study. The family systems concepts scale has not been previously used or validated, although it had an acceptable Cronbach's Alpha. It would benefit from going through further scrutiny for better validation and factor analysis. The family based questionnaire additionally limits the researcher's ability to make inferences.

In order to increase the response rate the researcher made the study as short as possible while eliciting enough information to answer the research questions and present some demographic questions. The researcher did not ask any questions seeking to inquire about the reasons behind counselors working with families; a few pilot participants noted this. This is especially important because of the counseling field's tendency to make decisions that are ultimately determined by third party payers or program requirements rather than therapeutic choice or judgment.

Implications for counselors

This study sheds light on the importance of training in family counseling within this specific sample. It is known that counselors within this sample whom see families often have more training to do so, especially beginning in graduate programs. While training and practice correlated for some participants, others reported practice without training and MCC and subsequent inconsistent integration of family counseling practices. One could postulate that those who don't have training do not practice family counseling because they don't feel competent to

do so rather than because of the therapeutic value. Within this sample family systems concepts are being used by a majority of counselors even if the family does not attend the counseling. Within this sample each counselor's experience counseling families is not a necessary component for those who use high levels of family counseling practice. Within this sample experience is not as important as training or multicultural counseling competence.

Another finding is the potential link between family counseling practices and multicultural counseling competence. This link previously has not directly been studied, once these finding can be replicated it could allow the counseling field to appreciate the relationship between a counselor's MCC and family counseling practices. This knowledge demonstrates another possible way to train and encourage MCC, through introduction of family counseling practices.

Implications for counselor educators

It has already been presented that the literature related to specific family counseling practices in counselor education is lacking. This study presents new information to begin a needed dialogue about family counseling training within the counseling field. This study's sample showed the extent to which counselors may be including family in their clinical practices; it can also be understood that within this sample training in family counseling was important for those using family counseling practices. This is even more significant when put in context of the MANOVA results in which the most important contributing factor of family counseling practices are directly related to family counseling training.

The link between family counseling practices and MCC being introduced in this study also further demonstrates the importance of training counselors to work with families potentially because they will likely be more multiculturally sensitive and aware. If replicated these finding can also support the inclusion of family systems education in multicultural counseling courses as well as other core courses. The 2015 ACA code of ethics encourages family inclusion in

counseling when it may be beneficial; these findings can help expand the use of beneficial to also include its multicultural value.

Implications for further research

This study introduces several potential areas and implications of future research. The first and foremost lies in the need for validated family counseling measures. It will be important for the counseling field to be able to gage each counselor's level of family counseling practices and for this reason having a developed measure could be helpful. Additional research could be useful in further examination of family counseling practices of counselors, such as understanding the motivations and purposes for clinicians who do or do not include family in the counseling process. Qualitative research regarding the use of specific practices used by counselors who include families in counseling could help encourage more inclusion of families in counseling. Additional research could be done with counselor educators and the ways family counseling is integrated into core curriculum courses. With the link to MCC it could be helpful to research what may lead to higher MCC within those who practice family counseling more. Is it possible that those graduating from marriage and family programs have a higher level of MCC? It could also be useful to replicate these findings with a broader population of less experienced counselors.

It would be beneficial to do more research to assess the impact of each CACREP specialization on family counseling practices, addressing the research question of whether there is a specialization that tends to be more MCC. It could also be helpful to further research the role gender and minority status may play in family counseling practices and MCC. Once the group protocols from this study has been further validated these factors could easily be researched by adding additional culturally relevant questions (such as sex orientation, religious identification, and ethnicity) as well as specialty training area. Once these factors and their interactions have been studied in relation to family counseling practices and MCC research could begin to expand

on the motivations and causes of various family counseling practice levels (through qualitative and quantitative methods).

Conclusion

This study helped understand the current family counseling practices within the counseling field. Within this sample it was found that counselors are counseling families (a quarter of counselors are counseling families a majority of the time) and a majority of counselors are using family systems concepts. It was also discovered that counselors who utilize higher levels of family counseling practices tend to be trained to do so and also have higher multicultural competence. While family-counseling experience is not related to the use of family systems concepts or family based counseling, it was found that total training and MCC was related to family counseling practices. It was also found that inconsistent family counseling practices may be related to lower MCC.

Chapter Six: Manuscript

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Abstract

The ACA code of ethics encourages the inclusion of family in the therapeutic process when doing so can be considered positive (ACA, 2014). Additionally, family dynamics are an important component of counseling for clients from diverse cultural backgrounds. A critical review of the literature reveals that there are differences between conceptual and physical inclusions of families in counseling. Counselors can use a family systems theoretical lens and/or incorporate family-based interventions. The purpose of this study was to investigate how counselors include families in counseling and what factors are associated with family counseling practice. Variables assessed include training and coursework, experience, and multicultural competence. A MANOVA showed that there is a significant difference between family counseling practice groups (High, Low, Inconsistent) and the multivariate dependent variables. Post Hoc analysis further described these differences as being focused on training in family counseling and also in reported multicultural counseling competence (as measured by the MCKAS). Limitations, implications for training and practices, and future directions for research are discussed.

Keywords: Family-Based Counseling, Family Systems Counseling, Multicultural Counseling

Factors associated with family counseling practices: The effects of training, experience, and multicultural counseling competence

In order to explicate an individual's pathology or to help remedy the individual's struggle, the founders of the counseling field occasionally integrated an individual's family in the counseling process (Walsh & McGraw, 2002). Those early founding practices contained aspects of family-systems counseling and family-based interventions, whether is be Freud's Oedipal or Electra complex or Berg's Solution Focused book entitled *Family-Based Services*. As the mental health field has evolved a dichotomy has developed; some counselors and therapists have become focused on the individual, while others, often called marriage and family therapists (MFT), have become focused on family units.

As the mental health field has evolved a dichotomy has developed; some counselors and therapists have become focused on the individual, while others, often called marriage and family therapists (MFT), have become focused on family units. This dichotomy is evident in professional identity but not necessarily in practice. Approximately half of the treatment provided by marriage and family therapists is individual in nature with mood disorders and behavioral problems being two of the top presenting problems seen (Doherty & Simmons, 1990).

Family counseling or therapy is often focused on systemic theories; these theories have evolved over the last 80 years since Adler's and Ackerman's introduction of families in counseling and the initial family systems theories were developed by Adler, Satir, and Bowen (Bitter, 2013). Systemic theories tend to view problems from a perspective of circular causation of individual dysfunctions. The term circular causation postulates that problems are not linear, or as simple as cause and effect, but more complex and circular.

This is distinctly different from the majority of counselors who are trained in psychodynamic, person centered, and cognitive-behavioral theories developed by Freud, Rogers, and Beck (to name a few). These theories have ranged in paradigms from Freud's focus on subconscious motivations to Beck's linear causality and most recently to symptom alleviation

such as de Shazer and Berg's Solution focused theory (Bitter, 2013). The manner in which these two schools of thought view pathology and best practices are very different from one another; with family system concepts looking toward outside influences and individuals counseling concepts looking at inward influences.

In the past, counseling programs typically trained counselors in linear, individual, or intra-psychoic counseling traditions (Sexton, 1994). Linear counseling focuses on the individual (personality and traits) as the client, seeking a Newtonian truth from a linear cause, and promotes the belief that actions can be understood with the use of objective reasoning (Smith, Carlson, Steven-Smith & Dennison, 1995). Today, counseling programs help train counselors in symptom identification and alleviation (Bitter, 2013). This type of training can often involve diagnosis of disorders and the introduction of ways to reduce or manage dysfunction. This type of counseling has become implicitly focused on individual experience rather than context (Bitter, 2013).

Family systems counselors see the family as the client, and the focus is on the relational patterns and interactions within which clients experience, define, and create their subjective mode of existence (Haley, 1961; Bowen 1978). They tend to believe that there is a complex set of multiple truths that can be understood only with systemic exploration from multiple perspectives (Minuchin & Nichols, 1993). The original family systems theorists promoted the view that there is rarely a linear (or causal) reason for an individual's actions; circularity is inevitable (Bateson, 1979). Family systems counselors see that actions are to always be considered within numerous contexts. There is a deep web of interconnectedness that guides actions, that is often unknown or unrealized (Haley, 1976; Bowen, 1978).

The term *family counseling* is often synonymous with the use of family systems concepts; these concepts are a theoretical framework in which the counselor views the family as the cause of dysfunctions and/or the focus of interventions (Bitter, 2013). However, there is also an area of literature that describes and discusses interventions that involve family members in counseling called family-based interventions (Sprenkle, 2002; Berg, 1994). The use of family systems

concepts is conceptual whereas the use of family-based interventions is concrete. The literature that addresses family counseling is vague, especially as it relates to the conceptual framework or concrete interventions used in counselors' work with families.

While research has validated the efficacy of family counseling, the literature that validates family counseling often lacks specificity regarding the practices being used (Sprenkle, 2002). When analyzing the use of family in counseling, there are two evidence-based family counseling practices that arise from the literature. First is family counseling that involves an individual's family in the treatment without adhering to a family systems' conceptualization per se (Kendell, 1994; Kendell, 1997). This mode of family involvement will be referred to as family-based counseling. Family-based interventions have proven to be cost-effective and provide strong therapeutic outcomes (Baldwin & Huggins, 1997; Shadish, Ragsdale, Glaser, & Montgomery, 1995).

Second, treatment provided by MFTs, most often trained in family-systems concepts, have shown to be efficacious in treating various populations or presenting problems including childhood disorders, addictions, and schizophrenics (Mari & Streiner, 1994; Montgomery, 1991; Shadish, 1993). Family-systems based interventions may, but do not always, include interaction between other members of the identified client's family unit and the counselor or therapist.

To reiterate, family-based counseling involves the intentional literal involvement of family members in the counseling process regardless of theoretical orientation. Family-systems counseling involves counseling from an explicit family-systems theoretical framework with or without the literal involvement of the identified client's family members. A counseling relationship can be both family-based and family-systems, one or the other, or neither. It is clear that both of the two family counseling practices are supported in the literature, but it is unclear how much counselors are using either of these practices.

A review of the literature reveals numerous studies that identify the importance of the family in counseling diverse populations. Unfortunately, research done in this area is limited to

obscure populations and presenting problems, which lead to small sample sizes and limited generalizability (Dupree, Bhakta, Patel & Dupree, 2013; Krieger, 2010). Although the research is limited, there are numerous studies that underscore the multicultural counseling implications of family inclusion in counseling. One study even found that counselors view different families as more or less symptomatic based on ethnicity alone (Gushue, Constatine, & Sciarra, 2008). Given this literature and the understood value of multicultural counseling, a possible link to family counseling practices seems appropriate to explore (Ponterro, Cases, Suzuki, & Alexander, 2001).

The purpose of this quantitative analysis is twofold; first to understand the current practices of counselors as they relate to family inclusion in counseling, and second to inquire as to what factors are associated with family counseling practice. While the first purpose will be answered with an array of descriptive statistics, the latter purpose will be answered using a MANOVA. The research hypothesis is that the amount of experience, education, and MCC differs significantly between each group that utilizes different levels of family counseling practices ($p < .05$).

Method

Design and Procedure

The data was collected using an online survey. The initial email included information about the survey purpose, confidentiality, and researcher contact information. The email also contained a link to informed consent that then led to a survey containing the four instruments being used. This online survey contained 60 questions, excluding the consent form. Prior to data collection, the Institutional Review Board at Old Dominion University approved this study.

The sample was obtained using convenience sampling; participants were recruited through emails sent through state counseling associations and LISTSERV email lists. Graduate program directors and instructors in various counseling programs also received an e-mail

requesting participants. After completing the entire survey participants were given the opportunity to be entered into the drawing.

The emails sent out included an initial description, purpose of the study and information related to consent and confidentiality. Within the email there was a link to the consent form that was signed electronically; within the consent form, each participant will be informed of the risks and benefits of participating and their right to refuse to participate or withdrawal from the study at any time. After completion of the consent form, each participant will begin the survey with the included instruments.

A MANOVA was chosen because of the desire to determine the conditions or factors that could explain the differences that exists between each of the groups representing different levels of the independent variable. This is different from a regression, which helps describe linear relationships between two or more within-group variables. The MANOVA procedure is more powerful than the ANOVA, as more variables can be assessed with fewer tests decreasing the likelihood of a type one error. By only running one tests rather than several there is less chance to generate a false positive also called a type one error. Each dependent variable is conceptually linked to the domain of counseling competence and so analyzing them together as a multivariate dependent variable is warranted. A multivariate analysis of variance was chosen for this study because of the hypothesized relevance each of the three dependent variables play in the use of family counseling practices. It is hypothesized that the three dependent variables compound in a manner that can explain a counselor's family counseling practices.

Power Analysis

In order to accept the research hypothesis, the analysis being done must be significant (often to a .05 significance level) (Aron, Coups, & Aron, 2013). In order to establish a meaningful result with moderate magnitude, the researcher desires a medium effect size of .0625, for a study addressing a novel topic in the counseling field is appropriate. Through the use of

G*Power it was determined that the total sample size must be 113 participants. The power of the study will be .80, which is acceptable in social sciences research (Cohen, 1992).

Participants

The researcher sent 557 personalized e-mails to obtain participants. At the conclusion of the data collection 162 participants started the survey with an initial completion rate of 29.6%. Eight participants were eliminated for not meeting the criteria of being fully licensed counselors (one participant had a distance counselor credential, one was a certified mental health counselor, three were licensed clinical social workers, one was a licensed professional counselor-intern, one was a licensed marriage and family therapist and one was a dual-licensed clinical social worker and marriage and family therapist). Thirty two of the participants did not finish the survey and were eliminated. The final number of fully completed surveys by participants whom met the research criteria was 122 with a final completion rate of 21.9%.

Participants were asked to identify their ethnicity. Of the 122 participants that responded, 105 (86.1%) identified as Euro-American or European, 8 (6.6%) participants identified as African American or African, 6 (4.9%) participants identified as Hispanic or Latino, 2 (1.6%) participants identified as Native American, and 1 (.8%) participant identified as biracial or multiracial. It is noted that no participants identified as Asian or Asian American. Participants were asked to identify their gender. Of the 122 participants, 89 (73%) identified as female, 32 (26.2%) identified male and 1 (.8%) did not respond. It is noted that no participants identified as transgender. Participants were asked to identify the highest degree they have earned. Seventy-five (61.5%) identified as having earned a Master's Degree, 5 (4.1%) identified as having earned an Educational Specialist Degree, 41 (33.6%) identified as having earned a Doctorate, and 1 person did not respond.

Participants were asked to identify their age and 118 participants responded to the question. The mean age was 46.51 years old with a standard deviation of 14.9 years. The youngest participant was 26 years old and the oldest participant was 78 years old.

Instrumentation

In order to answer the research questions, there were two instruments and two family counseling practices grouping protocols utilized. A previously developed and validated 32-item multicultural counseling measure along with three measures or protocols developed by the researcher (one demographic questionnaire and two family counseling group protocols) will be utilized. These four instruments provided the researcher with information about the variables and participants being studied.

Demographic Questionnaire

The purpose of the questionnaire is twofold. First, the demographic questionnaire allowed the researcher to provide a description of the participants within the study such as participants' age, sex, and ethnicity. Second, the demographic questionnaire collected several of the dependent variables; questions about each participant's number of family counseling graduate courses, training hours and experience counseling families. The demographic questionnaire can be found in Appendix C. Additional questions that were asked were the participants licenses, perceived competence in family counseling (both family-based and family systems) and whether they attended a CACREP-accredited program.

Multicultural Counseling Knowledge and Awareness Scale

To assess each participant's perceived multicultural competence, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) will be used (see Appendix D). This measure was chosen for several reasons. First, using the MCKAS negates the need for an additional social desirability response measure. Social desirability is a concern when doing research because people can answer questions either consciously or subconsciously in a manner that is more congruent with societal expectations rather than reality. This is especially true when doing research in the multicultural arena because of the strong societal beliefs in a topic with various hidden biases.

Second, the MCKAS was chosen because it is eight items shorter than the MCI (discussed in chapter two). The length of a measure can affect the reliability of the overall survey. The more succinct a survey, the more likely participants that start the survey will finish the survey. By minimizing dropout participants the researcher will be obtaining a wider swath of the intended population.

The third and final reason the MCKAS was chosen was for its proven reliability and validity. The initial validity and reliability measured at an alpha of .86, while later studies have the alphas being between .75 to .95, which even further demonstrates the measure's reliability (Choa 2012; Choa, 2013; Neville, Spanierman & Doan, 2006; Ponterro et al., 2002). Additional studies done since the original validation have further reinforced the validation and reliability (Hays, 2008; Ivers 2012). The MCKAS was developed in 2002 as a revised adaption of a Multicultural Counseling Awareness Scale in 1996 (Ponterro et al., 2002). When initially introduced and published it was tested and revised twice in order to prove strong validity. As it has continued to be used since 2002, it has shown to be reliable and valid.

The MCKAS has two subscales: one of knowledge and one of awareness, with 10 questions that are reverse scored for a negative case analysis. A sample question is: "I believe that all clients must view themselves as their number one responsibility" (Awareness subscale, negative case analysis) and "I am knowledgeable of acculturation models for various ethnic minority groups" (Knowledge subscale) (Ponterro et al., 2002).

Family Counseling Practice Group Protocols

As previously discussed there is one independent variable (family counseling practice). For the data analysis this independent variable is what distinguishes each of the groups from one another. These groups were created using a group scheme that utilized two grouping protocols; the two protocols are introduced below.

Family Systems Concepts Grouping Protocol. There are no specific instruments currently developed to provide insight into a counselor's family system's orientation practices. In order to

identify if counselors are using a family systems approach in counseling a conceptual grouping protocol was developed (see appendix E). This protocol was developed with four key family systems concepts, with a positive and negative case analysis for each of the four concepts. There are questions for each concept that allowed the researcher to ensure some internal consistency reliability.

Through reading texts that discuss the difference between individual counseling and family counseling, there were four main points identified by each text (Bitter, 2014; Nichols & Schwartz, 2005; Walsh & McGraw, 2002). These four main family systems concepts being assessed are as follows.

- The family systems counselor's desire to understand the family process and patterns rather than only trying to diagnose pathology.
- The systems counselor's desire to embrace the client's family and other influential systems rather than seeing the client as an autonomous individual.
- The system counselor's desire to understand the relational roots of problems rather than the individual's perceived struggles.
- The system counselor's desire focus on relational interactions as opposed to focusing on alleviating the client's individual symptoms.

Each of these four concepts were used in this protocol to provide questions for each concept as well as a negative case analysis. These four concepts are identified as underlying foundations of all family-systems counseling, especially when compared to individual counseling (Bitter, 2013; Walsh & McGraw, 2002).

Two strategies were used to establish construct validity of this protocol. After developing the questions using guidance from family counseling texts, the researcher met with four experts in both individual and family systems counseling. During this initial review, each expert critiqued the protocol and changes were made to each question. This process was evolutionary, with each

expert's critique leading to a new revision. Four revisions were made, with each revision improving upon the previous one. Prior to the final dissemination, the protocol was piloted with twenty practicing counselors. These pilot participants were given a five-dollar Starbucks card (using an e-mail address again to ensure maximum anonymity). After the 20 pilot participants had completed the entire survey, the researcher worked with a research team to review the feedback provided by the pilot participants. This process led to minor changes in overall survey but no change was suggested to this particular grouping protocol measure.

Family Based Intervention Grouping Protocol. In order to understand the participant's family-based usage, there is no need to assess for concepts, goals, or objectives. The goal was to inquire about how often they include the family of a client in counseling. This protocol was a short questionnaire about the participant's practice of including families, the question used to identify a participant's level of family based counseling is "I include a client's family at least once during the duration of the counseling" with multiple choice percentage responses to choose from "When I include family I tend to do so" with number of session responses to choose from (see Appendix F). Similar to the previous protocol, two strategies were used to establish construct validity initial expert review and pilot with 20 participants. Once again no major changes were suggested to this measure.

Results

Independent Variable: Family-Counseling Practices

The independent variable in this study is specific family counseling practices. The Family Systems concepts measure was used to identify each participant's use of family systems concepts. The family-based questionnaire simply inquires about a participant's physical inclusion of family in their counseling practice.

Family Based Grouping. This score was determined based on each participant's response to two questions in the family based questionnaire. Participants response to "1) I include a client's

family at least once during the duration of the counseling:” and “When I include a client’s family in counseling, I tend to do so:” Participants who responded to question 1 with *almost always* or *always* were coded as high family based usage, while participants who responded with *never* or *almost never* were coded as low family based usage. Participants who responded with more often than not were coded as high if they responded to question 2 with a tendency to include family every 4 session or more; Conversely participants that responded with less often than not were coded as low if they responded to question 2 with a tendency to include family every 5 sessions or less. This grouping resulted in 68 participants coded as low and 54 participants coded as high.

Family Systems Grouping. Each participant responded to the family systems concepts scale. Those with higher scores signified a high level of family systems conceptualization while lower scores signified lower levels of family systems conceptualization. The mean was 34.41, the median was 35, the mode was 37, and the standard deviation was 5.227. The scores ranged from 20 to 45, with 45 being the participant(s) with the highest family systems conceptualization.

Based on their responses each participant was identified as being either high or low in their use of family systems concepts. Participants with a score of 35 or higher were identified as high and participants with 25 to 34 were scored as low family systems. The score of 35 was chosen because of its relation to the mean and median. This resulted in 55 participants being coded as low in family systems concepts while 67 were coded as high.

Final Family Counseling Practices Groups. Each participant was identified as High or Low in family systems concepts and High or Low in family-based inclusion. Participants were then divided into three groups. One group had participants who were low in both family systems concepts and family-based inclusion, which will be called low family counseling practitioners (44 participants or 36.1%). The second group was high in both family systems concepts and family-based inclusion, which will be called high family counseling practitioners (43 participants or 35.2%). The final group with a high and a low in one or the other family counseling practices,

which will be referred to as inconsistent family counseling practitioners (35 participants or 28.7%).

Dependent Variables: Factors

Multicultural Counseling Competence. The MCKAS was used to determine each person's level of multicultural counseling competence. The mean was 178.99, the median was 181, and the standard deviation was 20.942. The minimum score was 110 and the maximum score was 224 with a range of 110. This dependent variable is also a continuous response variable as is required with a MANOVA.

Experience

Three questions were used to calculate the total hours of family counseling experience: the years of experience, the average number of direct contact hours each week, and the percent of experience that involves counseling families. These three questions resulted in an equation used to calculate their total number of family counseling hours.

The years of counseling experience ranged from 1 to 49 years of counseling. The mean was 14.86 years, the median was 10, the mode was 5, and the standard deviation was 11.655. For the average number of direct contact hours, the mean was 21.87, the median was 20, the mode was 30, and the standard deviation was 8.591. The range was from 4 hours each week to 40 hours each week.

Training. This dependent variable related to training is the result of three questions found in the demographic questionnaire. The three questions inquire about the number of graduate courses in family counseling, number of formal training hours in family counseling, and number of informal training hours in family counseling. Using a Pearson correlation all of these questions were found to be highly correlated (at a .001 significance), with graduate courses to formal training hours at .597, graduate courses to informal training hours at .442, and formal training hours and informal training hours at .686.

Group Dependent Variables

In order to see how each dependent variable varies within each of the three groups a table with this information has been developed. It can be seen that the means in the MCKAS and total training hours are different between each group, while the total experience mean is similar for two groups. It is also seen that MCKAS scores are lower in the inconsistent family counseling practice group than the other two groups. Both total training and MCKAS scores are higher for the high family counseling practice groups.

Table 1: Descriptive statistics for the dependent variables by groups

Variable	Assigned Group	Mean	Std. Deviation	N
MCKAS	Low FS/FB	177.14	19.847	44
	Inconsistent FS/FB	172.06	21.230	35
	High FS/FB	186.53	19.834	43
	Total	178.99	20.942	122
Total Training	Low FS/FB	8.32	4.787	44
	Inconsistent FS/FB	11.77	5.012	35
	High FS/FB	12.07	4.677	43
	Total	10.63	5.081	122
Total Experience	Low FS/FB	3024.69	5302.230	44
	Inconsistent FS/FB	6278.00	10817.852	35
	High FS/FB	6266.51	6001.440	43
	Total	5100.63	7604.413	122

Data Analysis

In order to run a MANOVA it is important to assess the data to ensure it is meeting the various assumptions required to provide a proper analysis. Each of these assumptions was addressed individually at different points in the data analysis. First, in regards to the assumption of independence, each participant was assigned to only one group representing the independent variable. The sample size was more than adequate; according G*Power, the minimum was exceeded. The assumption related to the outliers require that outliers be removed from each of the dependent variables in order to reduce the likelihood of making a type II error by failing to reject the null hypothesis. Within this data set and analysis there were no outliers in the dependent

variable for the result that was not significant. For this reason the researcher chose not to remove the other outliers. The researcher tested for normality of each group in each dependent variable. This check revealed that the data was normally distributed, as assessed by the Shapiro-Wilk test ($p > .05$). Each variable was identified as normal. The researcher then analyzed the relationship between the dependent variables, finding each to be linearly correlated but not too strongly to have multicollinearity. Finally there must be some homogeneity of variances; the variances of each group and the dependent variables must be homogenous. There was homogeneity of variance-covariance matrices, as assessed by Box's test of equality of covariance matrices ($p = .338$). With all of the assumptions met the researcher proceeded in using SPSS to compute the MANOVA.

MANOVA

A one-way MANOVA was run to identify how experience, training, and multicultural counseling competence affect different levels of family counseling practices. As described earlier, participants were placed in groups based on their use of family systems concepts and family based counseling. The dependent variables are the MCKAS scores, total training hours, and overall family counseling experience of each of the participants.

There was a statistically significant difference between each of the family counseling practices groups on the combined dependent variables, $F(6, 234) = 4.539, p < .0001$; Wilks' $\lambda = .802$, partial $\eta^2 = .104$. Follow-up univariate ANOVAs showed that both the MCKAS scores $F(2, 119) = 5.222, p < .007$; partial $\eta^2 = .081$ and total training hours $F(2, 119) = 7.990, p < .001$; partial $\eta^2 = .118$ were statistically significantly different between the family counseling practices groups, using a Bonferroni adjusted α level of .025. While the total experience was statistically not significant between family counseling practice groups $F(2, 119) = 2.634, p > .025$; partial $\eta^2 = .042$. Scheffe post-hoc tests showed that for MCKAS scores, participants from high family counseling practices had statistically significantly higher mean scores than participants from the

inconsistent family counseling practices group ($p < .005$). For total training hours, Scheffe post-hoc tests showed that low family counseling practice participants had statistically significant lower mean total training hours than participants from either the inconsistent family counseling practices participants ($p = .008$) or high family counseling practices participants ($p = .002$).

Discriminate Function Analysis

The MANOVA was followed up with a discriminate function analysis (using only the significant dependent variables), which revealed two discriminate functions. The first explained 71.4% of the variance, canonical $R^2 = .16$, whereas the second explained only 28.6%, canonical $R^2 = .07$. In combination these discriminate functions significantly differentiated the three family therapy practice groups, $\Lambda = 0.8$, $\chi^2(5) = 25.6$, $p < .0005$.

The correlations between outcomes and the discriminate functions revealed that total training hours loaded more highly on the first function ($r = .84$) than the second function ($r = -.55$), whereas the MCKAS score loaded more on the second function ($r = .88$) than on the first function ($r = .47$). The discriminate function plot showed that the first function (the training hours) discriminated the low family counseling practice group from the high family counseling practice group, while the second function (the MCKAS scores function) differentiated the inconsistent family counseling practice group from the other groups.

This analysis identified that total training hours differentiated the low family counseling practice group from the high family counseling practice group, this accounted for a majority of the significance. While MCC differentiated the inconsistent family counseling practices group from the other groups, this accounted for a small amount of the significance. These functions help expand on the significant MANOVA results.

Correlations

In order to understand the potential relationships within the data the researcher conducted a Pearson correlation between the demographic information and the dependent and independent

variables. It is noted that some of the highest correlations are those of age and total family training as well as age and total family counseling experience are highly correlated, which would be easily hypothesized. It can also be seen that nothing is highly correlated with Gender. The other significant correlations are those between the independent variable and dependent variables, which are expounded on using the MANOVA and post hoc analysis. The only other significant correlation is the between age and gender. The researcher chose not to include ethnicity or minority status within the correlation matrix because of the subjective nature of minority status, the demographic information did not include religious affiliation, sex orientation, or self-identified minority status.

Table 2: Correlations between demographics and variables

	1	2	3	4	5	6	7
1. Age	-	.185*	.257**	.356**	-.293	-.231*	-.105
2. Gender		-	.172	.105	-.149	.061	-.143
3. Total Training hours			-	.455**	-.053	.265**	.287**
4. Total Experience				-	-.085	.028	.214*
5. MCKAS Score					-	.148	.178*
6. FS Scores						-	.424**
7. FB Score							-

**Correlation is significant at the .01 level

* Correlation is significant at the .05 level

Discussion

This study provided insight into research question one “to what extent are counselors including family in their counseling practices?” We know that the majority (56.6%) of participants spent 25% or less of their total direct counseling hours counseling families. 20.5% reported counseling families approximately 5% of their total direct hours, while 13.9% of the participants counseled families 75% or more of their total direct hours. The majority of participants (72.1%) counseled families less than 50% of their total counseling hours. This also means that 27.9% of the participants spend a majority of their time counseling families.

Although the percentages provide insight into each participant’s physical inclusion of families in the counseling process, this only addressed physical inclusion rather than theoretical

or conceptual family inclusion. The family systems concept measure helps provide a glimpse into each participant's figurative inclusion of family systems in the counseling process. The family systems concept measure asked each participant to agree or disagree on a Likert-type scale to questions related to the manner in which they support and perceived their clients and counseling interactions. In order for participants to be considered to have no family systems conceptualization, they would score between 9-24, essentially strongly to slightly disagreeing to each and every family systems concept question. In this sample only three participants (2.5%) scored within that range (20-22). Conversely in order for participants to have a slight to strong family systems conceptualization they would score between 32-48, essentially strongly to slightly agreeing to each and every family systems conceptualization. In this sample, 83 participants (68%) scored within that range. This means that a vast majority of the sample had a slight to strong tendency to utilize family systems concepts when working with clients.

The study also answered the second research questions "How are counselors including families in their counseling practice?" We know that counselors are most often conceptually including families in their counseling very often (68%), while a very small percentage are rarely or not at all conceptually including family in their counseling sessions (2.5%). We also know that a majority of counselors are not physically involving family in counseling a majority of the time.

The underlying response to the first two research questions is that a few counselors are physically including family a lot, 26.1% of counselors include the family in the counseling at least once during their treatment of an individual at least 75% of the time. The majority of counselors are not physically including family in the counseling much they are however conceptually adhering to family systems concepts often.

This information allows us to understand that while the majority of the sample may not be counseling families a significant amount of time they are using family systems concepts. This also tells us that within the counseling field there are more than a quarter of counselors

counseling families a majority of the time. It is clear that within the sample family counseling both conceptually and physically is taking place.

A multivariate analysis of variance was used to determine whether the combination of the dependent variables differ by levels of family counseling practitioners. As previously stated the participants were divided into three groups (both high, both low, one high/one low). Using these three groups the dependent variables were analyzed. The three dependent variables were family counseling experience, multicultural counseling competence (as assessed by the MCKAS), and total family counseling training hours. The results of the MANOVA indicated a significant difference between each group and the combined dependent variables.

A Post Hoc discriminate function analysis showed that training differentiates counselors utilizing high levels of family counseling practices from other counselors. The MCKAS scores differentiated counselors with inconsistent family counseling practices from other counselors. Essentially emphasizing the importance of family counseling training and also multicultural competence.

To answer the final research question “What factors (education, skill, and attitude) influence a counselor’s family counseling practice?” the MANOVA, univariate ANOVAs, and discriminate function analysis identified that MCC and training most influence a counselors family counseling practices. Total training in family counseling was the most salient factor while MCC was also a factor that help influence a counselor’s family counseling practices.

It is difficult to compare previous research with these findings because the specific questions asked in this study had not previously been investigated with counselors. However there is some research that provides insight into this study’s findings. First the significant body of research that discusses family counseling using the terminology of family counseling and family-based counseling can now be solidified as one group with very similar practices; this study can help add a small notation to that practice by noting that a group of people may not have consistent family counseling practices (Sprenkle, 2002).

The link between multicultural counseling and family counseling has not been expanded on significantly in the past with large studies, but the articles found in the *Journal of Multicultural Counseling and Development* opened the door to a possible connection between MCC and family counseling (Hassert & Kurprios, 2011; Khodayarifard & McClenon, 2001; Krieger, 2010; Yeh, Borrero, & Tito, 2013). Finally Gushue, Constantine and Sciarra's findings noted that counselors with lower levels of MCKAS scores identified Hispanic and white case study families as having distinctly different levels of functioning (2008). While that study noted the difference in how counselors perceive a family's level of functioning is highly related to a counselor's level of reported MCC. This study similarly noted the importance of MCC and family counseling while providing counselor educators with knowledge regarding the power training in family counseling and multicultural counseling competence.

This research can also be compared to the research done with psychologist and MFTs. Psychologist work with families between 19 and 38% of the time and most MFT counsel families 50% of the time, it is now known that a higher percentage of counselors work with families significantly less often than most psychologist and MFTs (Doherty & Simmons, 1990; Norcross, Hedges, & Castle, 2002). However there are still a quarter of counselors that work with families a majority of the time (similarly to MFTs).

Within this study there are two initial limitations that must be acknowledged first the use of survey research and second a non-experimental design (Heppner, Wampold, & Kivlighan, 2007). With survey research there is no way of knowing the causal relationships between the variables and demographic items. For this reason this study can only present a small part of the knowledge and conjecture at possible relationships. By design there is also limited internal validity because of the potential outside influences that were not taken into account, which could have been eliminated with an experimental design and use of control group (Heppner, Wampold, & Kivlighan, 2007).

Limitations of the study

Within this study there are two initial limitations that must be acknowledged first the use of survey research and second a non-experimental design (Heppner, Wampold, & Kivlighan, 2007). With survey research there is no way of knowing the causal relationships between the variables and demographic items. For this reason this study can only present a small part of the knowledge and only conjecture at possible relationships. By design there is also limited internal validity because of the potential outside influences that were not taken into account, which could have been eliminated with an experimental design and use of control group (Heppner, Wampold, & Kivlighan, 2007).

Limitations of this study can be also found in the data collection process. Participants were recruited using an e-mail that stated the purpose of the study: “to understand the family counseling practices of counselors.” It is likely that participants with more family counseling experience and/or interest chose to take this survey while participants who had little or no interest in counseling families decided not to participate. This may be a reason for the participants that did not complete the survey and were not included in the final data. The lead researcher did receive response e-mails from several individuals confirming this tendency. For this reason the data may have limited generalizability. The sample also includes a high number of mature counselors, with the average age of 46.5 years old, which may also limit the generalizability to more experienced counselors. The participant sample had slightly more European American and male participants than what is found in CACREP vital statistics for 2013. This ultimately means that the data may be less generalizable to the younger generation of counselors, this is also observed in mean counselor age.

An additional limitation found in the data collection process is the limited generalizability. Since the primary data collection was online surveys to LISTSERVES and counselors located in two states the data will not be as easily generalized to a larger national population. For this reason further research and replication of this research would be beneficial.

Additional limitations can be found in the instrumentation used. Both of the family counseling practices grouping protocols were developed for this specific study, which is a significant limitation of this study. The family systems concepts scale has not been previously used or validated, although it had an acceptable Cronbach's Alpha. It would benefit from going through further scrutiny for better validation and factor analysis. The family based questionnaire additionally limits the researcher's ability to make inferences.

In order to increase the response rate the researcher made the study as short as possible while eliciting enough information to answer the research questions and present some demographic questions. The researcher did not ask any questions seeking to inquire about the reasons behind counselors working with families; a few pilot participants noted this. This is especially important because of the counseling field's tendency to make decisions that are ultimately determined by third party payers or program requirements rather than therapeutic choice or judgment.

Implications for counselors

This study sheds light on the importance of training in family counseling within this specific sample. It is known that counselors within this sample whom see families often have more training to do so, especially beginning in graduate programs. While training and practice correlated for some participants, others reported practice without training and MCC and subsequent inconsistent integration of family counseling practices. One could postulate that those who don't have training do not practice family counseling because they don't feel competent to do so rather than because of the therapeutic value. Within this sample family systems concepts are being used by a majority of counselors even if the family does not attend the counseling. Within this sample each counselor's experience counseling families is not a necessary component for those who use high levels of family counseling practice. Within this sample experience is not as important as training or multicultural counseling competence.

Another finding is the potential link between family counseling practices and multicultural counseling competence. This link previously has not directly been studied, once these finding can be replicated it could allow the counseling field to appreciate the relationship between a counselor's MCC and family counseling practices. This knowledge demonstrates another possible way to train and encourage MCC, through introduction of family counseling practices.

Implications for counselor educators

It has already been presented that the literature related to specific family counseling practices in counselor education is lacking. This study presents new information to begin a needed dialogue about family counseling training within the counseling field. This study's sample showed the extent to which counselors may be including family in their clinical practices; it can also be understood that within this sample training in family counseling was important for those using family counseling practices. This is even more significant when put in context of the MANOVA results in which the most important contributing factor of family counseling practices are directly related to family counseling training.

The link between family counseling practices and MCC being introduced in this study also further demonstrates the importance of training counselors to work with families potentially because they will likely be more multiculturally sensitive and aware. If replicated these finding can also support the inclusion of family systems education in multicultural counseling courses as well as other core courses. The 2015 ACA code of ethics encourages family inclusion in counseling when it may be beneficial; these findings can help expand the use of beneficial to also include its multicultural value.

Implications for further research

This study introduces several potential areas and implications of future research. The first and foremost lies in the need for validated family counseling measures. It will be important for the counseling field to be able to gage each counselor's level of family counseling practices and

for this reason having a developed measure could be helpful. Additional research could be useful in further examination of family counseling practices of counselors, such as understanding the motivations and purposes for clinicians who do or do not include family in the counseling process. Qualitative research regarding the use of specific practices used by counselors who include families in counseling could help encourage more inclusion of families in counseling. Additional research could be done with counselor educators and the ways family counseling is integrated into core curriculum courses. With the link to MCC it could be helpful to research what may lead to higher MCC within those who practice family counseling more. Is it possible that those graduating from marriage and family programs have a higher level of MCC? It could also be useful to replicate these findings with a broader population less experienced counselors.

It would be beneficial to do more research to assess the impact of each CACREP specialization on family counseling practices. Is there a specialization that tends to be more MCC? It could also be helpful to further research the role gender and minority status may play in family counseling practices and MCC. Once the group protocols from this study has been further validated these factors could easily be researched by adding additional culturally relevant questions (such as sex orientation, religious identification, and ethnicity) as well as specialty training area. Once these factors and their interactions have been studied in relation to family counseling practices and MCC research could begin to expand on the motivations and causes of various family counseling practice levels (through qualitative and quantitative methods).

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APPENDIX

Appendix A

IRB Approval



OFFICE OF THE VICE PRESIDENT FOR RESEARCH

Physical Address
4111 Monarch Way, Suite 203
Norfolk, Virginia 23508
Mailing Address
Office of Research
1 Old Dominion University
Norfolk, Virginia 23529
Phone(757) 683-3460
Fax(757) 683-5902

DATE: March 23, 2015

TO: Jeffry Moe, Ph.D.

FROM: Old Dominion University Education Human Subjects Review Committee

PROJECT TITLE: [666514-1] Family Counseling Competence

REFERENCE #: [666514-1]

SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS

DECISION DATE:

REVIEW CATEGORY: Exemption category # 6.2

Thank you for your submission of New Project materials for this project. The Old Dominion University Education Human Subjects Review Committee has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations. We will retain a copy of this correspondence within our records. If you have any questions, please contact Ed Gomez at 757-683-6309 or egomez@odu.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Old Dominion University Education Human Subjects Review Committee's records.

Appendix B
Informed Consent Document
Old Dominion University

Project Title: Family Counseling Practices

Introduction:

The purpose of this form is to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES.

The research involves surveying counselors who self-identify as part of the counseling field. Research questions will include participant demographics; current and past experience counseling families, multicultural counseling competency instrument, and family counseling interventions and concept measurements.

Researchers

Primary Researcher: Amanda Brookshear, MA, Old Dominion University, Darden College of Education, Department of Counseling and Human Services

Responsible Project Investigator: Jeffrey Moe, PhD, Old Dominion University, Darden College of Education, Department of Counseling and Human Services

Description of Research Study

There has been much research on the topic of counselor competence. Little research has been conducted on counselors' use of family-based and family systems interventions with individual and family clients.

If you decide to participate in this study, you will be asked to complete a questionnaire. Any computer can access the questionnaire with Internet access. The questionnaire data and feedback will be kept on a firewall, password-protected computer. Data will remain confidential, as we are not collecting identifiable information.

Risks and Benefits

Risks: There are no known risks in this study. As with any research, there is some possibility that you may be subject to risks that have not yet been identified.

Costs and Payments

After completion of the survey each participant will have the opportunity to enter his or her e-mail in order to enter into a drawing for one of eight \$25 Amazon gift cards.

Participation in research is entirely voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time.

Confidentiality

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations, and publications, but the researcher will not identify you personally.

Compensation for illness or injury

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm or discomfort arising from this study, neither Old Dominion University nor the researcher are able to give you any money, insurance coverage, free medical care, or another compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Jeffry L. Moe or, current IRB chair Dr. George Maibafer, at 757-683-4520, or the Old Dominion University Office of Research, at 757-683-3460. You may also contact the Human Subjects Review Committee Chair for the Darden College of Education, Dr. Ed Gomez at egomez@odu.edu.

Volunteer Consent

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any question later on, then the research should be able to answer them.

You may now print a copy of this consent to keep for your records.

If you are willing to participate in this online questionnaire, please continue on with the questionnaire.

Thanks,

Amanda A. Brookshear, Primary Researcher
abroo032@odu.edu
Old Dominion University

Jeffry L. Moe
jmoe@odu.edu
Old Dominion University

Appendix C

Demographic Questionnaire

1. Gender:
 - a) Female
 - b) Male
 - c) Transgender

2. Age: Write In

3. Ethnicity:
 - a) Black/African American
 - b) Asian American
 - c) Hispanic
 - d) Native American
 - e) White/European American
 - f) Biracial or Multiracial
 - g) Other not specified

4. Did you graduate from a CACREP-accredited programs?
 - a) Yes
 - b) No
 - c) Unsure

5. Highest Degree Completed:
 - a) Masters
 - b) Educational Specialist
 - c) Doctorate

6. Credentials (Certification/Licenses): Write-In

7. Of your total counseling experience what percentage of your direct contact hours has been spent working with families?

8. Of your total counseling experience how many direct contact hours a week has been spent counseling?

9. How many years have you been counseling? _____ years _____ months

10. How much graduate training have you received in family counseling?
 - a) 1 graduate course
 - b) 2 graduate courses
 - c) 3 graduate courses
 - d) 4 graduate courses
 - e) 5 graduate courses
 - f) More than 5 graduate courses

11. How much formal training (such as CEUs, supervision) have you received in family counseling?

- a) 0-10 hours
- b) 11-20 hours
- c) 21-30 hours
- d) 31-40 hours
- e) 41-50 hours
- f) more than 51 hours

12. How much informal training (consultation, personal reading, etc) have you received in family counseling?

- a) 0-10 hours
- b) 11-20 hours
- c) 21-30 hours
- d) 31-40 hours
- e) 41-50 hours
- f) more than 51 hours

13. How competent do you feel using family systems theories in counseling?

- a) Very Competent
- b) Somewhat Competent
- c) Slightly Competent
- d) Slightly incompetent
- e) Somewhat incompetent
- f) Very incompetent

14. How competent do you feel including family in the counseling process?

- a) Very Competent
- b) Somewhat Competent
- c) Slightly Competent
- d) Slightly incompetent
- e) Somewhat incompetent
- f) Very incompetent

Appendix D

Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

7-point Likert-Type Scale

ITEM CONTENT OF THE MULTICULTURAL COUNSELING KNOWLEDGE AND AWARENESS SCALE

1. I believe all clients should maintain direct eye contact during counseling. (A)
2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education. (K)
3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatments than majority clients. (K)
4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive. (A)
5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients. (K)
6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination. (K)
7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted. (A)
8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation. (K)
9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illness than are majority clients. (K)
10. I think that clients should perceive the nuclear family as the ideal social unit. (A)
11. I think that being highly competitive and achievement oriented are traits that all clients should work towards. (A)
12. I am aware of differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups. (K)
13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions. (K)
14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility. (K)
15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment. (K)
16. I am knowledgeable of acculturation models for various ethnic minority groups. (K)
17. I have an understanding of the role culture and racism play in the development of identity and world views among minority groups. (K)
18. I believe that it is important to emphasize object and rational thinking in minority clients. (A)

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups. (K)
20. I believe that my clients should view the patriarchal structure as ideal. (A)
21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship. (K)
22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs. (K)
23. I am aware of institutional barriers which may inhibit minorities from using mental health services. (K)
24. I think that my clients should exhibit some degree of psychological mindedness and sophistication. (A)
25. I believe that minority clients will benefit most from counseling with a majority counselor who endorses white middle class values and norms. (A)
26. I am aware that being born a white person in this society carries with it certain advantages. (A)
27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients. (K)
28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs. (K)
29. I am aware that being born a minority in this society brings with it certain challenges that white people do not have to face. (A)
30. I believe that all clients must view themselves as their No. 1 responsibility. (A)
31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group. (K)
32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions. (K)

Note: The following items are reverse scored: 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30. The Knowledge items are designated by the symbol K after the item, and the Awareness items are designated by the symbol A after the item.

Higher Scores=Higher MCC

Appendix E

Family Systems Grouping Protocol

Please answer all questions.

(Likert-Type Scale 1-6)

1 Strongly Disagree, 2 Disagree, 3 Slightly Agree, 4 Slightly Agree, 5 Agree, 6 Strongly Agree

1. Symptoms usually presented in counseling are a result of family patterns, rules, or influences. &
2. In an optimal scenario, I prefer to see a client's family in order to get the bigger picture. *
3. When working with a client I predominantly focus on the symptomatic individual.
(NCA) %
4. The client's family of origin provides significant insight into the client. \$
5. It is important to determine the client's pathology in order to make an appropriate diagnosis. (NCA). &
6. It is nearly impossible to understand a client's concerns without understanding his or her community, family, and various other systems. *
7. I generally focus on understanding the client as an autonomous individual who is ultimately in control of his or her destiny. (NCA) *
8. I almost exclusively focus on relational interactions and patterns. %
9. The best way to understand a client is by talking individually with him or her. (NCA) \$

&: Pathology v. systemic cause

***: Person as part of complex system**

%: Goal is Relational interaction Improvement v. Individual

\$: Understand the system to understand the Individual

(NCA)=Negative Case Analysis

Appendix F

Family Based Intervention Grouping Protocol

1. I include a client's family at least once during the duration of the counseling.

- a) Never 0%
- b) Almost never 1%-24%
- c) Less often than not 25%-49%
- d) More often than not 50%-74%
- e) Almost always 75-100% of the time
- f) Always 100% of the time

2. When I include a client's family in counseling, I tend to do so _____.

- a) Every session
- b) Every other session
- c) Every 3-4 sessions
- d) Every 5-6 sessions
- e) Every 7-8 sessions
- f) Every 9-10 sessions
- g) Less than every 10 sessions

3. When working with a client, I include family in the:

Intake Session:

Always Often Rarely Never

Goal Setting Session(s):

Always Often Rarely Never

Termination Session:

Always Often Rarely Never

Vita

Amanda A. Brookshear earned a Bachelor of Arts in Social Science in 2006 from the University of North Texas. Immediately following, she taught high school humanities in Denver, Colorado. She continued her education and received a Master's of Arts in Community and School Counseling in 2009 from Denver Seminary. After graduating, she did post-graduate coursework in Marriage and Family Counseling at the University of Northern Colorado in 2009. She then worked with children and families at a non-profit community-counseling agency in Central Texas for several years. She is a Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) in Texas.

She decided to pursue her doctorate in counselor education because of her love for the field and desire to encourage the future generations of counselors. While pursuing her doctorate at Old Dominion University she traveled to Malawi with the National Board of Certified Counselors to work with the Guidance, Counselling, and Youth Development Centre for Africa training counselors. She pursued a research cognate in qualitative and quantitative methods and served as a graduate teaching and research assistant.

Amanda is a member of the American Counseling Association, Texas Counseling Association, and is a Nationally Certified Counselor (NCC). She has presented at state, national, and international conferences. In the fall of 2015 Amanda will begin her career in counselor education at Tarleton State University as an Assistant Professor and Counseling Clinic Director.