# AN EXPLORATORY ANALYSIS OF SPECIFIC THERAPIST SKILLS AND CORRESPONDING CHANGES IN FAMILY BEHAVIORS DURING MARITAL AND FAMILY THERAPY SESSIONS

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# CHAPTER 1

## INTRODUCTION

### Background to the Problem

The practice of marriage and family therapy has rapidly grown in the past decade (Broderick and Schrader, 1981; Foley, 1974; Kaslow, 1977). While a portion of this growth can be attributed to increased student interest in marriage and family therapy (Foley, 1974; Glick and Kessler, 1980), the major impetus has come from the general public in the forms of requests and demands for relationship oriented treatment (Olson, 1976). Several factors are contributing to the rapidly increasing need for marriage and family therapy. It is estimated that the number of family units in the United States has almost doubled since the end of World War II (Glick and Kessler, 1980). In some years during the past decade there was one divorce for every two marriages (Kaslow, 1981). While 40% of the children born in the 1970s spent part of their childhood in single-parent homes, approximately 17% of children currently live in single-parent homes and about 18 million children are living with step-parents (Martin, 1979). Nathan Ackerman, one of the founding pioneers of the marriage and family therapy movement (Broderick and Schrader, 1981), wrote prophetically in 1966 about the American family.

> In the present era the extraordinary acceleration of social change crowds all of history into the life space of a single family. We ask: Is man's capacity to adapt to almost any living condition reaching the breaking point? Is the unique flexibility of the human family failing? Can the family take it? Troubled families are everywhere today. Family relations are out of kilter. After an upset, the family seems less able to bounce back and regain its balance. It looks for all the world as if it is falling apart. Unlike Humpty Dumpty, however, it may well pull itself together. But at what cost? And will it ever be the same again? (p. vii).

Understandably, marriage and family therapy has become a highly sought service in the present society.

The profession of marriage and family therapy has clearly come into existence in response to public need (Olson, 1976). The certifying body for the profession, the American Association for Marriage and Family Therapy, moved from a clinical membership of "973 in 1970, to 3,373 in 1975, to 7,565 in 1979--this represents an increase of 777% during the decade" (Gurman and Kniskern, 1981, p. xiii). As the demand for training in marriage and family therapy grew, training programs were established so that the masters could teach more students (Kaslow, 1977). The early marriage and family therapists were charismatic figures who became discouraged with traditional psychotherapy (Bowen, 1976; Kaslow, 1977; Nichols, 1979). These early leaders were self-trained in marriage and family therapy (Kaslow, 1977; Nichols, 1979) and departed from the psychoanalytic approaches that were in current practice (Bowen, 1976). The second generation of

family therapists was trained through observation of the first generation (Kaslow, 1977) in a hit or miss type of apprenticeship (Ivey, 1978). The content of these early programs was based on intuition and experiential processes rather than formalized processes of defined family therapy behaviors (Ackerman, 1973; Kaslow, 1977). These family therapy training programs lacked specific learning objectives.

While many marriage and family therapists and trainers strongly advocate an open discussion of training objectives (Barton and Alexander, 1977; Cleghorn and Levin, 1973; Epsten and Levin, 1973; Garrigan and Bambrick, 1977; Liddle and Halpin, 1978), very few trainers attempt to validate their training approaches through empirical and measurable learning objectives (Liddle and Halpin, 1978). However, there is no shortage of literature that describes in detail the needed behaviors for effective marriage and family therapy (Bandler and Grinder, 1976; Haley, 1976; Satir, 1967). Kniskern and Gurman assert that "an increasing body of knowledge about specific therapist factors that influence the outcome of family therapy does exist" (1979, p. 83). These therapist behaviors are divided into two general categories: Structuring skills and Relationship skills (Kniskern and Gurman, 1979).

A scale has been developed that can measure therapist activity in regard to structuring skills and relationship skills (See Appendix A) (Laird, 1981). This scale was

validated on the basis of videotaped role playing of a marriage and family therapy situation and could now be used to measure therapist skill in actual family therapy sessions.

A scale has also been developed to assess the level of sickness/health in families (See Appendix B) (Lewis, Beavers, Gossett, Phillips, 1976). This scale was validated on the basis of videotaped observation of families' interaction after they were left alone to solve an assigned task. This scale could be used to measure outcome of family therapy (Beavers, 1981) by comparing early family assessment with later family assessment after several family therapy sessions.

By comparing therapist skills with areas of family growth, it would be possible to determine which therapist skills correspond highly with certain areas of family growth. Furthermore, from the first family assessment, it would be possible to classify families into diagnostic types (Beavers, 1981). In this manner it could be determined which therapist skills correspond with certain areas of family growth in particular types of families.

## Statement of the Problem

The problem of this study is the discovery of the coexistence of therapist skills with changes in family behaviors during actual marriage and family therapy sessions.

## Purpose of the Study

The purpose of the study is to correlate therapist skills with changes which occur in family behaviors during actual marriage and family therapy sessions.

## Research Questions

One major research question undergirds this study: Are there certain therapist skills that are closely associated with changes in certain family behaviors? A second related question based on an affirmative answer to the major question is asked: In what type(s) of families do these associations exist?

## Significance of the Study

The answers to the questions posed above have significant implications to marriage and family therapy at several levels. A central issue in marriage and family therapy research and training is the determination of therapist competencies (Kniskern and Gurman, 1979; Liddle and Halpin, 1978). Without this process information it is difficult to determine any clinically useful knowledge from outcome studies (Pinsof, 1981). When process and outcome information is integrated it becomes possible to set learning objectives for marriage and family therapy training on what is known empirically to be effective therapy (Gurman and Kniskern, 1981; Kniskern and Gurman, 1979; Liddle and Halpin, 1978).

While some groups of therapist skills are associated with certain specific approaches to marriage and family therapy (See Appendix A), the first two groups of therapist skills have been shown to positively influence outcome of family therapy in general (Kniskern and Gurman, 1979). Therefore, the empirical information regarding the first two groups would have generalized application to the skills of all marriage and family therapists regardless of their theoretical orientations. The relationship skills information could have implications for criteria for selection of trainees for admission to marriage and family therapy training programs (Kniskern and Gurman, 1979, pp. 84 and 85). Structuring skills and relationship skills "are potentially teachable" (Kniskern and Gurman, 1979). The determination of important therapist skills that relate to positive outcome could provide extremely valuable direction to the setting of specific learning objectives for the teaching of relationship and structuring skills. Furthermore, these specific learning objectives could be used to guide the process of training and to measure the effectiveness of training in marriage and family therapy.

In terms of methodology of the study, two scales developed under different circumstances will be field tested on actual family therapy sessions. The outcome of this study could provide valuable information about the use and/or limitations of the two scales in particular and the

comparative approach in general. In summary, this study could generate many useful hypotheses about therapist skills associated with family growth during the course of actual marriage and family therapy.

## Definition of Terms

The following definitions of terms are used for the purpose of this study:

Therapist Skills: Verbal and nonverbal skills that a therapist performs during actual marriage and family therapy sessions as described in Appendix A.

Family Behaviors: Verbal and nonverbal behaviors that family member(s) produce(s) during actual marriage and family therapy sessions as described in Appendix B.

Marriage and Family Therapy: A therapeutic process which attempts to affect change in the relationship between two or more family members. In marriage and family therapy, the therapeutic focus is on the relationship interaction between individuals.

# CHAPTER 2

## REVIEW OF RELATED LITERATURE

### Restatement of Purpose to the Problem

The intention of this study is to correlate therapist skills with changes in family behaviors during actual marriage and family therapy sessions. In this study a discovery can be made of the therapist skills that correlate with changes in family behaviors during marriage and family therapy. This study is involved in three areas of research within the field of marriage and family therapy: (1) Family therapy training; (2) Family therapy outcome and (3) Family therapy process. After treating research of family therapy training, outcome and process research on family therapy is reviewed from the standpoints of the two important treatment factors of therapist and patient-family. The study of the therapist skills that correlate with changes in family behaviors during marriage and family therapy is a highly relevant concern to the research of family therapy training.

### Family Therapy Training

The field of family therapy is rapidly growing "by any standard used to assess such activity" (Gurman and Kniskern, 1981, p. 772). A brief history of marriage and family therapy training was addressed under background concerns. In the present era training programs in marriage and family

therapy are rapidly increasing (Beal, 1976; Stanton, 1975) in the forms of new specialized programs and of additions to existing psychotherapy training programs (Gurman and Kniskern, 1981). Before reviewing the literature of family therapy training, it is well to note some limitations. The literature reflects the early developmental phase in the training of family therapists in that most presentations are not specific about the methods and procedures used in training (Liddle and Halpin, 1978). Furthermore, training issues addressed by one source are not usually addressed by others. Hence, no formal theories of supervision and training have been identified (Liddle and Halpin, 1978). "While the experientially based literature on family therapy training and supervision is enormous" (Gurman and Kniskern, 1981, p. 772), it is also "fragmented and disorganized" (Liddle and Halpin, 1978, p. 78).

A variety of important training issues have been thoroughly discussed (Erickson, 1973; Napier and Whitaker, 1973; Shapiro, 1975a, 1975b). Several training models have been presented and described in general terms (Ard, 1973; Bodin, 1969a; Cleghorn and Levin, 1973; Constantine, 1976; Dell et al., 1977; Duhl and Duhl, 1979; Epstein and Levin, 1973; Everett, 1979; Ferber and Mendelsohn, 1969; Garfield, 1979; Haley, 1974; Nichols, 1979; Rosenbaum and Serrano, 1979; Skynner and Skynner, 1979; Stier and Goldenberg, 1975; Tomm and Wright, 1979). However, only three detailed

accounts of specific teaching strategies have been presented (Birchler, 1975; Bodin, 1969b; Permutter et al., 1967). While a few common areas such as goals of training, supervisory techniques, supervisor-supervisee relationship and personal therapy for trainees can be compared in some of these models (Liddle and Halpin, 1978), there is insufficient information to make the most general type of hypotheses regarding the processes to be researched in family therapy training. The absence of process research in family therapy training is well attested (Gurman and Kniskern, 1978a, p. 883; Gurman and Kniskern, 1981; Kniskern and Gurman, 1979, p. 83; Liddle and Halpin, 1978).

Unsurprisingly, the state of outcome research of family therapy training suffers an equal condition (Gurman and Kniskern, 1978a; Gurman and Kniskern, 1981; Kniskern and Gurman, 1979; Liddle and Halpin, 1978). Hence, "there now exists no research evidence that training experiences in marital and family therapy in fact increase the effectiveness of clinicians" (Kniskern and Gurman, 1979, p. 83). The barrier to family therapy training research that has not been breached has to do with the inseparable connection between training evaluation and family therapy evaluation (Liddle and Halpin, 1978). "The question of what kinds of therapist behavior produces change must be answered before any training program can define its goals" (Liddle and Halpin, 1978, p. 89).

Unfortunately, at the present time family therapy training programs predicate their goals upon theoretical concepts. Liddle and Halpin assert that training objectives "are dependent upon the theoretical assumptions and orientation of the supervisor" (1978, p. 78). Since "trainees learn by what they live in the immediacy of their interaction with their supervisors" (Kniskern and Gurman, 1979, p. 87), the techniques employed by the supervisor and his/her style of supervision make a significant impact upon the trainee's approach to marital and family therapy. It is important to note that the techniques and style of supervision are heavily influenced by the supervisor's theoretical and therapeutic orientation (Kniskern and Gurman, 1979). For example, "a directive, problem-oriented therapist (Haley, 1976) will tend to supervise in a direct, problem-orientated way" (Kniskern and Gurman, 1979, p. 87). By contrast, "process-oriented therapists will tend to be more concerned with the personal growth of their supervisees (e.g., Whitaker et al., 1981)" (Kniskern and Gurman, 1979, p. 87). Kniskern and Gurman state that "such stylistic differences in supervision will likely be translated into differences in therapeutic style by supervisees" (1979, p. 87). This comment is significant in view of the three primary methods of training in current usage: didactic, supervisory and experiential (Kniskern and Gurman, 1979). Of these three Kniskern and Gurman state that "the primary teaching of family therapy

occurs in supervision" (1979, p. 87). Therefore, in current practice, training objectives are largely determined by the theoretical concepts of the trainer. In a most recent presentation a conceptual model of training is offered as a guide to trainers to set learning objectives upon a theoretical orientation (Liddle and Saba, 1982).

Liddle and Halpin state that "the goals of training and supervision and the skills of the supervisor are dependent upon the theoretical orientation of the particular program" (1978, p. 80). Accordingly, experientially-oriented (Constantine, 1976; Ferber and Mendelsohn, 1969; Luthman and Kirschenbaum, 1974) and psychodynamically-oriented (Ackerman, 1973) programs are likely to emphasize personal growth and affective aspects of the trainee (Liddle and Halpin, 1978). In contrast, structural (Minuchin, 1974), behavioral (Cleghorn and Levin, 1973) and strategic (Haley, 1976) programs are likely to emphasize cognitive goals and the definition of particular sets of therapist skills needed to intervene with dysfunctional systems (Liddle and Halpin, 1978). When therapist skills are used in training they are defined according to a single theoretical school of thought (Garrigan and Bambrick, 1977). Therefore, the movement toward definition of therapist behaviors (Liddle and Halpin, 1978) is circumscribed by the theoretical orientation of the trainer(s).

This emphasis seems most unfortunate in the light of current empirical knowledge of therapist skills (Alexander et al., 1976). Alexander and colleagues report findings that indicate 60% of outcome variance can be explained by certain therapist skills (1976). Gurman and Kniskern argue strongly "that therapist variables are at least as salient as technique variables" (1978, p. 277) in the study of family therapy outcome. The crucial therapist variables are defined as structuring skills and relationship skills (Alexander et al., 1976). The focus on technique variables is concerned with defining "therapist competencies according to differing theoretical schools of thought" (Liddle and Halpin, 1978, p. 80). In contrast, the focus on therapist variables is concerned with therapist skills that "appear to be related to positive outcome regardless of the theoretical orientation of the therapist" (Kniskern and Gurman, 1979, p. 84). Between the two important sets of skills, relationship skills are the more influential by accounting for 44.6% of the outcome variance (Gurman and Kniskern, 1978). Therefore, it now seems possible to identify sets of therapist competencies that cut across differing schools of thought. In this manner more than one half of the effective therapist skills can be empirically defined without dependence upon theoretical assumptions. In this light Kniskern and Gurman conclude:

> An increasing body of knowledge about specific therapist factors that influence the outcome of family therapy does exist . . . To the degree these factors are teachable, learnable and focused upon in training programs, their identification provides indirect support for the potential effectiveness of family therapy training programs. (1979, p. 84)

A focus on these sets of skills seems important at a time when "much of family therapy may evolve into a technology without a soul" (Gurman and Kniskern, 1981, p. 760) by competing theories and techniques of marital and family therapy.

Furthermore, an investigation of these skills could make a significant contribution to the dispelling of "the field's collective empirical ignorance" (Gurman and Kniskern, 1981, p. 772) of the processes and outcomes of family therapy training. A further investigation into the specific competencies of structuring and relationship skills appears to be one way to erect a bridge to connect

> empirical study of the training processes with empirical study of the outcomes of family therapies themselves, so that the next generation of family therapist can benefit fully from our advances in both realms, rather than blindly repeating our clinical and training errors (Gurman and Kniskern, 1981, p. 772).

Such an investigation can begin with a review of studies that focus upon the observed therapist skills that influence treatment.

Therapist Factors

Therapist factors influencing treatment can be considered from two perspectives: Family therapy process issues and family therapy outcome issues. Pinsof, in his recent treatment of process research literature, states "if the field of family therapy outcome research is still in its infancy (Gurman and Kniskern, 1978), the field of family therapy process research has just been born" (1981, p. 700). In light of "the dearth of family therapy process research and the developmental primitiveness of the field" Pinsof's review is mainly descriptive (1981, p. 700). The review treats process research because it focuses on therapist factors. However, the separation between process and outcome issues is not real because the focus is upon therapist factors influencing outcome. Therefore, process and outcome issues are interrelated and inseparable (Gurman and Kniskern, 1981) when considering structuring and relationship skills.

In the area of direct observation measures of family therapist factors several studies have relevance to an investigation of structuring and relationship skills (Pinsof, 1981). Kniskern and Gurman (1979) contend that the most impressive demonstration of the powerful effects of relationship skills on the outcome of family therapy has been presented by Alexander et al. (1976). James Alexander at the University of Utah and colleagues developed a coding system that comprised eight five point ordinal scales that could be

used to rate the following verbal and nonverbal components of family therapist behaviors: Affect-behavior integration; Humor; Warmth; Directiveness; Self-confidence; Self-disclosure; Blaming; and Clarity (Alexander et al., 1976).

The scale ratings were performed by the training supervisor on the basis of direct observation of 21 family therapy trainees during training sessions (Alexander et al., 1976). This study examined the outcome relationship between therapist characteristics before therapy and family behaviors (as measured on a system discussed in section on patient-family factors) in therapy (Alexander et al., 1976). The therapist scores on Blaming, Clarity and Self-disclosure did not correlate with changes in family behaviors (Alexander et al., 1976). The other five scales did correlate with changes in family behavior and were blocked into two distinct dimensions (Alexander et al., 1976). While the first block, comprising Affect-behavior integration, Warmth and Humor scales, represents what they termed a relationship dimension, the second block, comprising the Directiveness and Self-confidence scales, represents what they termed a structuring dimension (Alexander et al., 1976). Relationship skills alone accounted for 44.6% of the variance in outcome and structuring skills alone accounted 35.8%. However, structuring skills with the intercorrelated effects of relationship skills partialed out accounted for 15% of the outcome variance (Alexander et al., 1976). "The initial findings

with Alexander et al.'s (1976) eight scales support the predictive validity of five of them. The three relationship scales seemed to have the greatest predictive power" (Pinsof, 1981, p. 711). From this study it is clear that the presence and interaction with each other of structuring and relationship skills account for a significant (60%) degree of positive outcome in family therapy.

In an examination of factors that influence the occurrence of deterioration Gurman and Kniskern found that "therapist variables appear to play a central role in the outcomes of marital and family therapies, especially those variables involving relationship-building skills" (1978b, p. 11). A growing body of information indicates the importance of relationship skills to positive family therapy outcome according to supervisors (Alexander et al., 1976), trained judges (Thomlinson, 1974) and clients (Beck and Jones, 1973; Burton and Kaplan, 1968; Mezydlo et al., 1978). In summary Gurman and Kniskern conclude:

> the available evidence points to a composite picture of deterioration in marital-family therapy being facilitated by a therapist with poor relationship skills who directly attacks "loaded" issues and family members' defenses very early in treatment, fails to intervene in or interpret intra-family confrontation in ongoing treatment and does little to structure and guide the opening of therapy or to support family members (1978b, p. 14).

In poor family therapy outcome, the absence of structuring and relationship skills and their interaction with each other is clear.

Gurman and Kniskern report that the "client-centered triad", which is therapist empathy, warmth and genuineness, strongly appears to be the factors that keep families in therapy after the first interview (1978a). In Waxenberg's findings (1973) higher levels of empathy had the power to keep both white and nonwhite families in treatment. However, Shapiro and Budman (1973) found that empathy was less important to therapy continuation in family therapy than in individual therapy and that families respond more to active therapist involvement in early sessions than to expressions of understanding alone.

Kniskern and Gurman state that "the family therapist must generally be active and provide early structure, but without assaulting defenses too soon" (1979, p. 84). The Montreal group associated with the Jewish General Hospital in Montreal devised a two category coding system wherein a trained coder rates the therapist behavior as either a Drive (D) or Interpretation (I) statement (Postner et al., 1971). Accordingly, interpretation statements are designed to enlarge understanding about the family, label unconscious motives, suggest alternative behaviors and clarify motivation, whereas drive statements are intended to stimulate interaction, obtain information and provide support (Postner et al., 1971). Postner et al. found that in the second session a high drive level and a low interpretation level correlated positively with outcome and "that without the

appropriate level of Drive, a solid therapeutic alliance is not established" (1971, p. 466). This study indicates a need for the employment of structuring skills early in the treatment process.

Clearly, both structuring skills and relationship skills are connected with very good therapy outcomes (Alexander et al., 1976). While "only relationship skills was able to discriminate between good and very good outcome" (Kniskern and Gurman, 1979, p. 84), there seem to be times when structuring skill is imperative to avoid worsening of pretreatment functioning (Gurman and Kniskern, 1978a) or termination of treatment (Gurman and Kniskern, 1978b). At any rate the presence and interactive combination of relationship and structuring skills account for 60% of what is now known to be effective marital and family therapy (Alexander et al., 1976) from the standpoint of specific therapist factors that influence outcome (Kniskern and Gurman, 1979). While there exist descriptions of these specific therapist factors (Barton and Alexander, 1981; Barton and Alexander, 1977) no operationalized definitions of relationship skills and structuring skills have been tested in actual therapy (Laird, 1981).

An excellent proposal (Gurman, 1981) of operationalized definitions has been made by Laird (1981) in the form of two therapist behavior rating scales measuring structuring skills and relationship skills (See Appendix A). A pool of

375 items were taken from family therapy skills considered necessary by several well-known authors representing three theoretical models: Historical, Structural/Process, and Experiential (Foley, 1980; Levant, 1980). Descriptive statements were paraphrased into more specific behavioral terms from many writers of which the major contributors included Ables and Brandsma (1977), Anderson and Anderson (1962), Bowen (1976), Cleghorn and Levin (1978), Haley (1976), Minuchin (1974), Napier and Whitaker (1978) and Satir (1967). After all duplicate and quite lengthy items were removed, the pool was reduced to 213 items (Laird, 1981).

Construct validity was achieved by item placement by experts and experts' judgement of item importance (Laird, 1981). Laird (1981) asked three independent doctoral-level judges who were then involved in family therapy training to place each item under one of five categories of therapist behaviors (See Appendix A). The two general categories reflected Structuring skills and Relationship skills (Kniskern and Gurman, 1979) and the three theory-specific categories reflected skills relevant to Historical, Structural/Process and Experiential models of family therapy (Foley, 1980; Levant, 1980). Judges were given photocopies of Kniskern and Gurman (1979), Levant (1980) and Foley (1980) as guides for placement (Laird, 1981). After two of the three judges agreed on category placement, 140 items remained

in the pool (Laird, 1981). Next, the judges classified each remaining item as essential, important or unimportant (Laird, 1981). After at least two of the three judges classified each item as either essential or important, 71 items remained in the pool (Laird, 1981).

The first stage of criterion-related validity was achieved by the development of videotaped vignettes of simulated family therapist skills (Laird, 1981). To assess validity of the rating scales, 142 videotaped vignettes of effective and ineffective therapist behaviors were made with the aid and to the level of satisfactory specifications of the three judges (Laird, 1981). An actor/therapist was videotaped with a role-played family for short segments of less than two minutes to portray effective and ineffective therapist behaviors for each item in the five categories (Laird, 1981). Each segment was made or remade until it passed the following criteria by the three judges:

> (a) The behavior of actor/therapist was believable and reflected the behavior stated by the item; (b) The behavior of the actor/therapist was believable and reflected actual behavior that could be observed in bona fide therapy situations; and (c) All vignettes clearly demonstrate either effective or ineffective therapist behaviors (Laird, 1981, p. 9).

Next, ten doctoral students with at least two academic courses and two years experience in family therapy were asked to rate both effective and ineffective portrayals of each of the 71 therapist behaviors (Laird, 1981). Each

rating scale was presented with the corresponding vignette in a randomized order and both effective and ineffective representations of the 71 items were rated (Laird, 1981).

The second and final stage of criterion validity was achieved by statistical analysis of the items (Laird, 1981). The videotaped vignettes of simulated family therapy were viewed by the ten raters in three different groups of five, three and two raters with no information given to the raters as to which tapes they would be viewing (Laird, 1981). The following instructions were given to each group of raters immediately prior to the rating session:

> What you will be doing is rating the behavior of a family therapist. You each have a copy of a family therapist rating scale. It contains 142 statements about the behavior of a family therapist. Beside each of the statements is a six-point scale where you are to rate the therapist's behavior identified by the statement. The six-points on the scale all deal with how effective the therapist was in demonstrating the behavior described in the statement. Your rating is your judgement of how well the therapist performed the behavior described by the statement . . . The therapist will be demonstrating several different models of family therapy. Some of the behaviors done by the therapist may come from a model which you personally disagree with. Try to be neutral and rate the therapist behavior as effective or ineffective within the model he is using and not in terms of whether you agree or disagree with the type of intervention . . . (Laird, 1981, p. 10).

From the ratings of the 142 items means, standard deviations, standard errors of the mean and 90 percent confidence limits were computed (Laird, 1981).

Effective and ineffective conditions of each item were graphically plotted according to standard error and

confidence limits so that item selection for the final scale could be made by identifying and choosing the ten items within each of the five categories which had the best discrimination between effective and ineffective conditions (Laird, 1981). The final ten items within each of the five categories were selected on the basis of the degree to which they had low standard error (reflecting high reliability among raters) and a wide separation between confidence limits for the effective as opposed to the ineffective model (a representation of each item's validity) (Ivey, 1978, p. 491). The means, standard deviations, standard errors of the mean and separation between the confidence limits about each mean for both the effective and ineffective conditions for the 50 items which constitute the final form of the scale are represented in Appendix C (Laird, 1981). All of the items discriminated significantly ($p < .05$) between each set of effective and ineffective vignettes and, with the exception of two, all items discriminated beyond the 99 percent confidence limits (Laird, 1981).

Pearson product-moment correlation coefficients were computed between all possible pairs of the ten raters to provide interrater reliability (Laird, 1981). In the ten by ten matrix of the correlation coefficients (See Appendix D), the correlation coefficients ranged from .61 to .87 with a mean score of .77 (Laird, 1981). All of the correlation

coefficients were statistically significant ($p < .001$) (Laird, 1981).

The potential utility of this scale is significant (Gurman, 1981) and holds promise of an effective instrument to measure therapist skills in actual marital and family therapy sessions. A scale that could accurately measure in therapy therapist skills would have many implications to family therapy outcome and training content and outcome issues. While Laird's study is impressive, it is based on simulated family therapy and therapist skills role played by an actor/therapist who is not doing actual family therapy. It appears that it would be instructive to see this scale applied to the therapist skills of a therapist doing actual marital and family therapy. A significant portion of the present study is committed to the achievement of this application.

Patient-Family Factors

The patient-family factors have different dimensions in comparison to the therapist factors. The patient-family factors need to be considered at two levels: (1) Patient-family factors influenced during treatment and (2) Patient-family factors influencing treatment. Patient-family factors influenced during treatment are those functions or behaviors of the family that progress or fail to progress toward health and growth during the treatment process. These changes in

either direction or failure to change are often the central focus of process and outcome research of marital and family therapy (Beavers, 1981; Pinsof, 1981). In contrast, patient-family factors influencing treatment include specific individual-oriented diagnostic categories, various couple or family categories, style of family interaction, family constellation variables and family demographic characteristics (Gurman and Kniskern, 1981). For the present study, patient-family factors influenced during treatment are defined as family behaviors and levels of functioning. Patient-family factors influencing treatment are defined as types of family interaction.

Several coding systems have been developed to measure family behavior during therapy (Pinsof, 1981). Unfortunately, a careful survey of these coding systems used to measure patient-family factors influenced during treatment reveal "important methodological problems and/or limitations with most if not all of the client system studies" (Pinsof, 1981, p. 720). The reason for such problems and/or limitations is "that this research area is so young and undeveloped that clear trends or patterns of findings have not emerged" (Pinsof, 1981, p. 721). Therefore, the present review has three concerns: (1) A survey of the findings of these early studies; (2) A discussion of the Alexander et al. outcome measures from which the significance of structuring and relationship skills was obtained; and (3) A discussion of

the Beavers-Timberlawn Family Evaluation Scale which measures family functioning and appears useful to family therapy outcome studies as an instrument to measure family change.

In the Montreal group's category system of measuring underlying affective content expressed in verbal statements by family members during family therapy, Postner et al. found no relationship between family affect expression and family therapy outcome (1971). Postner et al. (1971) did find that as therapy progressed family members expressed more emotions such as pleasure, love, joy, happiness and liking to each other. In another study that focused on the direction and intent of speech, Heckel (1975) found significant differences in his comparison between outpatient family therapy and outpatient group therapy in that family therapy patients interacted more with each, less with the therapist and in a less polite and more open and direct manner. In another study based on Klein et al.'s (1970) method of evaluating the patient's self involvement in individual psychotherapy, De Chenne (1973) compared spouse responses to their mates with their responses to the therapist and found that spouse-following-therapist statements reflected higher self-involvement than spouse-following-spouse statements.

In a study designed to measure the degree of differentiation of self from the undifferentiated family ego mass (Bowen, 1966), Winer (1971) found that during group marital therapy couples moved to a higher degree of differentiation

of self. In a study designed to measure laughter in family therapy as a disguise for feeling and/or a reflection of anxiety, Zuk et al. (1963) found inconclusively that one family in therapy systematically varied in laughter frequency. By measuring ten different ways in which families disrupt the focus of their attention during family therapy, Morris and Wynne (1965) found that a trained judge could accurately predict the nature of an inpatient's mental illness by listening to segments of family therapy sessions with his/her family. All of these exploratory studies need further replication before any firm conclusions can be made (Pinsof, 1981). Along with the Allred and Kersey (1977) study, which was totally inconclusive, these exploratory studies offer no instrument of choice to provide comparative information useful in outcome studies.

The instrument that provided comparative information for Alexander et al. (1976) in the discovery of the importance of the therapist's structuring and relationship skills was based on an earlier study by Alexander (1973) on family interaction patterns. This two category nominal scale, derived from Gibb's (1961) study of defensive communication in small non-family groups over an eight year period, revealed differences in the interaction patterns of delinquent and non-delinquent families (Alexander, 1973). The delinquent sample consisted of 20 families who met qualifications for treatment, whereas the "normal" sample consisted

of 22 families who volunteered from a larger group to participate in the study (Alexander, 1973). After the families answered a family questionnaire and discussed suggested topics as a family unit, they were asked to discuss the questions on the questionnaire (Alexander, 1973). The examiner left the room and the family discussion was videotaped for 15 minutes (Alexander, 1973).

> All behaviors, verbal and nonverbal were scored according to a manual developed from the criteria presented by Gibb (1961). The manual consisted of two major categories of behavior with four subcategories under each major dimension: Defensive communications: (a) judgmental dogmatism, (b) control and strategy, (c) indifference, (d) superiority. Supportive communications: (a) genuine information seeking and giving, (b) spontaneous problem solving, (c) empathic understanding, (d) equality (Alexander, 1973, p. 225).

Alexander developed his instrument by combining numbers 2 and 3 and omitting number 6 of Gibb's list of behavior characteristics of supportive and defensive climates in small groups:

| Defensive Climates | Supportive Climates |
|---|---|
| 1. Evaluation | 1. Description |
| 2. Control | 2. Problem orientation |
| 3. Strategy | 3. Spontaneity |
| 4. Neutrality | 4. Empathy |
| 5. Superiority | 5. Equality |
| 6. Certainty | 6. Provisionalism |

(1961, p. 143)

This system discriminated defensive and supportive communications between the two types of families (Alexander, 1973).

This instrument was used in Alexander et al.'s (1976) process-outcome study with 91% interrater reliability on

audiotapes of actual therapy sessions of 21 families with 21 different therapists. Two 15 minute segments were rated from the first and last parts of the initial interview and one 15 minute segment from first part of the next to last session (Alexander et al., 1976). The focus of treatment was on "family system functions served by the delinquency" as opposed to "delinquent target behaviors per se" (Alexander, 1976, p. 658). Alexander et al. (1976) found that better outcomes were significantly and powerfully associated with much increased family supportive communication with each other at the end of therapy and a zero recidivism rate 12-15 months following intervention. The two early segments were not found to be significant which indicates that the difference at the end of therapy was due to treatment intervention (Alexander et al., 1976). On the basis of these findings the Support/Defensive system "appears to have discriminant (types of families and outcomes) validity" (Pinsof, 1981, p. 716) in regard to patient-family factors both influenced during treatment and influencing treatment. While this study is impressive (Gurman and Kniskern, 1981), no replication of these procedures has been published (Pinsof, 1981).

Pinsof (1981) laments the fact that quite few family therapy researchers have utilized the experience and knowledge gained by investigators in the related research of family interaction. Pinsof concludes his discussion by

indicating "hopefully more researchers will apply the knowledge and systems of the family interaction field to the in-therapy behavior of family members" (1981, p. 721). One comprehensive coding system from the field of family interaction research has the proven capability of measuring multiple and complex levels of family functioning (Lewis et al., 1976). Surprising, this comprehensive coding system has not been utilized in research on either patient-family factors influenced during treatment or patient-family factors influencing treatment. This omission is most curious in view of the claims made by the author of the coding system that the scales have practical utility for research on patient-family factors influenced during treatment and patient-family factors influencing treatment (Beavers, 1981).

These claims are based on the seven year Timberlawn Research Foundation study about which the authors contend that they attempted to produce "the most intensive study of the ingredients of the healthy family in our society" (Lewis et al., 1976, p. xxi). The striking feature of this research project is that it focuses on the presence as well as the absence of family psychological health (Lewis et al., 1976), whereas health has been traditionally defined as the absence of sickness (Gantman, 1980). Concerning the central importance of a focus upon psychological health in family systems, Lewis et al. write:

> Our work originated with the hope that if the qualities of families which produce capable, adaptive, and healthy individuals can be known and understood, we may be able to teach those involved in helping roles: parents, teachers, mental health professionals. Thus, this research is aimed at finding facts and concepts useful in primary prevention as well as treatment intervention (1976, p. xvii).

Clearly, a coding system that can reflect family psychological health and dysfunction has significant value in the study of patient-family factors influenced during treatment and patient-family factors influencing treatment.

The continuing research of this group began as a follow-up study of families of adolescents who had been treated and discharged from an inpatient psychiatric hospital (Lewis et al., 1976). Information from family interviews was used to assess family factors contributing and not contributing to the adolescents' difficulties. However, the need for a more quantifiable means of comparing families eventually led to the design of a videotaped interview which included five assigned tasks (Lewis et al., 1976). In two of the interactional tasks each family was asked to discuss the main problem in the family and to plan a realistic one hour activity together while the experimenter left the room and they were videotaped for 10 minutes each time (Lewis et al., 1976). The third task provoked the couple only to discuss the greatest source of pain in their relationship while the experimenter left the room for 5 minutes and the couple was videotaped (Lewis et al., 1976). In the fourth task each

family was provoked through an individual closeness exercise to discuss as a family what closeness means in their family while the experimenter was present and the family was being videotaped (Lewis et al., 1976). In the fifth and final interactional task each family was reminded of previously presented information on family characteristics and were asked to discuss what is strong about their family (Lewis et al., 1976).

Thus, the study of a small sample of 23 families was begun. The sample consisted of 12 families who had just admitted an adolescent member for inpatient psychiatric treatment and the 11 control families who were volunteers from a local Protestant Church (Lewis et al., 1976). The interrater reliability was high (mean score of .77) as indicated on the table below:

Interrater Reliability

| Raters | Test Section(s) | r | p |
|---|---|---|---|
| A & B | Family Strengths | .75 | .001 |
| E & B | Main Problems | .90 | .001 |
| B & B | Strengths/Problems | .75 | .001 |
| F & G | Main Problems | .65 | .001 |
| H & I | Family Closeness | .78 | .001 |

(Lewis et al., 1976, p. 33)

The original intent of this research project to find a way to quantify data that could be used to compare families and determine the effect that family interaction had on eventual outcome of treated adolescents was achieved (Lewis et al.,

1976). However, the most significant aspect of the study was the generation of interest of the research staff to the interactional study of healthy family systems (Lewis et al., 1976). This early study also attracted the involvement of W. Robert Beavers, M.D. to the research team to serve first as a rater, then an originator of a rating system and finally as a theoretician regarding family systems (Lewis et al., 1976). While the family interactional information continues to be used by the staff of the adolescent inpatient hospital, the research team began another investigation of a larger sample of nonpatient or healthy families (Lewis et al., 1976).

Another 33 healthy or nonpatient families were supplied as a sample from the same pastor and church staff that provided the 11 families for the pilot study (Lewis et al., 1976). Each of these 33 volunteer families was videotaped in response to five interactional tasks and interviewed (Lewis et al., 1976). The first interactional task was the family strengths question that was used as the fifth task in the pilot study (Lewis et al., 1976). In the second task each family was asked to listen to an audiotape vignette of a situation where a family member seemed to be near death in a hospital and complete the story as the audiotape is stopped at an uncertain point (Lewis et al., 1976). The third interactional task of marital testing was altered slightly from the pilot study to ask the couple to discuss for 10 minutes

what had been the best and worst in their marriage, whereas the family closeness task was repeated in the same form as it had been presented in the pilot study (Lewis et al., 1976). The fifth and final task was the exercise of planning something together that had been the second interactional task in the pilot study (Lewis et al., 1976). A segment of the videotaped response was viewed and rated independently by four psychiatrists as to family health at the global level (Lewis et al., 1976). Correlations of the four raters are presented below:

Correlations Between Rank Order of 33 Families' Global Health/Pathology by Four Raters

| Raters | r* | p |
|---|---|---|
| E:I | .54 | .03 |
| C:K | .38 | .10 |
| C:E | .28 | .10 |
| C:I | .45 | .06 |
| K:E | .47 | .05 |
| K:I | .39 | .09 |

*Spearman Rank Order Coefficient
(Lewis et al., 1976, p. 44)

From these ratings the six top and six bottom families of the original 33 families were consistently identified (Lewis et al., 1976).

A further videotaped 3 hour interview and individual testing were the bases of more intensive study of the 12 healthy families whose later subdivision terms became the optimally functioning families and the adequately functioning families (Lewis et al., 1976). These videotapes and

individual psychological evaluations provided assessment data at the levels of clinical observations and individual evaluations, whereas a detailed examination of the Riskin and Faunce method (the fifth interaction task for the 33 families) provided assessment data at the level of microanalysis (Lewis et al., 1976).

The central finding of the study, however, related to the specific items included in the Beavers-Timberlawn Evaluation Scales. The relationships between these scales and the global scale are presented below according to the ratings of 33 healthy families by an experienced psychiatric social worker and the 70 families of hospitalized adolescents by an experienced clinical psychologist:

Relationship Between
Beavers-Timberlawn Evaluation Scales and
Global Family Health-Pathology Scales*

| | | |
|---|---|---|
| I. | Structure | |
| | Style of Leadership | .77 |
| | Coalition | .70 |
| | Closeness | .60 |
| II. | Autonomy | |
| | Self-Disclosure | .52 |
| | Responsibility | .74 |
| | Invasiveness | .30 |
| | Permeability | .68 |
| III. | Affect | |
| | Expressiveness | .63 |
| | Feeling Tone | .69 |
| | Conflict | .78 |
| | Empathy | .75 |

| | | |
|---|---|---|
| IV. | Perception of Reality Mythology | .79 |
| V. | Task Efficiency Negotiation | .67 |
| | SUM OF SUB-SCALES | .90 |

*Pearson Product Moment Correlation Coefficient, level of significance on each scale was $p < .005$. (Lewis et al., 1976, p. 93)

Both of these raters had showed significant interrater reliability with a third rater, a registered nurse graduate student, who had rated subsamples of the two populations (Lewis et al., 1976).

> As can be noted, there was a significant correlation for each of the Beavers-Timberlawn Family Evaluation Scales and the Global Family Health-Pathology Scale. The high correlation of the sum of the 13 scales with a measure of global family health-pathology supported the hypothesis that most of the relevant dimensions implicitly used by clinical raters were included in the 13 scales (Lewis et al., 1976, p. 92).

In light of these significant correlations and the healthy as well as pathological scope of these scales (Gantman, 1980), it appears that the primary goal of the Timberlawn Research Foundation's study to measure family interactional data has been achieved (Lewis et al., 1976). Therefore, for the present study, the Beavers-Timberlawn Family Evaluation Scale is the observational instrument of choice to measure patient-family factors influenced during treatment and patient-family factors influencing treatment.

## Conceptual Frameworks

The problem of this study is the discovery of the coexistence of therapist skills with changes in family behaviors during actual marital and family therapy sessions. More specifically, a determination needs to be made of which therapist skills correspond highly with certain areas of family growth in particular types of families. Accordingly, the intention of this study is to correlate therapist skills with changes in family behaviors during actual marital and family therapy sessions. Up to this point in the literature review various studies have been discussed as to their utility in the measurement of therapist skills and family behaviors and the studies involved in the development of the two instruments of choice (See Appendices A and B) were presented in detail. In the present section the conceptual frameworks of the two instruments are presented in order to identify and describe the assumptions and theoretical orientations which were foundational to the development of the instruments.

In the identification of the therapist factors representing structuring and relationship skills Laird (1981) relied entirely upon the descriptors presented by Kniskern and Gurman (1979). Of the eight descriptors used by Kniskern and Gurman (1979), six of them were taken from Alexander et al.'s study (1976), whereas the two remaining descriptors were taken from Sigal et al.'s studies (1973; 1967). For

structuring skills, directiveness, clarity and self-confidence were taken from Alexander et al.'s (1976) study, whereas information-gathering and stimulating interaction were taken from the studies of Sigal et al. (1973; 1967). For relationship skills affect-behavior integration, humor and warmth were taken from Alexander et al.'s study (1976).

According to Barton and Alexander (1981) directiveness is the therapist's ability to control optimally the processes of the family and "includes process forms such as giving instructions, prompting family members to speak, and giving them corrective feedback or support for their efforts toward adaptive behavior change" (p. 432). The stylistic trait of self-confidence is the impression conveyed to the family of the therapist's mastery of himself/herself and the procedures which are being presented to the family (Barton and Alexander, 1981). It is important for the therapist to reflect competence, confidence in himself/herself and, "probably most importantly for the family, confidence in the procedure" (Barton and Alexander, 1981, p. 433). Clarity is the therapist's ability to portray in a clear and sequentially organized fashion information and specific descriptions of skills that the family needs to learn (Barton and Alexander, 1981).

The structuring skill of stimulating interaction is described by Barton and Alexander (1981) when they speak of "prompting family members to speak" (p. 432). However, this

structuring skill was mainly taken from Sigal et al. (1967) who contend that one of the principal aims of the therapist is to help the family to improve the clarity and directness of communication with each other so that all of the family members can participate equally and appropriately. Sigal et al. (1973) found that information-gathering along with the provision of support and interaction stimulation was a needed skill for the therapist to execute in early therapy sessions. Information-gathering becomes a crucial skill because it is critical for the therapist to identify accurately the idiosyncratic needs of each family in order to establish goals for therapy (Barton and Alexander, 1981).

According to Barton and Alexander (1981) the integration of the affect and behavior realms is the relationship skill that "is stylistically represented when the therapist complements family members' reports of either realm with the other" (p. 430). This relationship skill involves relabeling and reattribution of a charge such as, "He's a rotten kid." to an integration of affect associated with a specific behavior, such as, "You both feel frustrated when he doesn't act in ways you'd like him to, such as going to school." (Barton and Alexander, 1981, p. 430). The relationship skills of warmth and humor are employed by a therapist to confuse family members and create an atmosphere in which family members can view themselves objectively (Barton and Alexander, 1981). In an accusatory or blaming argument between a husband and

wife the warmth of a therapist can lead to intimacy or closeness-seeking when a therapist responds: "Gee, I'm really concerned with how upset you're getting. Let's talk about it some more so I can understand it better." (Barton and Alexander, 1981, p. 431). Alternatively, the humor of a therapist can effectively produce distance if the couple in this same situation are having difficulty dealing with the seriousness of emotions, when the therapist says, "Do you folks issue crash helmets." (Barton and Alexander, 1981, p. 431). In both responses a therapist can alter the family members' perceptions of their behavior and emotions and help them to respond in new and different ways when he/she revalences the typical affect usually associated with the situation (Barton and Alexander, 1981).

In terms of sequence in actual family therapy sessions relationship skills are typically employed first by a therapist and they are followed by the use of structuring skills (Barton and Alexander, 1981). While there may be exceptions when the therapist must employ structuring skills in order to have an opportunity to use relationship skills (Gurman and Kniskern, 1981), relationship skills are utilized most often by a therapist to build an adaptive relationship that make it possible later in therapy for him/her to structure adaptive ways for a family to change (Barton and Alexander, 1981). The relationship skills are both statistically (Alexander et al., 1976) and conceptually interdependent (Barton and

Alexander, 1981) and are the best predictor of effectiveness of a therapist (Alexander et al., 1976). Laird refers in summary form to the category of relationship skills as "establishing rapport" (1981, p. 13).

Relationship skills are used in the therapy phase of intervention while structuring skills are used in the education phase of intervention (Barton and Alexander, 1981).

> It is presumed that a therapist's relationship skills will influence the family in ways that prepare them for change, while the structuring skills will be more important in helping families implement change technology (Barton and Alexander, 1981, p. 432).

Structuring skills are also statistically (Alexander et al., 1976) and conceptually interdependent (Barton and Alexander, 1981). Laird refers in summary form to the category of structuring skills as "establishing administrative control" (1981, p. 13). The two categories of structuring skills and relationship skills have been found to be statistically interdependent (Alexander et al., 1976) and both are needed fundamentally and universally (Laird, 1981) to move a family actively toward change (Barton and Alexander, 1981).

The conceptual framework that is foundational to the Beavers-Timberlawn Family Evaluation Scale is provided by W. Robert Beavers, M.D. (Lewis et al., 1976). Beavers (1976) acknowledges that his theory of family systems was significantly influenced by general systems theory. Entropy is a systems' term referring to a closed system with no energy

coming from the outside and a rigid structure with little or no flexibility (Beavers, 1976). The opposite of entropy is negentropy which is the development of structure and flexibility needed to utilize energy from the less organized and less structured outside world (Beavers, 1976). Beavers (1976) compares the concept of negentropy in family systems to a world in which there is no external source of energy and where mountains would disorganize, disintegrate and fall into the sea. Beavers (1976) also compares negentropy of family systems to a one-celled organism receiving energy from the entropic outside world which is used to develop and sustain the organism's structure and flexibility.

> Healthy families show the characteristic of a highly negentropic system. Structure is clear and flexible, but carried lightly. Function is the greater concern. Changes in direction are not threatening . . . They enjoy negotiations and welcome new input into the system--examine, evalute, but nevertheless welcome . . . When an organism is not at war with itself (whether that organism is a person or a family) and is able to accept and affirm its basic qualities, the most negentropic state is attained: structure with flexible, adaptive function (Beavers, 1976, p. 50).

In a time when technology and social structures are changing at an extremely rapid rate, a rapidly adapting family system is more of a necessity than a luxury (Beavers, 1976).

One striking feature of Beavers' notion of negentropy is that families can be classified anywhere on a continuum between and including total entropy and total negentropy (Beavers, 1977).

> For purposes of simplicity and coherence, we can place all family systems on a continuum from the most entropic--those most disorganized and chaotic--to some that are rigid and inept, on to the healthy systems--those most organized and yet flexible. For this purpose we will discuss three general levels of family functioning: the seriously disturbed, the midrange, and the healthy . . . Descriptions of family characteristics at stages along the continuum emphasize the view that most human psychopathology evolves not from a specific, qualitatively different kind of system but as a result of the deficiency of needed qualities along several dimensions of family interaction (Beavers, 1974, p. 183).

The concept of negentropy makes it possible to classify families "on a continuum reflecting functioning which can also accommodate different family styles that are important but unrelated to specific levels of competence" (Beavers, 1977, p. 29). While the general categories of severely dysfunctional family, midrange family and healthy family reflect relative levels of family functioning on a continuum, the style of a family is determined by how members relate to the outside world (Beavers, 1981). The two "styles are related to the degree that family members tend to leave the family (centrifugal) or cling together (centripetal)" (Beavers, 1976). While family functioning can be measured anywhere on the continuum (Severely dysfunctional, midrange, or healthy), family style (centrifugal or centripetal) is of more value in understanding the system variables of the severely dysfunctional and midrange families (Beavers, 1981). Influenced by the concept of negentropy, Beavers (1976) concluded from data published at that time, clinical observations

and early research at the Timberlawn Foundation that the five qualities considered important in the development of capable, adaptive and healthy individuals were: (1) power structure, (2) the degree of family individuation, (3) acceptance of separation and loss, (4) perception of reality, and (5) affect. Therefore, the health and sickness of a family system are viewed from these theoretical perspectives.

The power structure or "pecking order" of families can be viewed on a continuum ranging from a low end where family interaction is so poorly defined and delicately balanced that little or nothing can change or develop to a high end where power is held rigidly and inflexibly by one family member who is viewed and accepted as dominant (Beavers, 1976). In quite flexible family structures power is shared and relating competence is developed through experiencing a generous and benign leader (Beavers, 1976). The interactional pattern of power is greatly determined by the family's assumption about the nature of human beings and human encounter (Beavers, 1976). If encounters are seen as painful yet necessary, family structure is based on an assumption of opposition and members become either dominant or submissive (Beavers, 1976). If encounters are seen to be affiliative, then the power is shared and the structure is more egalitarian (Beavers, 1976). Identity formation in a child is aided when the family structure is complete in the sense of two adult role models of the opposite sex involved in an intimate committed relationship

(Beavers, 1976). While the most dysfunctional families often have a powerless father and strong coalitions between mother and child, the healthy families have a clear hierarchy of power in which father exerts the most leadership with a strong coalition with mother as the next most powerful person and with child having less power and yet able to contribute and influence family decisions through the process of negotiation and compromise (Beavers, 1976). While the centrifugal midrange families, which often produce behavior disorder children, have a shifting pattern of dominance in which neither parent is able to wrest control consistently from the other, the centripetal midrange families, which often produce neurotic children, are able to establish a consistent hierarchy of power in which one parent is in charge (Beavers, 1976).

In family systems the degree to which individuation is tolerated and encouraged relates to the development of autonomy in family members (Beavers, 1976). Without autonomy a child is likely to fail in separating from his family of origination and remain overly dependent (Beavers, 1976). In the severely dysfunctional families there is a marked failure of members to take responsibility for their own actions, feelings, motivations or future goals (Beavers, 1976). There is little or no individuation as members often speak for each other, invade each other's space and are impermeable to being receptive and open to other members (Beavers, 1976). Since

for midrange families, man is evil in nature, much control is needed and ambivalence is mismanaged by producing family scapegoats (Beavers, 1976). Accordingly, centrifugal midrange families see any effort to be noble or competent as fraudulent, whereas centripetal midrange families develop external scapegoats outside of the families (Beavers, 1976). To reduce significant individuation centripetal midrange families avoid personal responsibility by appealing to an invisible referee, whereas the centrifugal midrange families use blame to avoid personal responsibility (Beavers, 1976). In midrange families discipline of children extends beyond behaviors to the control of thoughts and feelings (Beavers, 1976). Impermeability is accomplished by centripetal midrange families through communication by taking turns speaking with no interruptions of feeling expressions and by centrifugal midrange families through several conversations in progress at once with no acknowledgement of each other as parts of the family units (Beavers, 1976). Since healthy families see the nature of man as good and are comfortable with ambivalence, individual family members can be known, visible, make mistakes, give and receive respect for individual thoughts and feelings and openly acknowledge each others' communications in family negotiations (Beavers, 1976).

One important sign of successful individuation is the acceptance of separation and loss (Beavers, 1976). The family self-destructs in that children grow up and leave home

and parents grow old, have failing functions and die (Beavers, 1976). Since severely dysfunctional families are the least individuated, they have great difficulty in dealing with change in a healthy and direct way (Beavers, 1976). Midrange families also deal poorly with separation of parent from child and child from parent by having problem parent-child relationships over three generations and failing to mourn losses of death or growth through recreating family relationships with susceptible people outside of the family units (Beavers, 1976). The healthy families handle object loss capably through a strong marital coalition, meaningful contacts outside the family system and a transcendent value system (Beavers, 1976).

Families develop a shared view of themselves as they continually interact and influence each other (Beavers, 1976). Some families view themselves or have a family mythology that closely corresponds with what outside observers see, whereas other families hold distorted and unrealistic perceptions and beliefs about themselves (Beavers, 1976). For the severely dysfunctional families the disparity between family mythologies and reality is so great that these families operate in a shared fantasy (Beavers, 1976). Midrange families have mythologies more in tune with reality except in the area of feelings. Centripetal midrange families watch and control behavior carefully and consequently have a largely congruent mythology in the area of performance.

However, both centripetal and centrifugal midrange families have incongruence in the area of emotional pain (Beavers, 1976). The myths of healthy families are quite close to the observers' views. They are quick to deal with emotional pain and can adjust from their typical roles if circumstances require such change (Beavers, 1976). People are different from animals in that each new generation of human beings can potentially begin where the former generation stopped (Beavers, 1976). However, severely dysfunctional families do not deal well with the passage of time in that they obscure the biological clock by replacing reality with fantasy through family interaction that is repetitive, stereotyped and absent of real encounter (Beavers, 1976). For midrange families the reality of the passage of time is first distorted and then painfully and gracelessly accepted (Beavers, 1976). Since healthy family members are individuated, the pain of separation and loss is significantly lessened and in the light of the reality of change true encounters occur (Beavers, 1976).

The dimensions of family affect include the prevailing mood or feeling tone, the degree of feeling expression, the quality of empathy and the degree of unresolvable conflict reflected in the family's feeling tone (Beavers, 1976). In severely dysfunctional families the absence of individuation and presence of a high level of maladaptive interpersonal behaviors create a markedly negative affective climate

(Beavers, 1976). Midrange families frequently experience an assortment of negative moods including depression, sadness, criticism and low level bickering with occasional explosive and argumentative interchanges (Beavers, 1976). Healthy families strongly demonstrate direct and open expressions of tenderness, warmth, hopefulness and humor (Beavers, 1976). The highly positive affective climate (a warm and expressive tone) is considered a byproduct of effective healthy family function which is made possible through a shared power structure, a high degree of individuation, acceptance of separation and loss and a realistic family self-perception (Beavers, 1976).

The conceptual framework that led to the development of the instrument called the Beavers-Timberlawn Family Evaluation Scale has been presented. One additional and related conceptual framework still needs to be presented. After several years of clinical and research work and refinement Beavers (1981) developed a family typology that is derived from scores from the Beavers-Timberlawn Family Evaluation Scale. This identification of family types reflects two family dimensions: (1) Competence of family behaviors, and (2) Style of relating to the outside world (Beavers, 1981). The conceptual framework for the development of Beavers' (1981) categories for family types is a refinement, elaboration and extension of the theoretical assumptions and orientations that have been reviewed earlier in this study. Beavers

(1981) reorganized and added to his earlier works (1976; 1977) to identify seven types of families. Healthy families are typed as (1) optimal and (2) adequate, whereas midrange families are typed according to the three styles of (3) midrange centripetal (MRCP), (4) midrange centrifugal (MRCF) and (5) midrange mixed (MR Mixed) (Beavers, 1981). Severely dysfunctional families are typed according to the two contrasting styles of (6) severely dysfunctional centripetal (SDCP) and (7) severely dysfunctional centrifugal (SDCF) (Beavers, 1981). Beavers (1981) refined an earlier diagram (1977) to develop a visual representation of this sytem of family types (See Appendix E).

Lewis et al. (1976) found healthy families to be divided into optimal families and adequate families. Optimal families (Type 1) are considered a model of effective functioning in that they experience reciprocal behavior interaction, attempt many different approaches to reach solutions to the families' problems, seek and most often achieve intimacy, respect individual boundaries and achieve individuation (Beavers, 1981). In optimal families parents share power flexibly and conflict is ordinarily resolved quickly in that individual differences and needs are respected. While children of adequate families (Type 2) appear as healthy as their counterparts from optimal families, parents of adequate families struggle more for control and find themselves less able to experience intimacy and trust and to be spontaneous

and happy than their optimal families' counterparts (Beavers, 1981). In sex role stereotyping males are more powerful and unemotive, whereas females are less powerful and more emotive (Beavers, 1981). While experiencing some pain and loneliness, adequate families are infrequently seen by mental health professionals (Beavers, 1981).

The midrange group of families are sane, but are vulnerable to emotional illnesses (Beavers, 1981). Midrange centripetal families (Type 3) and midrange centrifugal families (Type 4) have been thoroughly described and identified earlier in this study. Mixed midrange families (Type 5) experience alternating and conflicting behavior. The parental coalition varies from a stable dominance and submission arrangement to continual bickering and blaming, whereas the children alternate between accepting and resisting control from the parents (Beavers, 1981).

The severely dysfunctional centripetal families (Type 6) have an almost impermeable boundary to the outside world (Beavers, 1981). In these families rules remain unclear and unchanged and ambivalence is denied (Beavers, 1981). The energy needed for clinging is supplied by the acceptance of positive feelings and the tangential or behavioral expression of negative feelings (Beavers, 1981). Children rarely individuate from the family and a schizophrenic break is one faulty attempt to achieve individuation (Beavers, 1981). Severely dysfunctional centrifugal families (Type 7) have

almost no boundary to separate them from the outside world (Beavers, 1981). These families, who are sometimes uncertain about who has membership in the families, interact with open hostility and contempt (Beavers, 1981). In these families transactions are incomplete and confused and ambivalence is denied, whereas expressions of negative feelings are expected and warm and tender feelings are indirectly or behaviorally expressed (Beavers, 1981). In this way energy is provided for these families to experience a cycle of leaving angrily and returning sullenly (Beavers, 1981). The lack of nurturing, warmth and tenderness for children of these families often results in offsprings who develop antisocial personalities (Beavers, 1981). Child abuse, drug abuse and sexual deviance are problems often experienced in these families (Beavers, 1981).

# CHAPTER 3

## METHODOLOGY

### Restatement of Conceptual Frameworks

Each of the two instruments that have been chosen to measure therapist skills (See Appendix A) and family behaviors (See Appendix B) has an underlying conceptual framework. The framework represents the assumptions and theoretical orientations which were foundational to the development of each of the instruments. In the present section these assumptions and theoretical orientations are summarized for both of the instruments. This summary begins with a consideration of the framework for therapist skills.

In the categorization of groups of therapist factors two sets of skills have been identified: (1) structuring skills and (2) relationship skills (Alexander et al., 1976). Structuring skills have been specified as directiveness, clarity, self-confidence (Alexander et al., 1976), information gathering and stimulating interaction (Sigal et al., 1973; Sigal et al., 1967). Relationship skills have been specified as affect-behavior integration, humor and warmth (Alexander et al., 1976). Laird (1981) summarizes structuring skills as "establishing administrative control" (p. 13) and relationship skills as "establishing rapport" (p. 13). There is a statistical (Alexander et al., 1976) and conceptual (Barton and Alexander, 1981) interdependence within and between each

set of skills as they have an interactive effect on each other and cannot be considered separately in actual therapy sessions. Relationship skills are typically employed by a therapist to form an adaptive relationship with a family that is needed for a therapist, through the use of structuring skills, to structure adaptive ways for a family to change (Burton and Alexander, 1981).

In the categorization of family behaviors the competencies of a family are measured on a continuum reflecting family illness to family health (Beavers, 1976). Beavers (1976) applies the general systems concept of negentrophy to family systems and contends that the healthy negentropic family system constructively utilizes energy from outside of the system through the development of a flexible family structure. In measuring family competencies largely in terms of family functioning and interaction, Beavers (1976) categorizes a family at three general locations along the continuum from family illness to family health according to the following descriptors: (1) Severely dysfunctional, (2) mid-range, and (3) healthy. In addition to measuring family competencies Beavers (1976) also classifies a family according the style that a family employs in relating to the outside world. The two styles are centripetal (family members tend to cling together) and centrifugal (family members tend to leave the family) (Beavers, 1976). The dimensions of level of family competency and functioning and style of

relating to the outside world can be analyzed in terms of the following five negentropic qualities of families who produce capable, adaptive and healthy individuals: (1) power structure, (2) the degree of family individuation, (3) acceptance of separation and loss, (4) perception of reality, and (5) affect (Beavers, 1976).

At the low end of the competence continuum are the severely dysfunctional families (Beavers, 1976). Their power structure is chaotic with a strong parent-child coalition often existing between mother and an identified patient-child while father is impotent and excluded (Beavers, 1976). Fusion among family members often leads to blurred boundaries, unclear identities, shifting roles, scapegoating, evasion of responsibility and invasiveness (Beavers, 1976). These families are unable to cope with change and loss in that they are often timeless, repetitive in routine and deny separation or death through escaping into fantasy (Beavers, 1976). These families have a very poor sense of reality in general as they often escape into fantasy satisfactions (Beavers, 1976). In terms of affect these families often suffer with cynicism, sadism, hopelessness, hostility and despair (Beavers, 1976).

In the middle section of the competence continuum are midrange families (Beavers, 1976). The power structure of these families is one of rigid control with little negotiation between members (Beavers, 1976). In these families

parents are either competing for dominance (centrifugal style) or form a dominant-submissive relationship (centripetal style) (Beavers, 1976). In these families individual identities are defined at the high costs of emotional distancing, restriction of potential and spontaneity and male/female role stereotyping (Beavers, 1976). For these families change and loss are accepted painfully and gracelessly in that separation and death are handled by finding a substitute outside of the family units as a recipient of transferred and uninternalized feelings (Beavers, 1976). Sense of reality for these families is adequate for daily functioning, although distortions of perception cause interpersonal pain and turmoil (Beavers, 1976). Affect in these families is observed as hostile (centrifugal style) or subdued, restricted and joyless (centripetal style) (Beavers, 1976).

At the high end of the competence continuum are the healthy families (Beavers, 1976). These families have a flexible structure of shared power in a strong parental coalition where children are consulted and decisions are reached through negotiations (Beavers, 1976). In this structure there is a clear hierarchy with mutual respect (Beavers, 1976). Individual identities in these families are well defined and secure which allows both high levels of closeness/intimacy and individual responsibility (Beavers, 1976). In these families change, growth and death are accepted realistically and handled in a healthy way through a strong

parental coalition in relation to younger and older generations, important relationships outside of the family and a meaningful transcendent value system (Beavers, 1976). These families have images of themselves individually and collectively that are congruent with reality as seen by outside observers (Beavers, 1976). The affect of these families has an expressed feeling tone of empathy, warmth, humor, wit, enjoyment and tenderness (Beavers, 1976).

After several years of refinement and elaboration through further research and clinical experience, Beavers (1981) revised the dimensions of family competence and family style to develop a family assessment system for family therapists whereby families are classified according to one of the following seven types: Type 1. Optimal Families; Type 2. Adequate Families; Type 3. Midrange Centripetal Families (MRCP); Type 4. Midrange Centrifugal Families (MRCF); Type 5. Midrange Mixed Families (MR Mixed); Type 6. Severely Dysfunctional Centripetal Families (SDCP); and Type 7. Severely Dysfunctional Centrifugal Families (SDCF). Beavers (1981) developed a diagram (See Appendix E) to provide a visual representation of this family classification system. This system can be largely understood from the earlier theoretical account (Beavers, 1976) that has been presented. However, some modifications and additions require further explanations. Types 1 and 2 are subdivisions of the group of families termed healthy families with Type 1 representing

the model of effective functioning and Type 2 representing to a slight degree some of the coalition and affective difficulties of the midrange families. The midrange families of Types 3 and 4 (Beavers, 1981) are essentially the same as the groups of families presented earlier by the same descriptors (Beavers, 1976). Midrange mixed families (Type 5) are the midrange families who exhibit alternating and conflicting centripetal and centrifugal styles of behavior (Beavers, 1981).

Severely dysfunctional centripetal families (Type 6) are those severely disturbed families whose family members are handicapped by an extremely low level of individuation (Beavers, 1981). A schizophrenic break of children from these families is one faulty solution often attempted to resolve the lack of individuation (Beavers, 1981). Severely dysfunctional centrifugal families (Type 7) are those severely disturbed families whose perimeter is so poorly defined that sometimes members are uncertain about who constitutes the family (Beavers, 1981). These families, who interact through open hostility and contempt, often produce children with antisocial personalities (Beavers, 1981).

Instrumentation Derived From Conceptual Frameworks

Through the measurement of therapist's structuring and relationship skills (Laird, 1981) obtained from videotapes of marital and family therapy sessions a picture of therapist

skills during therapy was obtained. Through the measurement of family competencies and style (Lewis et al., 1976) a picture of family behaviors during therapy was provided. By comparing the measurements of family competencies and style obtained from a videotape of session two with the measurements from a videotape of session seven, a picture of changes in family behaviors that occurred during family therapy was obtained. Furthermore, through these measurements of family competencies and style, it was thought that the type (Beavers, 1981) of a particular family could be determined. By employing the rating scales that have been developed (See Appendices A and B) measurements of therapist skills (Laird, 1981) and changes in family behaviors (Lewis et al., 1976) were obtained. Through the conceptual frameworks of these two instruments some answers to the primary research question were provided: Are there certain therapist skills that are closely associated with changes in certain family behaviors? From measurements obtained through these two instruments correlations between therapist skills and changes in family behaviors were determined.

## Research Design

The present study is an exploration of the correlations between the therapist skill variables and changes in family behavior variables that occur during actual marital and family therapy. Accordingly, information sought to answer

the primary research question: Are there certain therapist skills that are closely associated with changes in certain family behaviors? The information for this study was obtained from ratings of videotaped sessions of actual marital and family therapy.

After comprehensive and intensive search efforts, five sets of videotapes were obtained from university family therapy training centers where permission for training and research use of the videotapes had been obtained from all parties involved. Each set contained videotapes of sessions two and seven in their entirety (Alexander, 1982). Each session was edited by making a videotape copy that consisted of three segments of the first four minutes, the middle four minutes and the last four minutes (Alexander et al., 1976). This editing procedure was consistently applied to sessions two and seven of each of the videotapes of the five different therapists and families. The sequence of the twelve minute segments of each session was in the order in which the original videotape had been produced. To conceal the original order of session two being followed by session seven for each of the five families, all ten sessions were numbered one through ten and these ten numbers were reordered according to a random digits' table (Hopkins and Glass, 1978). In this way family raters could not discriminate session two from session seven on the basis of the order of presentation on the videotape.

Three therapist raters were randomly selected from available and qualified raters. The qualifications of raters to rate therapists according to the Family Therapist Rating Scale were: (1) Two courses in marital and family therapy; (2) Two years experience in the practice of marital and family therapy (Laird, 1981). Each of the three therapist raters viewed the twelve minute segments of each of the five therapists alone without interaction between other raters or the experimenter. Each of the raters was lead into a room that had a video monitor and tables and chairs. Each rater was asked to be comfortably seated. Lighting and temperature were consistent for all three raters. Each rater was given the Family Therapist Rating Scale and the instructions at the top of the first page (See Appendix A) were read to each rater. Each rater was asked by the experimenter if he/she had any questions regarding rating instructions. None of the three raters asked any questions at this point. The experimenter then left the room and each of the three raters viewed the prepared videotape and rated each of the five therapists. At the end of the viewing of the prepared videotape the experimenter returned to the room and collected the five completed rating sheets from each of the three raters. In this way each of the raters viewed and rated the videotape of the same five therapists independently from each other.

While the raters of the therapists required no former training on the Family Therapist Scale (Laird, 1981) the raters of the families required extensive training to use the Beavers-Timberlawn Family Evaluation Scale (Lewis et al., 1976). Accordingly, the qualifications of the candidates for family raters were one unit of internship training in the use of the Beavers-Timberlawn Family Evaluation Scale under the instruction of W. Robert Beavers, M.D. Three family raters were randomly selected from available raters who met the qualification stated above. These three raters experienced the exact same procedures that have been described in connection with the three therapist raters with the exception of certain appropriate differences.

These differences are now described. Each rater was given the Beavers-Timberlawn Family Evaluation Scale and the instructions at the top of the first page (See Appendix B) were read to each rater. Additionally, each rater was asked to type the family viewed in each session according to Beavers' family typology (Beavers, 1981). Each rater was asked by the experimenter if he/she had any questions regarding rating instructions. None of these three raters asked any questions at this point. While therapist raters rated only session two on the five therapists' skills (Alexander et al., 1976), family raters rated both sessions two and seven so that a change score for each of the five families could be calculated. With the exception of these

stated differences, the procedures of family raters were exactly the same as the procedures of the therapist raters that were described in detail.

After all the rating forms were completed, the data were tabulated, checked and entered into a computer for the performance of several operations. The tabulation and change scores were verified by the computer. Pearson Product-Moment Correlation Coefficients were obtained to determine the degree of agreement between the raters. From data with acceptable rater agreement (.72) Spearman Rank Correlation Coefficients were obtained to represent the degree of association that existed between certain therapist skills and certain changes in family behaviors that occurred during therapy. Bayes theorem was applied to the data that were treated by the Spearman Rank Correlation Coefficients to determine the conditional or posterior probabilities of the discovered associations between therapist skills and changed family behaviors.

The data were reorganized in several ways. Lists were composed to reflect in descending order the highest to lowest scored therapist skills and areas of family change. Another list was composed to reflect in descending order the strongest to weakest associations between therapist skills and changed family behaviors. The typology ratings were tabulated and compared to determine the type(s) of families being treated in family therapy. Other lists were composed

to reflect the degree of association that existed between the various therapist skills and changed family behaviors. The presentations and analyses of the findings of this study are predicated upon the procedures and data treatment that have been described in this section.

# CHAPTER 4

## PRESENTATION OF DATA

### Interrater Reliability

In this section the data on the interrater reliability are presented. In general interrater reliability is quite low. The specific levels of disagreement experienced by the three raters who rated the five therapists are presented in Table 4.1.

Table 4.1

Correlations of Ratings of
Therapist Skills By Three Raters

| RATERS | r |
|---|---|
| A:B | .36 |
| A:C | .20 |
| B:C | .23 |

The highest level of agreement existed between raters A and B. The next highest level of agreement existed between raters B and C. The lowest level of agreement among raters of therapist skills was between raters A and C. The interrater reliability of the three sets of ratings using Cronbach Alpha was .52.

The level of disagreement between the raters of family behaviors is slightly more than the disagreement experienced

between the raters of therapist skills. The specific levels of disagreement experienced by the three raters who rated behaviors in the five families are presented in Table 4.2.

Table 4.2

Correlations of Ratings of Family Behaviors By Three Raters

| RATERS | r |
|---|---|
| D:E | .04 |
| D:F | .53 |
| E:F | .13 |

The highest level of agreement existed between raters D and F. The next highest level of agreement existed between raters E and F. The lowest level of agreement among raters of changes in family behaviors was between raters D and E. The interrater reliability of the three sets of ratings using Cronbach Alpha was .42. Furthermore, these raters disagreed on typology to the point that the types of the five families could not be identified.

Therapist Ratings

The data from which the interrater reliability was determined for therapists are presented. Raters for each therapist by each rater are presented in Table 4.3

Table 4.3

Ratings of Structuring (Si) and Relationship (Ri) Skills of Five Therapists By Three Raters

| Therapist | 1 | | | 2 | | | 3 | | | 4 | | | 5 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Raters | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |
| S1 | 3 | 2 | 3 | 5 | 1 | 3 | 2 | 1 | 2 | 5 | 3 | 3 | 4 | 3 | 2 |
| S2 | 0 | 0 | 3 | 2 | 1 | 2 | 0 | 3 | 0 | 5 | 3 | 2 | 2 | 3 | 2 |
| S3 | 0 | 1 | 2 | 0 | 0 | 3 | 3 | 1 | 2 | 3 | 4 | 2 | 2 | 1 | 2 |
| S4 | 0 | 1 | 1 | 5 | 2 | 3 | 3 | 1 | 3 | 5 | 4 | 3 | 4 | 1 | 2 |
| S5 | 3 | 3 | 2 | 4 | 3 | 3 | 3 | 3 | 3 | 5 | 4 | 1 | 4 | 3 | 3 |
| S6 | 0 | 3 | 0 | 0 | 3 | 2 | 0 | 3 | 0 | 0 | 2 | 2 | 0 | 3 | 2 |
| S7 | 0 | 1 | 0 | 4 | 0 | 0 | 3 | 3 | 4 | 3 | 1 | 3 | 0 | 0 | 2 |
| S8 | 0 | 1 | 2 | 2 | 0 | 2 | 2 | 0 | 3 | 5 | 4 | 3 | 2 | 0 | 2 |
| S9 | 0 | 1 | 3 | 4 | 0 | 0 | 3 | 0 | 0 | 5 | 3 | 2 | 3 | 0 | 2 |
| S10 | 0 | 1 | 2 | 5 | 1 | 2 | 3 | 2 | 3 | 4 | 5 | 1 | 3 | 1 | 2 |
| S $\bar{x}$ | .6 | 1.4 | 1.8 | 3.1 | 1 | 2 | 2.2 | 1.7 | 2 | 4 | 3.3 | 2.2 | 2.4 | 1.5 | 2.1 |
| R1 | 3 | 2 | 3 | 5 | 1 | 2 | 2 | 3 | 3 | 4 | 4 | 2 | 2 | 3 | 3 |
| R2 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 2 | 5 | 0 | 2 | 2 | 0 | 3 |
| R3 | 2 | 2 | 4 | 3 | 2 | 3 | 2 | 2 | 3 | 5 | 4 | 3 | 3 | 3 | 4 |
| R4 | 4 | 2 | 4 | 4 | 2 | 2 | 4 | 3 | 3 | 4 | 3 | 3 | 4 | 3 | 4 |
| R5 | 3 | 2 | 5 | 5 | 3 | 3 | 3 | 4 | 3 | 5 | 3 | 1 | 3 | 3 | 4 |
| R6 | 0 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | 3 | 5 | 4 | 1 | 4 | 1 | 4 |
| R7 | 3 | 3 | 3 | 4 | 2 | 3 | 3 | 2 | 3 | 5 | 4 | 2 | 4 | 4 | 4 |
| R8 | 2 | 4 | 4 | 5 | 1 | 3 | 2 | 3 | 0 | 5 | 3 | 1 | 3 | 3 | 4 |
| R9 | 0 | 3 | 3 | 4 | 2 | 3 | 2 | 3 | 3 | 5 | 4 | 3 | 2 | 3 | 4 |
| R10 | 0 | 0 | 1 | 4 | 0 | 2 | 0 | 0 | 2 | 5 | 4 | 3 | 4 | 3 | 4 |
| R $\bar{x}$ | 1.7 | 2.2 | 3.1 | 3.8 | 1.6 | 2.8 | 2.2 | 2.4 | 2.5 | 4.8 | 3.3 | 2.1 | 3.1 | 2.6 | 3.8 |

The specific therapist skills that are represented by Si and Ri Skills can be seen in Appendix A.

The mean scores of the ratings of structuring and relationship skills of the five therapists by three raters (See Table 4.3) are presented in Table 4.4.

Table 4.4

Mean Rating Scores of Si and Ri Skills of Five Therapists

| THERAPIST | Si | Ri | $\bar{x}$ |
|---|---|---|---|
| 1 | 1.27 | 2.33 | 1.8 |
| 2 | 2.07 | 2.73 | 2.4 |
| 3 | 1.97 | 2.37 | 2.17 |
| 4 | 3.17 | 3.4 | 3.29 |
| 5 | 2 | 3.17 | 2.59 |
| $\bar{x}$ | 2.1 | 2.8 | 2.45 |

The mean score of all structuring skills was 2.1, whereas the mean score of all relationship skills was 2.8. The mean score of all therapist skills was 2.45. According to the categories of effectiveness listed in Appendix A, each of the three mean scores is neutral.

Changes in Family Behaviors

Changes in family behaviors were determined by a subtraction of each score of family behavior of session two from each score of session seven. In this way a change score on each behavior was obtained and represented either a loss or a gain that had occurred during marital and family therapy between session two and session seven. This operation may be expressed symbolically in the form of a formula.

$$(F3 \text{ at } t_2) - (F3 \text{ at } t_1) = \Delta F3$$

For example, the change score for F3 in family one by rater D was determined in the following way.

$$(F3 \text{ at } t_2) - (F3 \text{ at } t_1) = \Delta F3$$

$$4 - 4.5 = -.5$$

According to rater D, family one experienced a loss of .5 on F3 between session two and session seven. All observed changes for each family behavior ( Fi) is recorded for each of the five families in Table 4.5.

Table 4.5

Changes in Behaviors (ΔFi)
of Five Families As Determined By Three Raters

| Families' Behavior | 1 | | | 2 | | | 3 | | | 4 | | | 5 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Raters | D | E | F | D | E | F | D | E | F | D | E | F | D | E | F |
| ΔF1 | -.5 | -1 | .5 | .5 | 1 | .5 | 0 | -.5 | .5 | -1 | 0 | -.5 | -1.5 | 0 | -2 |
| ΔF2 | N/A | -.5 | -.5 | N/A | 1.5 | 1.5 | 0 | -.5 | 1.5 | -.5 | .5 | -2.5 | N/A | 1 | 0 |
| ΔF3 | -.5 | -.5 | -1 | .5 | 0 | .5 | 0 | 0 | 2 | -.5 | 1 | -.5 | -.5 | 0 | -1.5 |
| ΔF4 | -1 | 2 | -2 | .5 | .5 | 2 | -.5 | 0 | .5 | -1 | 0 | -1 | -.5 | 1 | -.5 |
| ΔF5 | -1 | -1 | 1 | 0 | .5 | N/A | 0 | 0 | N/A | -1 | .5 | -2 | -1.5 | -.5 | N/A |
| ΔF6 | -1.5 | -.5 | -1.5 | .5 | -.5 | 1.5 | 1 | .5 | .5 | -1.5 | 1.5 | -2 | -2 | -1 | -3 |
| ΔF7 | -1 | -.5 | 1.5 | 1 | 1.5 | 3 | .5 | -.5 | 1.5 | -.5 | .5 | 1.5 | -1.5 | -1 | -2 |
| ΔF8 | 0 | 0 | 0 | 0 | -1 | 3 | .5 | -2.5 | 3 | 0 | .5 | 0 | 0 | 1 | -3 |
| ΔF9 | -1 | -1 | -.5 | 1 | 0 | 1.5 | -.5 | 0 | 1.5 | -1 | 0 | -2 | -1.5 | -1 | -2.5 |
| ΔF10 | -1 | 0 | .5 | .5 | -.5 | 2 | .5 | .5 | 2 | -1 | 1 | -.5 | -.5 | -1.5 | -2.5 |
| ΔF11 | -1 | 0 | -.5 | .5 | 1.5 | 3.5 | 1.5 | 0 | 0 | -1 | 0 | 0 | -1 | 0 | -3.5 |
| ΔF12 | .5 | -2 | 2 | 0 | .5 | 3 | 0 | 0 | 1 | -.5 | -1 | -.5 | -1.5 | -.5 | -3.5 |
| ΔF13 | -.5 | -1.5 | -.5 | .5 | 0 | 2 | .5 | -.5 | 0 | -.5 | .5 | -1.5 | -.5 | 0 | -2.5 |
| ΔF14 | 0 | -1 | -1 | 0 | 0 | 5 | 0 | 0 | 3 | -1.5 | 1 | N/A | -1 | -1 | -6 |

The specific family behaviors that are represented by Fi behaviors can be seen in Appendix B. The mean change score for all families and all behaviors according to three raters was -.13. Since this mean score falls between -.99 and .99, it represents a same condition for the families.

Highly Selected Ratings

Since interrater reliability was quite low among raters of therapist skills (.52) and among raters of family behaviors (.42), an effort was made to select therapist skills and changes in family behaviors where the two pairs of raters (A:B and D:F) had the highest level of agreement ($r_p \geq .72$). The therapist skills and respective scores that qualified for inclusion into a group of highly selected skills are listed in ascending order in Table 4.6.

Table 4.6

Mean Scores of Therapist Skills On Which Raters A and B Agreed ($r_p = .72$)

| THERAPIST SKILL | MEAN SCORE |
|---|---|
| S5 | 3.5 |
| R7 | 3.4 |
| R3 | 2.8 |
| S4 | 2.6 |
| R10 | 2 |
| S8 | 1.6 |
| S3 | 1.5 |

The changes in family behaviors and respective scores that qualified for inclusion into a group of highly selected behaviors are listed in ascending order in Table 4.7.

Table 4.7

Mean Scores of Changes in Family Behavior On Which Raters D and F Agreed ($r_p$ = .85)

| CHANGE IN FAMILY BEHAVIOR | MEAN SCORE |
|---|---|
| ΔF12 | .05 |
| ΔF1 | -.35 |
| ΔF4 | -.35 |
| ΔF9 | -.5 |
| ΔF6 | -.8 |

These two groups of highly selected variables represent a quite small fraction (12.5%) of the original data yielded from the total ratings. The selection was made as an effort to overcome the poor interrater reliability problem and fulfill, in a quite small way, the original purpose of the study to correlate therapist skills with changes in family behaviors.

Of the 35 possible correlations between the highest correlated ratings ($r_p \geq .72$) of therapist skills and changes in family behaviors, no significant ($r_p$ or $r_s \geq .72$ at $\leq .05$ level of significance) correlations were determined. Therefore, the purpose of the selection of highly correlated ratings ($r_p \geq .72$) was not fulfilled because no significant

correlations were discovered to exist between therapist skills and changes in family behaviors.

However, these highly selected data were utilized for a different purpose. The application of Bayes theorem (Hayes, 1963) to these data resulted in several conditional probabilities. The data from which the therapists effectiveness was determined are presented in Table 4.8.

Table 4.8

Therapist Skills On Which Raters A and B Agreed ($r_p$ = .72)

| THERAPIST | S3 | S4 | S5 | S8 | R3 | R7 | R10 | $\bar{x}$ |
|---|---|---|---|---|---|---|---|---|
| 1 | .5 | .5 | 3 | .5 | 2 | 3 | 0 | 1.36 |
| 2 | 0 | 3.5 | 3.5 | 1 | 2.5 | 3 | 2 | 2.21 |
| 3 | 2 | 2 | 3 | 1 | 2 | 2.5 | 0 | 1.79 |
| 4 | 3.5 | 4.5 | 4.5 | 4.5 | 4.5 | 4.5 | 4.5 | 4.38 |
| 5 | 1.5 | 2.5 | 3.5 | 1 | 3 | 4 | 3.5 | 2.71 |
| $\bar{x}$ | 1.5 | 2.6 | 3.5 | 1.6 | 2.8 | 3.4 | 2 | 2.49 |

A skill score of 3 or more is considered effective, whereas a skill score of neutral is from 2 to 2.99. A skill score from 0 to 1.99 is considered ineffective. The mean skill score for all therapists on all skills was 2.49.

The data from which the family conditions were determined are presented in Table 4.9.

Table 4.9

Changes in Family Behavior
On Which Raters D and F Agreed ($r_p$ = .85)

| | ΔFi | | | | | |
|---|---|---|---|---|---|---|
| FAMILY | ΔF1 | ΔF4 | ΔF6 | ΔF9 | ΔF12 | $\bar{x}$ |
| 1 | 0 | -1.5 | -1.5 | -.75 | 1.25 | -.5 |
| 2 | .5 | 1.25 | 1 | 1.25 | 1.5 | 1.1 |
| 3 | .25 | 0 | .75 | .5 | .5 | .4 |
| 4 | -.75 | -1 | -1.75 | -1.5 | -.5 | -1.1 |
| 5 | -1.75 | -.5 | -2.5 | -2 | -2.5 | -1.85 |
| $\bar{x}$ | -.35 | -.35 | -.8 | -.5 | .05 | -.39 |

A family behavior score of 1 or more is considered an improved family condition, whereas a score from -.99 to .99 is considered a same family condition. A family behavior score of -1 or below is considered a worsened family condition. The mean family behavior score for all families on all behaviors was -.39.

Bayes theorem was applied to these data to determine the conditional or posterior probabilities of associations between therapist skills and changes in family behaviors. It was found that an improved family condition could be associated with neutral level therapy 100% of the time. It was further found that a same condition of family could be associated with effective therapy 50% of the time and with ineffective therapy 50% of the time. In addition, a worsened condition of family could be associated with effective therapy 50% of the time and with neutral therapy 50% of the time (See Appendix F).

# CHAPTER 5

## ANALYSIS AND DISCUSSION

### Interrater Reliability

Low rater agreement prevented the fulfillment of the major intentions of the present study. The meaning of an average score on either a therapist skill or a change in family behavior is quite suspect when three raters did not agree on what they observed. However, this result is an important finding in the field tests of two instruments that have never been applied directly to family therapy sessions. It is instructive that these instruments were applied according to the specifications of their respective authors (Beavers, 1981; Laird, 1981) and yet low interrater reliability resulted.

What is the meaning of this finding? Does the low interrater reliability of the two scales when they are applied to actual marital and family sessions mean that they have little or no utility in the measurements of therapist skills or changes in family behaviors? There are serious methodological problems that prevent an answer to this question for both instruments at the present time. Other studies need to be conducted on these two instruments before their utility can be fairly determined.

Two serious limitations attend the present field testing of the Family Therapist Family Rating Scale. At the present

time no manual has been produced to give raters some common reference points in the rating process. The second limitation is closely related to the absence of a training manual. No training of the raters was provided. The raters of therapist skills in the present study were read the rating instructions (Laird, 1981) and asked if they had any questions regarding the task. In the light of the claim made by the author (Laird, 1981) and the findings of the present study, it appears that a more accurate picture of the instrument's capacity to measure therapist skills could be obtained if two additional conditions were fulfilled: (1) The development of a training manual would ensure common reference points for the process of rating and (2) Rater training according to the developed manual would ensure a common understanding of the nature and characteristics of the observed skills. Both of these conditions are often inadequately met or neglected entirely in the small amount of research that has been conducted on instruments to measure therapist skills (Pinsof, 1981).

The same two limitations also attend the present field testing of the Beavers Timberlawn Family Evaluation Scale. At the time that this study was conducted no manual had been developed to equip raters with some common reference points in the rating process. However, the raters of the family behaviors did have one unit of rating training on the instrument. Unfortunately, the common training experience did not

provide the raters with an agreement of reference points for rating. In the light of the common training that these raters experienced and the results of the present study, it appears that a more accurate picture of the instruments capacity to measure in-therapy family behaviors could be obtained if the rater training were conducted on the basis of a rating manual. Thus, it seems that a common understanding of the nature and characteristics of the observed family behaviors would be made possible. The lack of common training according to a clear rating manual is often cited as a weakness in the small amount of research that has been conducted on instruments to measure family behaviors (Pinsof, 1981).

Based on the findings of the present study, it is suggested that manuals be developed for both instruments. Furthermore, it is suggested that future raters of the scales receive common and systematic training based on the developed manuals. After these suggestions have been implemented it will then be possible to repeat the remainder of the present study and get some valuable indicators of the utility of the two scales for measurement of therapist skills and changes in family behaviors that occur during marital and family therapy sessions. After raters have been trained according to the two developed manuals, it can be determined if these two instruments represent the research technology needed to correlate therapist skills with changes in family behaviors

within a certain type of family. If the results of the next field test of both instruments are positive a word of caution is in order because clear conclusions can come only from repeated field testing of the two instruments (Pinsof, 1981). The present study does not discourage further research on the two instruments of choice, but it does provide vitally important direction to such research efforts.

Highly Selected Ratings

In spite of the quite low interrater reliability an effort was made to obtain some extremely broad notion of association between therapist skills and changes in family behaviors. A strong word of caution needs to be mentioned in relation to the following analysis and discussion of data. The entire study was quite limited in scope in that it focused on therapist skills of only five therapists and changes in behaviors of only five families. The following discussion is based only on those selected ratings of the best two out of three raters in each of the two sets who achieved a high ($\geq .72$) level of agreement. In addition to rater selection, the items that qualified for correlation represent only a small part of the total data of the study. Because of extremely low interrater reliability only 12.5% of the total study qualified for correlational and probability computations. Therefore, the following discussion is extremely limited in scope.

Unfortunately, from a possible 35 correlations, no significant correlations were found. From the data in Table 4.8 and Table 4.9 no acceptable ($r_p \geq .72$ or $r_s \geq .72$ at $\leq .05$ level of significance) correlations were computed. Therefore, it became impossible to fulfill in any way the original intention of the study to correlate therapist skills with changes in family behaviors during marital and family therapy sessions.

From the same limited data that yielded no correlations several conditional probabilities were determined through the use of Bayes theorem. Specifically, it was found that an improved family condition could be associated with neutral therapy 100% of the time. It was also found that a same condition of family could be associated with effective therapy 50% of the time and with ineffective therapy 50% of the time. It was further found that a worsened condition of family could be associated with effective therapy 50% of the time and with neutral therapy 50% of the time.

Many practicing therapists would quickly see the plausibility of the family outcomes of same condition based on the notion that some family systems are firmly set and have such resistance to change that they are not changed to any significant degree by either positive or negative therapist influences. Many therapists would also see the connection between a worsened family condition and neutral therapy on the idea that a family which enters treatment and is moving

toward deterioration does not experience a halt or reversal in movement from neutral therapy. However, the connections between an improved family condition and neutral therapy and between a worsened family condition and effective therapy may appear strange and perplexing to many marital and family therapists. Specifically, how can the work of an effective family therapist result in a worsened condition of a family? How can a family worsen under the treatment of an effective therapist and improve under the treatment of a neutral therapist?

The answers to these questions could quite possibly be found in an examination of the phases of marital and family therapy. Practitioners of marital and family therapy have observed that in the early phase of treatment the family may become less functional.

> In this stage, the situation may appear to worsen, rather than improve. Symptomatology may accelerate, new symptoms may arise, and families may talk about quitting treatment. This upheaval usually is related to the family's barely perceived awareness that for things to get better, some member will have to change. Rather than change, a family member may accentuate or exaggerate symptoms. Family therapy changes have to be made sequentially. A family cannot let go of an offspring until the marital couple has found increased satisfaction in their own lives and in their relationship (Glick and Kessler, 1980, p. 156).

The findings of the present study may be harmonious with the clinical observations that are described above. Thus, a worsened condition of a family may result from the work of

an effective therapist during a time after the need for change has been identified, but before the change has been implemented. Accordingly, a family may improve under the treatment of a neutral therapist as no need for change has been identified by the family to disrupt the pattern of family functioning and interaction and pre-therapy positive movement is not impaired (Beavers, 1981; Carkhuff and Berenson, 1967). From this perspective the present findings may provide credence to what practitioners have observed in families during the early phase of treatment.

## Family Therapy Research

The meaning of the present study is greatly colored by its context within family therapy research. The early infancy of the field of family therapy research was noted earlier in this study. Because of the flux that attends the early stage of research in the field research directed toward discovery is appropriate (Gurman and Kniskern, 1981). The present study indicated technology difficulty that prevented successful exploration of the object of the search. The object of the search was the discovery of effective marital and family therapy.

Effective marital and family therapy can be determined upon three bases: (1) Therapist report; (2) Family report; and (3) Outside and somewhat objective observation (Gurman and Kniskern, 1981). Gurman and Kniskern (1981) contend that

assessment of change needs to be multiperspective. Of the three perspectives, the somewhat objective judgement is extremely difficult because of overt and covert levels of inference involved in rating therapists and families (Gurman and Kniskern, 1981). "Finally, we believe it is a myth that there exist any criteria for assessing the outcomes of family therapy that are truly 'objective'" (Gurman and Kniskern, 1981, p. 769). Based on this contention and the present findings "objective data" is called "somewhat objective." It is important to view the interrater reliability issue of this study in the context of what is presently known about somewhat objective data used to assess change in marital and family therapy. The interrater reliability problem of this study is expressive of the more general problem of levels of inference that prevents truly objective data in the assessment of change that occurs during marital and family therapy.

Therefore, the present study was exploratory in many ways. It sought to discover the coexistence of certain therapist skills with certain changes in family behaviors in certain type(s) of families. It sought to discover ways to apply existing coding systems to measure in-therapy therapist skills, changes in family behaviors and types of families in treatment.

Exploratory studies are often conducted by innovators within a profession.

> At the upper end of the continuum of active practitioners are the people, here called innovators, who continuously seek to improve their performance, sometimes in highly unconventional ways. They are attracted to ideas and practices that are still untested but seem to offer great promise (Houle, 1980, p. 156).

It was thought that the scales that were previously untested might offer great promise to the profession of marital and family therapy by providing a way to identify and hence teach those clinical skills that could be known to produce changes in family behaviors. "At the upper limit are the innovators, who make up about 2.5 percent of the distribution and whose chief characteristic is venturesomeness" (Houle, 1980, p. 153). Perhaps this exploratory study could be called venturesome because of the questions it sought to answer and the questions it raised in its pursuit of answers.

The study sample was five therapists working with five families. No definite or general conclusions can be reached from the findings based on such a small sample size. In addition, "the validity and reliability of a coding system cannot stand or fall on the results of one or two initial studies. More research needs to be done before any definite conclusions can be drawn" (Pinsof, 1981, p. 714). Therefore, the scope and application of the present study is quite limited. The recommendations that are proposed in the following section are made with a recognition of these limitations. This exploratory study does contribute

contribute methodological information that is needed in the process of the discovery and identification of a technology that will enable future researchers to answer the research questions of this study.

# CHAPTER 6

## SUMMARY AND RECOMMENDATIONS

The purpose of the present study was to answer two important research questions: (1) Are there certain therapist skills that are associated with certain changes in family behaviors? and (2) In what type(s) of families do these associations exist? Unfortunately, it has not been possible to answer these two questions. The barrier that blocked the possibility of answering the questions was an extremely high level of rater disagreement on the observations of therapist skills, changes in family behaviors and family types. After a careful and extensive literature review of possible instruments, the two scales that were field tested in this study were considered the best choices of instrumentation. The results of the present study raises several unanswered questions.

Perhaps the central unanswered question at this point in the field of marital and family therapy research is: Does the technology presently exist to discover the coexistence of certain therapist skills with certain changes in family behaviors in certain types of families? The authors of the two scales of choice contended that the instruments represent the technology needed to answer the two research questions (Beavers, 1981; Laird, 1981). How can these claims and the findings of the present study be reconciled?

It is entirely possible that the answer to this question lies within further refinement of the use of the two instruments. Two serious limitations have been presented and discussed in connection with the present field testing of the two scales. Until manuals are developed for the two instruments and two sets of raters are trained according to the two manuals, the question of the utility of these two scales cannot be fairly resolved. Therefore, what is needed in terms of further research is a replication of the present field tests on the two instruments with the exception of one important additive change. In future field tests of the two instruments raters need to be trained according to developed manuals before they rate therapist skills, changes in family behaviors and the type of families in treatment. In this way a determination can be made about the utility of the two instruments in the measurements of in-therapy therapist skills, changes in family behaviors during therapy and the type of family in treatment.

Therefore, three major and critically important research questions remain unanswered: (1) Is there a way to measure therapist skills during marital and family therapy? (2) Is there a way to measure change in family behaviors that occurs during marital and family therapy? (3) Is there a way to classify families in marital and family therapy according to family types? All three of these questions can be summarized into one general question: Does the technology exist to

determine effective marital and family therapy? The same concern was addressed in a slightly different way when Jones (1980) wrote "an issue central to a review of family therapy research is whether or not the richness of family functions and interactions can be described in the language of science" (p. 135). Based on current literature (Glick and Kessler, 1980) and the results of this study, this fundamental technology question remains unanswered.

As long as this question remains unanswered, another important question cannot be answered. What can marital and family therapists do to help certain types of families to change? This question is a clinical question from which the earlier research questions were developed. The research form of this question which incorporates all the above questions is: "What are the specific effects of specific interventions by specified therapists upon specific symptoms or patient types?" (Bergin, 1971, p. 245). It is hoped that the present study will make a contribution to the development of a technology that will enable future research to answer the question that is so important to the practitioners of marital and family therapy who want to know how to help the families under their treatment to change.

As long as this clinical question remains unanswered, one additional question also remains unanswered and unanswerable. What do trainers of therapists train the therapists to do/be in order to perform effective marital and family

therapy? The identification of appropriate and specific learning objectives for the training of marital and family therapists is dependent upon the identification of effective marital and family therapy (Liddle and Halpin, 1978). Therefore, it is hoped that the present study will make a contribution to the development of a technology that will enable future research to answer the question that is so important to the supervisors/trainers of marital and family therapists who want to know how to help the therapists under their training to become effective practitioners of marital and family therapy.

In summary, since the field of marital and family therapy research is in early infancy (Gurman and Kniskern, 1978; Pinsof, 1981), the present study has been exploratory in nature. In a quite young field of research, exploratory studies are quite appropriate and needed (Gurman and Kniskern, 1981). Replications or field tests of instruments developed to measure therapist and family factors occurring during marital and family therapy are quite useful research in newly developed fields (Pinsof, 1981). The study sample of five therapists treating five families is extremely small. Therefore, the data and results of this study are quite circumscribed and are not acceptable information for generalization. However, the results of this exploratory study are useful as quite broad indicators of how the five important questions summarized above may and may not be answered. The

present study can be viewed as a state of the art statement on what is empirically known at the present time about the identification of effective marital and family therapy from the perspective of outside and somewhat objective observers. The value of the present study to practitioners and researchers of marital and family therapy is to put clear focus on the important questions which need answers and provide tentative suggestions as to how the questions may be best answered. It is hoped that the results of the present study will be instructive to future research in an effort to answer some important questions about marital and family therapy.

## APPENDIX A

### FAMILY THERAPIST RATING SCALE

Roger A. Laird and Fred P. Piercy

Not Present (0)

Ineffective (1)

Neutral (2)

Minimally effective (3)

Effective (4)

Very effective (5)

Maximally effective (6)

Directions: Rate the relative effectiveness with which the family therapist engages in the behaviors listed below. Some of these behaviors may be associated with a school of therapy other than your own. Try to be neutral and rate the relative effectiveness with which the therapist performs each behavior irregardless of whether you agree or disagree with the type of intervention. In other words, try not to rate the model of therapy, just the behavior as identified by the statement on the rating scale.

#### Structuring Behaviors

S1. __:__:__:__:__:__:__: Helps the family define their needs.

S2. __:__:__:__:__:__:__: Stops chaotic interchanges.

S3. __:__:__:__:__:__:__: Shifts his approach when one way of gathering information is not working.

S4. __:__:__:__:__:__:__: Uses short, specific and clear communications.

S5. __:__:__:__:__:__:__: Asks open ended questions.

S6. __:__:__:__:__:__:__: Helps clients rephrase "why" questions into statements.

S7. __:__:__:__:__:__:__: Makes a brief introductory statement about the purpose of the interview.

S8. __:__:__:__:__:__:__: Lays down ground rules for the therapeutic process.

S9. __:__:__:__:__:__:__: Clarifies own and clients expectations of therapy.

S10. __:__:__:__:__:__:__: Explicitly structures or directs interaction among family members.

Relationship Behaviors

R1. __:__:__:__:__:__:__: Engenders hope.

R2. __:__:__:__:__:__:__: Uses self-disclosure.

R3. __:__:__:__:__:__:__: Demonstrates warmth.

R4. __:__:__:__:__:__:__: "Communicates" the attitude that the client's problem is of real importance.

R5. __:__:__:__:__:__:__: Tone of voice conveys sensitivity to the client's feelings.

R6. __:__:__:__:__:__:__: Speaks at a comfortable pace.

R7. __:__:__:__:__:__:__: Empathizes with family members.

R8. __:__:__:__:__:__:__: Confirms family members experience of an event.

R9. __:__:__:__:__:__:__: Attempts to improve the self-esteem of individual family members.

R10. __:__:__:__:__:__:__: Demonstrates a good sense of humor.

## Historical Behaviors

1. __:__:__:__:__:__:__: Directly asks about the current relationship between a spouse and their parents and siblings.
2. __:__:__:__:__:__:__: Explores the couple's mate selection process.
3. __:__:__:__:__:__:__: Emphasizes cognitions.
4. __:__:__:__:__:__:__: Assembles a detailed family history.
5. __:__:__:__:__:__:__: Avoids becoming triangulated by the family.
6. __:__:__:__:__:__:__: Attempts to help clients directly deal with parents and adult siblings about previously avoided issues.
7. __:__:__:__:__:__:__: Assigns or suggests that family members visit extended family members.
8. __:__:__:__:__:__:__: Maintains an objective stance.
9. __:__:__:__:__:__:__: Makes interpretations.
10. __:__:__:__:__:__:__: Collects detailed information about the etiology of the identified problem.

## Structural/Process Behaviors

1. __:__:__:__:__:__:__: Checks out pronouns to see who did what to whom.
2. __:__:__:__:__:__:__: Assigns tasks both within the session and outside it.
3. __:__:__:__:__:__:__: Concentrates on the interaction of the system rather than the intrapsychic dynamics.
4. __:__:__:__:__:__:__: Employs paradoxical intention.
5. __:__:__:__:__:__:__: Re-labels family symptoms.

6. __:__:__:__:__:__:__: Reorders behavioral sequences (order of speaking, who speaks to whom).

7. __:__:__:__:__:__:__: Rearranges the physical seating of family members.

8. __:__:__:__:__:__:__: Helps the family establish appropriate boundaries.

9. __:__:__:__:__:__:__: Elicits covert family conflicts, alliances and coalitions.

10. __:__:__:__:__:__:__: Assumes the role of expert technician who observes and then intervenes.

Experiential Behaviors

1. __:__:__:__:__:__:__: Uses family sculpting.

2. __:__:__:__:__:__:__: Encourages family members to find their own solutions.

3. __:__:__:__:__:__:__: Encourages individuals to share their fantasies.

4. __:__:__:__:__:__:__: Asks for current feelings.

5. __:__:__:__:__:__:__: Lets the clients choose the subject of the session.

6. __:__:__:__:__:__:__: Attempts to focus on process rather than content.

7. __:__:__:__:__:__:__: Uses role playing.

8. __:__:__:__:__:__:__: Responds to his/her own discomfort.

9. __:__:__:__:__:__:__: Uses own affect to elicit affect in family members.

10. __:__:__:__:__:__:__: Keeps the interaction in the here and now.

FAMILY THERAPIST RATING SCALE

PROFILE

THERAPIST'S NAME _____ COMMENTS _____

DATE _____ _____

RATER _____ _____

| | Structuring | Relationship | Historical | Structural/ Process | Experiential | |
|---|---|---|---|---|---|---|
| 50 | - | - | - | - | - | - |
| 45 | - | - | - | - | - | - |
| 40 | - | - | - | - | - | - |
| 35 | - | - | - | - | - | - |
| 30 | - | - | - | - | - | - |
| 25 | - | - | - | - | - | - |
| 20 | - | - | - | - | - | - |
| 15 | - | - | - | - | - | - |
| 10 | - | - | - | - | - | - |
| 5 | - | - | - | - | - | - |
| Score | ____ | ____ | ____ | ____ | ____ | |

BEAVERS-TIMBERLAWN Family Name _____ Rater _____

FAMILY EVALUATION SCALE Segment _____ Date _____

Instructions: The following scales were designed to assess the family functioning on continua representing interactional aspects of being a family. Therefore, it is important that you consider the entire range of each scale when you make your ratings. Please try to respond on the basis of the videotape data alone, scoring according to what you see and hear, rather than what you imagine might occur elsewhere.



I. Structure of the Family

F1 A. Overt Power: Based on the entire tape, check the term that best describes your general impression of the power structure of this family.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Chaos | | Marked dominance | | Moderate dominance | | Led | | Egalitarian |
| Leaderless; no one has enough power to structure the interaction. | | Control is close to absolute. No negotiation; dominance and submission are the rule. | | Control is close to absolute. Some negotiation, but dominance and submission are the rule. | | Tendency toward dominance and submission, but most of the interaction is through respectful negotiation. | | Leadership is shared between parents, changing with the nature of the interaction. |

If 2 to 4, indicate:

Who is #1 in power: Father_____ Mother_____ Child (specify)_____

Who is #2 in power: Father_____ Mother_____ Child (specify)_____

F2 B. Parental Coalitions: Check the terms that best describe the relationship structure in this family.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Parent-child coalition. | | | | Weak parental coalition. | | | | Strong parental coalition. |

F3 C. Closeness.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Amorphous, vague and indistinct boundaries among members. | | | | Isolation, distancing. | | | | Closeness, with distinct boundaries among members. |

OMIT D. The power structure, or "pecking order," in this family is:

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Hard to determine. | | Relatively hard to determine. | | | | Relatively easy to determine. | | Quite easy to determine. |

F4 II. Mythology: Every family has a mythology; that is, a concept of how it functions as a group. Rate the degree to which this family's mythology seems congruent with reality.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Very congruent. | | Mostly congruent. | | | | Somewhat incongruent. | | Very incongruent. |

F5 III. Goal-Directed Negotiation: Rate this family's overall efficiency in negotiation and problem solving.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Extremely efficient. | | Good. | | | | Poor. | | Extremely inefficient. |

IV. Autonomy.

F6 A. Communication of Self-Concept: Rate this family as to the clarity of disclosure of feelings and thoughts. This is not a rating of the intensity of feelings, but rather of clarity of expression of individual thoughts and feelings.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Very clear. | | | | Somewhat vague and hidden. | | | | Hardly anyone is ever clear. |

F7 B. Responsibility: Rate the degree to which the family members take responsibility for their own past, present, and future actions.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Members regularly are able to voice responsibility for individual actions. | | | | Members sometimes voice responsibility for individual actions, but tactics also including sometimes blaming others, speaking in 3rd person or plural. | | | | Members rarely, if ever, voice responsibility for individual actions. |

F8 C. Invasiveness: Rate the degree to which the members speak for one another, or make "mind reading" statements.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Many invasions. | | | | Occasional invasions. | | | | No evidence of invasions. |

F9 D. Permeability: Rate the degree to which members are open, receptive and permeable to the statements of other family members.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Very open. | | Moderately open. | | | | Members frequently unreceptive. | | Members unreceptive. |

V. Family Affect

F10 A. Expressiveness: Rate the degree to which this family system is characterized by open expression of feelings.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Open, direct expression of feelings. | | Direct expression of feelings despite some discomfort. | | Obvious restriction in the expressions of some feelings. | | Although some feelings are expressed, there is masking of most feelings. | | No expression of feelings. |

F11 B. Mood and Tone: Rate the feeling tone of this family's interaction.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Usually warm, affectionate, humorous and optimistic. | | Polite, without impressive warmth or affection; or frequently hostile with times of pleasure. | | Overtly hostile. | | Depressed. | | Cynical, hopeless and pessimistic. |

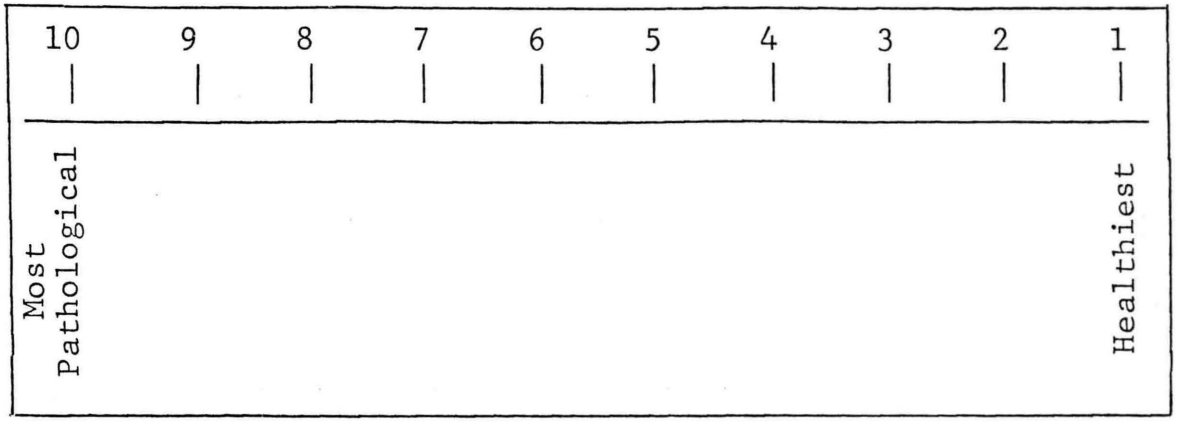
F12 C. Conflict: Rate the degree of seemingly unresolvable conflict.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Severe conflict, with severe impairment of group functioning. | | Definite conflict, with moderate impairment of group functioning. | | Definite conflict, with slight impairment of group functioning. | | Some evidence of conflict, without impairment of group functioning. | | Little, or no conflict. |

F13 D. Empathy: Rate the degree of sensitivity to, and understanding of, each other's feelings within this family.

| 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|
| Consistent empathic responsiveness. | | For the most part, an empathic responsiveness with one another, despite obvious resistence. | | Attempted empathic involvement, but failed to maintain it. | | Absence of any empathic responsiveness. | | Grossly inappropriate responses to feelings. |

F14 VI. Global Health-Pathology Scale: Circle the number of the point on the following scale which best describes this family's health or pathology.



Means, Standard Deviations, Standard Errors of the Mean, and Separation Between Confidence Limits About Each Mean For the Ratings of the Effective and Ineffective Videotaped Conditions

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| Structuring Behavior Items | | | | | | | |
| 1. Helps the family to find their needs. | 1.0 | 0.000 | .000 | 5.4 | 0.490 | .163 | 4.100 |
| 2. Stops chaotic interchanges. | 1.0 | 0.000 | .000 | 5.4 | 0.663 | .221 | 3.995 |
| 3. Shifts approach when one way of gathering information is not working. | 1.0 | 0.000 | .000 | 5.0 | 0.775 | .358 | 3.527 |
| 4. Uses short, specific, and clear communications. | 1.2 | 0.600 | .200 | 5.1 | 0.700 | .233 | 3.105 |
| 5. Asks open ended questions. | 1.1 | 0.300 | .100 | 4.6 | 1.114 | .371 | 2.637 |

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| 6. Helps clients rephrase "why" questions into statements. | 1.2 | 0.600 | .200 | 4.8 | 1.166 | .389 | 2.520 |
| 7. Makes a brief introductory statement about the purpose of the interview. | 1.3 | 0.900 | .300 | 4.9 | 0.943 | .314 | 2.474 |
| 8. Lays down ground rules for the therapeutic process. | 1.4 | 0.800 | .267 | 4.7 | 0.900 | .300 | 2.261 |
| 9. Clarifies own and clients expectations of therapy. | 1.4 | 0.663 | .221 | 4.5 | 0.806 | .269 | 2.202 |
| 10. Explicitly structures or directs interaction among family members. | 2.0 | 1.265 | .422 | 5.3 | 0.781 | .260 | 2.050 |
| Relationship Behavior Items | | | | | | | |
| 1. Engenders hope. | 1.2 | 0.600 | .200 | 5.4 | 0.663 | .221 | 3.428 |
| 2. Uses self-disclosure. | 1.1 | 0.300 | .100 | 4.8 | 0.980 | .327 | 2.918 |
| 3. Demonstrates warmth. | 1.7 | 1.100 | .367 | 5.6 | 0.663 | .221 | 2.823 |

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| 4. "Communicates" the attitude that the client's problem is of real importance. | 1.4 | 0.800 | .267 | 4.5 | 0.671 | .224 | 2.201 |
| 5. Tone of voice conveys sensitivity to the client's feelings. | 1.3 | 0.640 | .213 | 4.5 | 1.025 | .342 | 2.183 |
| 6. Speaks at a comfortable pace. | 1.1 | 0.300 | .100 | 4.0 | 1.342 | .447 | 1.897 |
| 7. Empathizes with family members. | 1.9 | 0.943 | .314 | 4.6 | 0.800 | .267 | 1.635 |
| 8. Confirms family members experience of an event. | 2.1 | 0.943 | .314 | 4.4 | 0.490 | .163 | 1.425 |
| 9. Attempts to improve the self-esteem of individual family members. | 2.1 | 1.136 | .379 | 4.8 | 0.980 | .327 | 1.407 |
| 10. Demonstrates a good sense of humor. | 1.3 | 0.640 | .213 | 3.6 | 1.428 | .476 | 1.036 |

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| Historical Behavior Items | | | | | | | |
| 1. Directly asks about the current relationship between a spouse and his/her parents and siblings. | 1.6 | 0.800 | .267 | 5.4 | 0.490 | .163 | 3.012 |
| 2. Explores the couple's mate selection process. | 1.2 | 0.600 | .200 | 5.0 | 0.775 | .258 | 2.960 |
| 3. Emphasizes cognitions. | 1.1 | 0.300 | .100 | 4.5 | 0.671 | .224 | 2.807 |
| 4. Avoids becoming triangulated by the family. | 1.5 | 0.806 | .296 | 5.0 | 0.775 | .258 | 2.534 |
| 5. Attempts to help clients directly deal with parents and adult siblings about previously avoided issues. | 1.6 | 0.917 | .306 | 4.9 | 0.700 | .233 | 2.312 |
| 6. Assigns or suggests that family members visit extended family members. | 1.9 | 0.943 | .314 | 4.9 | 0.539 | .180 | 2.095 |
| 7. Maintains an objective stance. | 1.2 | 0.600 | .200 | 4.1 | 0.943 | .314 | 1.957 |

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| 8. Makes interpretations. | 1.9 | 1.136 | .379 | 5.0 | 0.775 | .258 | 1.933 |
| 9. Collects detailed information about the etiology of the identified problem. | 2.4 | 1.020 | .340 | 5.1 | 0.700 | .233 | 1.649 |
| 10. Assembles a detailed family history. | 2.7 | 1.005 | .335 | 5.2 | 0.748 | .249 | 1.429 |
| Structural/Process Behavior Items | | | | | | | |
| 1. Checks out pronouns to see who did what to whom. | 1.0 | 0.000 | .000 | 5.2 | 0.748 | .249 | 3.743 |
| 2. Assigns tasks both within the session and outside it. | 1.6 | 0.917 | .306 | 4.9 | 0.539 | .180 | 2.411 |
| 3. Concentrates on the interaction of the system rather than the intrapsychic dynamics. | 1.0 | 0.000 | .000 | 4.3 | 1.487 | .496 | 2.392 |
| 4. Employs paradoxical intention. | 1.9 | 1.044 | .348 | 4.8 | 0.748 | | 1.805 |

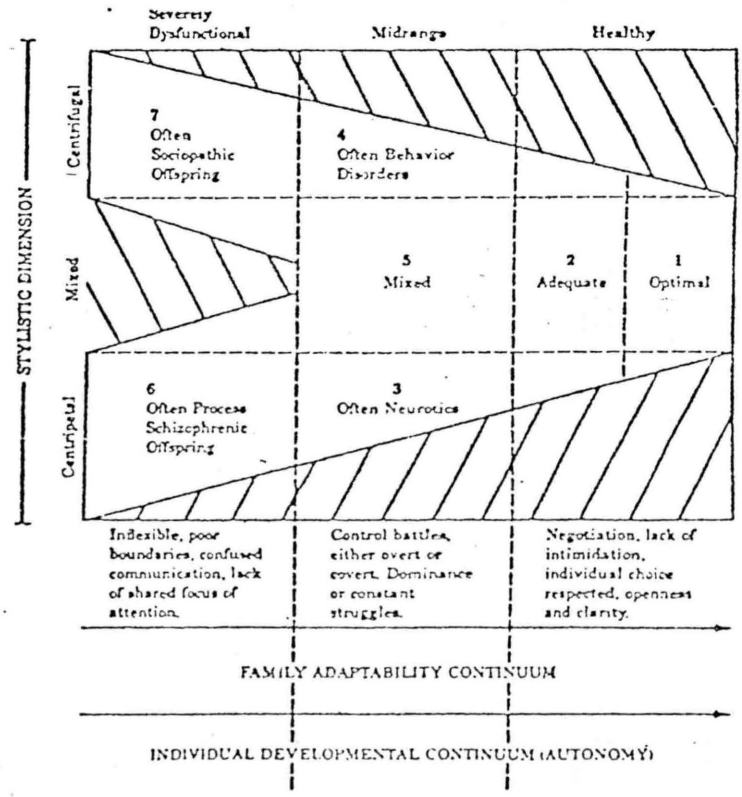
| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| 5. Re-labels family symptoms. | 2.1 | 1.221 | .407 | 4.4 | 0.663 | .221 | 1.149 |
| 6. Reorders behavioral sequences (e.g. order of speaking, who speaks to whom). | 2.4 | 0.917 | .306 | 4.7 | 1.005 | .335 | 1.126 |
| 7. Rearranges the physical seating of family members. | 2.5 | 1.118 | .373 | 5.0 | 1.183 | .394 | 1.094 |
| 8. Helps the family establish appropriate boundaries. | 3.0 | 1.265 | .422 | 4.6 | 0.663 | .221 | 0.422 |
| 9. Elicits covert family conflicts, alliances and coalitions. | 2.7 | 1.005 | .335 | 4.4 | 1.428 | .478 | 0.213 |
| 10. Assumes the role of expert technician who observes and then intervenes. | 2.9 | 1.221 | .407 | 4.6 | 1.281 | .427 | 0.172 |
| Experiential Behavior Items | | | | | | | |
| 1. Uses family sculpting. | 1.0 | 0.000 | .000 | 5.1 | 0.943 | .314 | 3.524 |

| Items | Ineffective | | | Effective | | | Separation Between Confidence Limits |
|---|---|---|---|---|---|---|---|
| | mean | SD | error | mean | SD | error | |
| 2. Encourages family members to find their own solutions. | 1.4 | 0.800 | .267 | 5.2 | 0.748 | .249 | 2.854 |
| 3. Encourages individuals to share their fantasies. | 1.7 | 0.900 | .300 | 5.4 | 0.490 | .163 | 2.851 |
| 4. Lets the clients choose the subject of the session. | 1.1 | 0.300 | .100 | 3.9 | 0.700 | .233 | 2.189 |
| 5. Attempts to focus on process rather than content. | 1.9 | 1.300 | .433 | 5.0 | 0.894 | .298 | 1.760 |
| 6. Uses role playing. | 1.9 | 0.943 | .314 | 4.6 | 0.663 | .221 | 1.719 |
| 7. Responds to his/her own discomfort. | 1.9 | 1.136 | .379 | 5.0 | 1.183 | .394 | 1.683 |
| 8. Uses own affect to elicit affect in family members. | 2.1 | 1.300 | .433 | 4.9 | 0.700 | .233 | 1.578 |
| 9. Keeps the interaction in the here and now. | 1.4 | 0.800 | .267 | 3.8 | 1.077 | .359 | 1.253 |
| 10. Asks for current feelings. | 1.8 | 0.980 | .327 | 4.1 | 1.300 | .433 | 0.907 |

INTERRATER CORRELATIONS FOR THE TEN RATERS

| Raters | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1.00 | | | | | | | | | |
| 2 | 0.61 | 1.00 | | | | | | | | |
| 3 | 0.69 | 0.78 | 1.00 | | | | | | | |
| 4 | 0.68 | 0.77 | 0.77 | 1.00 | | | | | | |
| 5 | 0.65 | 0.75 | 0.81 | 0.74 | 1.00 | | | | | |
| 6 | 0.72 | 0.77 | 0.81 | 0.87 | 0.75 | 1.00 | | | | |
| 7 | 0.70 | 0.67 | 0.75 | 0.76 | 0.72 | 0.76 | 1.00 | | | |
| 8 | 0.71 | 0.79 | 0.83 | 0.86 | 0.78 | 0.84 | 0.82 | 1.00 | | |
| 9 | 0.69 | 0.74 | 0.76 | 0.84 | 0.76 | 0.78 | 0.78 | 0.86 | 1.00 | |
| 10 | 0.71 | 0.75 | 0.79 | 0.87 | 0.76 | 0.84 | 0.74 | 0.83 | 0.81 | 1.00 |

# APPENDIX E


Severely Dysfunctional
Midrange
Healthy
STYLISTIC DIMENSION
Centrifugal
Mixed
Centripetal
7
Often Sociopathic Offspring
4
Often Behavior Disorders
5
Mixed
2
Adequate
1
Optimal
6
Often Process Schizophrenic Offspring
3
Often Neurotics
Inflexible, poor boundaries, confused communication, lack of shared focus of attention.
Control battles, either overt or covert. Dominance or constant struggles.
Negotiation, lack of intimidation, individual choice respected, openness and clarity.
FAMILY ADAPTABILITY CONTINUUM
INDIVIDUAL DEVELOPMENTAL CONTINUUM (AUTONOMY)

# APPENDIX F

## Bayes Theorem

### Random Variable

Therapist Activity — Family Outcome

| Prior Probabilities | |
|---|---|
| Effective | .400 |
| Neutral | .400 |
| Ineffective | .200 |

| Conditional Probabilities | | |
|---|---|---|
| Improved | Same | Worsened |
| .000 | .500 | .500 |
| .500 | .000 | .500 |
| .001 | .998 | .001 |

Posterior Probabilities

| Therapist Activity | Family Conditions | | |
|---|---|---|---|
| | Improved | Same | Worsened |
| Effective | .000 | .501 | .500 |
| Neutral | .999 | .000 | .500 |
| Ineffective | .001 | .499 | .000 |

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