Old Dominion University
ODU Digital Commons

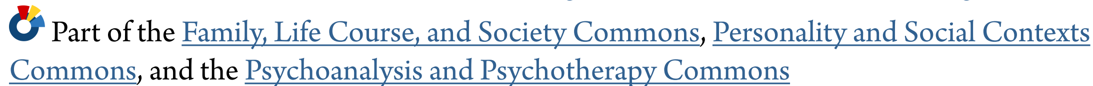
Psychology Theses & Dissertations | Psychology

Winter 1998

A Discovery-Oriented Process Study of Enactment in Family Therapy: Development of the Family Therapy Enactment Rating Scale

Elizabeth Ong-Mythuan Fong
Old Dominion University

Follow this and additional works at: https://digitalcommons.odu.edu/psychology_etds


Part of the Family, Life Course, and Society Commons, Personality and Social Contexts Commons, and the Psychoanalysis and Psychotherapy Commons

Recommended Citation

Fong, Elizabeth O.. "A Discovery-Oriented Process Study of Enactment in Family Therapy: Development of the Family Therapy Enactment Rating Scale" (1998). Doctor of Psychology (PsyD), dissertation, Psychology, Old Dominion University, DOI: 10.25777/1kjd-ay03
https://digitalcommons.odu.edu/psychology_etds/273

This Dissertation is brought to you for free and open access by the Psychology at ODU Digital Commons. It has been accepted for inclusion in Psychology Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact digitalcommons@odu.edu.

المنارة للاستشارات

www.manaraa.com

A DISCOVERY-ORIENTED PROCESS STUDY OF ENACTMENT IN FAMILY THERAPY: DEVELOPMENT OF THE FAMILY THERAPY ENACTMENT RATING SCALE

by

Elizabeth Ong-Mythuan Fong
B.A. May 1993, University of Virginia

A Dissertation submitted to the Faculty of the
College of William and Mary,
Eastern Virginia Medical School,
Norfolk State University, and
Old Dominion University
in Partial Fulfillment of the Requirement for the Degree of

DOCTOR OF PSYCHOLOGY

PSYCHOLOGY

VIRGINIA CONSORTIUM PROGRAM IN CLINICAL PSYCHOLOGY
December 1998

Approved by:

Michael P. Nichols (Director)

Neill P. Watson (Member)

Joy Kannarkat (Member)

John David Ball (Member)

Larry Ventis (Member)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ABSTRACT

A DISCOVERY-ORIENTED PROCESS STUDY OF ENACTMENT IN FAMILY THERAPY: DEVELOPMENT OF THE FAMILY THERAPY ENACTMENT RATING SCALE.

Elizabeth Ong-Mythuan Fong
Virginia Consortium Program in Clinical Psychology, 1998
Director: Dr. Michael P. Nichols

With the effectiveness of psychotherapy now well-supported in both the individual and family literatures (Garfield & Bergin, 1994), we are entering an era where questions of how and why therapy works are of interest. More specifically, there has been support and encouragement by some researchers (Rice & Greenberg, 1984; Mahrer, 1988) for the use of discovery-oriented methodologies to explore clinical phenomena that have yet to be empirically validated. The following is a discovery-oriented study of enactment, a structural family therapy intervention. The theoretical goals of enactments, their relevance to clinical practice, as well as how they are actually implemented in family therapy sessions, are discussed. A methodological review of the discovery-oriented and task analysis literature is presented. Four phases of enactment are delineated: pre-enactment preparation, enactment initiation, enactment facilitation, and enactment conclusion. Observations of therapist interventions and client responses are presented. The Family Therapy Enactment Rating Scale, an observational measure, is described and reliability data are presented. Unfortunately, the overall reliability of the scale was found to be low. However, given the extensive observational data derived from this study, some tentative results and discussion of them are offered. Observational scale

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

items, their reliability data, a tentative performance model of enactment, and implications of the findings are presented and discussed.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Copyright, 1998 by Elizabeth Ong-Mythuan Fong. All Rights Reserved.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

This dissertation is dedicated to Mylan Thi Doan,

my mother, whose love, acceptance, and protection

has made it possible for me to pursue my goals and dreams.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ACKNOWLEDGEMENTS

My greatest thanks to Michael P. Nichols, my dissertation director, mentor, supervisor, friend, and confidant. With his patience and help, I have developed a "knack of listening" to those people in my personal as well as professional life.

My appreciation to the College of William and Mary for their research grant to help with purchasing videotapes and my traveling expenses to Philadelphia.

Thank you to Howard A. Liddle and Guy Diamond from the Center for Research on Adolescent and Drug Abuse at Temple University, for your help in providing the clinical sample for this dissertation.

My appreciation to my family and my in-laws, for their continued support of my accomplishments. Special thanks to my husband, William, whose encouragement and belief in me made it possible to finish this dissertation. And to my daughter, Victoria, whose birth has given me much joy (and also challenged my motivation!).

Among the people I would like to also thank are my committee members -- Neill P. Watson, Joy Kannarkat, John D. Ball, and W. Larry Ventis. I would especially like to extend my greatest appreciation to Neill P. Watson, who helped me with my statistical analyses. A final thank you to my raters for their hard work and dedication to this project.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS

Page

LIST OF TABLES ix
LIST OF FIGURES x

Chapter

I. INTRODUCTION 1

GENERAL OVERVIEW: PSYCHOTHERAPY RESEARCH THEN AND NOW 1
EFFECTIVNESS OF FAMILY THERAPY, IN GENERAL, AND STRUCTURAL FAMILY THERAPY, IN PARTICULAR 2
DISCOVERY-ORIENTED RESEARCH: GOALS, AIMS, AND METHODS 4
TASK ANALYSIS: PURPOSE AND METHODS 7
THE CHANGE EVENT UNDER INVESTIGATION 9

II. LITERATURE REVIEW 13

OVERVIEW OF PROCESS RESEARCH 13
DISCOVERY-ORIENTED RESEARCH METHODOLOGIES 14
SUMMARY AND CONCLUDING COMMENTS 23
PURPOSE AND AIMS OF THE PRESENT STUDY 24

III. METHODS 25

DEFINING ENACTMENT 25
SELECTING THE CLINICAL SAMPLE 26
DEVELOPING THE ENACTMENT RATING SCALE AND TRAINING MANUAL 29
TRAINING OF RATERS 30
RATING THE CLINICAL SAMPLE 33

IV. RESULTS 35

THE FAMILY THERAPY ENACTMENT RATING SCALE 35
RELIABILITIES FOR THE FAMILY THERAPY ENACTMENT RATING SCALE 49
EXPLORATORY ANALYSES 56

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

V. DISCUSSION 58

RELIABILITY OF THE FAMILY THERAPY ENACTMENT RATING SCALE 58
VARIABLES RELATED TO SUCCESSFUL ENACTMENTS 61
ESSENTIAL ELEMENTS OF ENACTMENTS 62
IMPLICATIONS OF FINDINGS 66
LIMITATIONS OF THE STUDY 69
CONCLUSION 73

REFERENCES 76

APPENDICES 83

A. DEFINITIONS OF PRODUCTIVE AND UNPRODUCTIVE ENACTMENTS 83
B. FAMILY THERAPY ENACTMENT RATING SCALE 86
C. FAMILY THERAPY ENACTMENT RATING SCALE TRAINING MANUAL 93
D. RATER INSTRUCTIONS 104
E. SEGMENT LISTS 106
F. SEGMENT INTRODUCTIONS 113
G. DISCREPANCY DISTRIBUTION GRAPHS FOR CONTINUOUS CLIENT VARIABLES 117
H. DISCREPANCY DISTRIBUTION GRAPHS FOR CONTINUOUS THERAPIST VARIABLES 121

VITA 126

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF TABLES

TABLE Page

1. Continuous Variables of Client Behaviors: Reliability Coefficients among Three Independent Raters 50
2. Categorical Variables of Client Behaviors: Kappa Values among Three Independent Raters 52
3. Continuous Variables of Therapist Behaviors: Reliability Coefficients among Three Independent Raters 53
4. Categorical Variables of Therapist Behaviors: Kappa Values among Three Independent Raters 55

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF FIGURES

FIGURE Page

1. A Performance Model of Enactment: The Four Phases 67

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER I

INTRODUCTION

The introduction of this study will be presented in four parts. First, a general overview of the state of psychotherapy and family therapy research will be provided. Next, the goals, aims, and methods of the discovery-oriented research approach will be discussed. The third section will address the purpose and methods of "task analysis," a discovery-oriented methodology employed in the present study. Finally, the therapeutic event under investigation will be described in terms of its relevance to clinical practice and empirical understanding.

General Overview: Psychotherapy Research Then and Now

Now that the global question on psychotherapy effectiveness, "Does psychotherapy work?" has been consistently answered in the affirmative (Garfield & Bergin, 1994), psychotherapy researchers have turned to more specific questions about how and why various forms of therapy work. The "why and how" of psychotherapy's effectiveness is answered through process research methodologies. Process research strategies have been proposed and employed by a growing number of researchers to promote understanding of various psychotherapy phenomena (Rice & Greenberg, 1984; Mahrer, 1988).

This manuscript is prepared in accordance with the Publication Manual of The American Psychological Association, Fourth Edition.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Within the area of psychotherapy process research, there is a distinction between traditional process research and research that utilizes innovative conceptual and methodological strategies. Whereas earlier studies relied on frequency counts of variables to provide information about the therapeutic experience (Alexander et al., 1976; Chamberlain et al., 1984), more recent studies link in-session client and therapist behaviors to specific immediate and intermediate changes (Greenberg et al., 1993; Friedlander et al., 1994). These more recent studies are made possible by the methodologies introduced by "change event," or "discovery-oriented," process research.

Effectiveness of Family Therapy, In General, and Structural Family Therapy, In Particular

Because this is a study focusing on a particular kind of therapy (structural family therapy), before we move to review the discovery-oriented methodologies, it may be helpful to start with a brief overview of the overall effectiveness of family therapy. In general, there are ample data that support the efficacy of family therapy (Pinsof, Wynne, & Hambright, 1996; Pinsof & Wynne, 1995). In a meta-analysis of twenty-three studies comparing family therapy and individual therapy, results revealed no substantial differences regarding effectiveness of treatment (Shadish, Ragsdale, Glaser, & Montgomery, 1995). This finding is particularly encouraging when combined with research done up to 1980, suggesting that individual therapy is effective for approximately 75 percent of the people who seek treatment (Smith & Glass, 1977).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Because there are many different approaches in family therapy, we might wonder whether one approach tended to yield better outcome than the others. At present, comparative studies of different kinds of family therapy suggests that no one approach is better than the others (Shadish et al., 1995). However, this does not mean that there are not at least some differences in success rates with the variety of family approaches (Pinsof et al., 1996). For example, structural family therapy approaches have been found effective in specific areas, including reducing drug use (Alexander & Parsons, 1982) and engaging youth and families in treatment (Szapocznik, Perez-Vidal, Brickman, Foote, Stantisteban, Hervis, & Kurtines, 1988).

Other studies have found structural family therapy to be effective for treating particular adult and childhood problems. Several well-designed, controlled outcome studies of people with psychotic symptoms have obtained results that suggest that structured family therapy can reduce the potential for relapse of symptoms (Falloon, Boyd, & McGill, 1982, 1985; Leff, Kuipers, Berkowitz, Eberlein-Fries, & Sturgeon, 1982), is more effective than taking antipsychotic medication alone (Goldstein & Miklowitz, 1995), and is more cost-effective than inpatient care (Pinsof & Wynne, 1995).

Structural family therapy has been shown to be effective in treating adolescents with conduct disorders and delinquency (Alexander & Parsons, 1982) with overall behavioral improvement (Szapocznik, Rio, Murray, Cohen, Scopetta, Rivas-Vazquez, Hervis, Posada, & Kurtines, 1989). Structural family therapy has also been shown particularly effective with adolescents suffering from anorexia nervosa of fewer than three years duration (Campbell & Patterson, 1995), and this is consistent with results of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

case studies and long-term follow-ups by other researchers (Minuchin, Rosman, & Baker, 1978). Although no differences between family and individual treatments were shown for the treatment of bulimia in adolescents, one study found that younger children with anorexia did better under the structural family therapy approach (Russell, Szmukler, Dare, & Eisler, 1987).

Although we can say that different approaches are effective for particular kinds of family problems or particular kinds of families, the general consensus appears to be that there is no substantial evidence that one approach in family therapy is better than the others. Hence, family research appears to be moving towards studies of the process of change, including clients' perceptions of the therapeutic alliance and in-session behavior (Friedlander & Heatherington, 1989), impasses in parent-child relationships (Diamond & Liddle, 1996), "disengagement" and "sustained engagement" (Friedlander, Heatherington, Johnson, & Skowron, 1994), and "shift intervention" (Diamond & Liddle, 1996). Discovery-oriented methodologies appear to hold great promise in looking at the process of change in family therapy.

Discovery-Oriented Research: Goals, Aims, and Methods

The goal of the discovery-oriented or exploratory approach is to describe what happens within psychotherapy sessions with the goal of developing theories based on the replication of findings (Hill, 1990). As an alternative to hypothesis-testing research, where one is concerned with confirming or disconfirming theoretical propositions and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

contributing to a cumulative body of knowledge, discovery-oriented research aims to take an in-depth look at psychotherapy and to discover interconnections among the conditions (patients and context), operations (interventions), and consequences (outcomes) of psychotherapy (Mahrer, 1988).

The first aim of discovery-oriented research is taking a closer look at the process of psychotherapy to uncover patterns of relationship between therapist interventions and client responses. Alvin Mahrer (1988) has proposed five steps to be followed by the researcher to accomplish this aim. First, the researcher must select a target area in psychotherapy into which to take a closer look. Examples of target areas include the use of paradox, client-response to interpretations, and challenges to irrational thinking. In selecting the target area for study, one is encouraged to set aside psychotherapeutic laws or principles and just be open to whatever is his or her interest. Next, the researcher must obtain samples of the target of investigation-- ideally, audiotapes or videotapes. Samples of the target area are sometimes difficult to obtain, but researchers are encouraged to select exemplary instances of the target of interest. Although samples of graduate students' therapy may be easier to obtain, it would seem that more can be learned about effective therapy by studying the work of more experienced practitioners.

Third, the researcher must select or develop an instrument to take a closer look at the target. This may mean developing a category system such as a rating scale or a checklist. Then, the researcher must gather the data, applying the instrument to all instances of the selected target. Finally, the researcher must make sense of the data. The investigator attempts to make sense of the data either by developing hypotheses, which

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

could later be tested, or by constructing a performance model to explain the relation between interventions and outcome.

The second aim of discovery-oriented research is to identify interconnections among conditions (patient variables), operations (therapist interventions), and consequences (outcomes) of psychotherapy. Three possible questions arise in order to study these interconnections: 1) If a therapist makes a certain intervention (operation) when the patient is behaving in a certain way (condition), what will happen (consequence)? 2) What can a therapist do (operation) when the patient is behaving in a certain way (condition) to promote a particular desired result (consequence)? 3) Given the patient condition, what result does a therapist want (consequence), and how can this be accomplished (operation)?

Alvin Mahrer (1988) has proposed three steps to carry out these aims of discovery-oriented research. First, the researcher must frame a specific question based on the general discovery-oriented research question proposed. Take, for example, a researcher who might wish to study the family therapy technique of enactment, a technique of instructing family members to discuss among themselves possible solutions to a particular problem (Minuchin, 1974). In order to discover the steps used in producing an enactment, the question proposed might be: What does a therapist do (operation) to promote a couple talking productively (consequence) when they are at an impasse (condition)? The second step is to obtain the data from actual tapes and transcripts of therapy sessions. Here, a researcher is advised to specify the meanings of the terms used when describing the conditions, operations, or consequences. The final

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

step is to examine the data to obtain a discovery-oriented answer. Each of the three general questions promotes a different method of investigation.

If the variable of interest is the consequence, one can use a category system tailor-made for these consequences. If the variable of interest is the operation, one can use a category system tailor-made for the therapist and patient operations. If the variable of interest is the condition, the method of choice is to use a number of independent raters to examine the antecedent conditions.

Although a number of general steps have been delineated by Mahrer (1988) to take a closer look at any particular clinical phenomenon, Rice and Greenberg's (1984) "task analysis" approach is also deemed relevant to this study. Hence, the methodology of task analysis will be outlined in the next section.

Task Analysis: Purpose and Methods

The purpose of the task analytic approach is to explore and build a model of a particular clinical event. The model is a presentation of the pathways of client and/or therapist in-session behaviors or "performances" during the occurrence of a specific therapeutic challenge or "task" that leads to therapeutic progress. The term "task" refers to a conflict or problem state that the family or therapist identifies to be worked on during the session. The "task environment" during an in-session episode consists of a beginning, middle, and end. The beginning phase is designated by a "marker" (Greenberg, 1984) indicating that the therapist or family member has identified a particular problem. The

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

middle phase consists of the "working through" of the problem with the family's participation and the intervention provided by the therapist. Finally, the end phase is the "resolution," signifying that the problem has been resolved to some degree.

The task analysis paradigm proposed by Rice and Greenberg (1984) involves several steps. First, the researcher must identify a specific task to be studied, based on theoretical assumptions and clinical experience. For instance, tasks that might be explored include challenging irrational thoughts (cognitive therapy), interpretations (psychodynamic therapy), paradoxical interventions (strategic family therapy), or enactments (structural family therapy). After selection of the task to be explored, the investigator must operationalize and define the marker and resolution of the task.

Selection of clinical examples of the task is the next step in task analysis. Clinical examples are usually selected from videotapes or transcripts. During sample selection, reliability studies are completed to ensure objective agreement about the presence of the specific task within selected episodes. In the next step, the investigators describe the family and therapist behaviors that occur as the task is worked through. This is the labor-intensive step of task analysis, during which time the investigator might use theoretical ideas to guide observations and descriptions of the behavior of interest. At the completion of this inductive step, an initial performance model is developed. Finally, the investigator uses psychometrically validated instruments to analyze the data base. These instruments should be able to accommodate for and assess the family functioning before, during, and after the change event. With the concepts and methods of discovery-oriented

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

research and task analysis outlined above, the next section will describe the change event to be investigated in this study.

The Change Event Under Investigation

The change event to be investigated in this study is the enactment, a clinical intervention originating from the structural school of family therapy (Minuchin, 1974). An enactment is "an interaction stimulated in structural family therapy in order to observe and then change interactions which make up the family structure" (Nichols & Schwartz, 1995). This technique was developed by Salvador Minuchin in the 1960s and is widely used today. Consistent with the notion that human problems occur within the context of the family and its interactions, this technique was developed as a way to bring the family's problematic ways of relating into the treatment room. By having family members actually act out these problematic sequences, the therapist can first observe and then modify their interactions.

From a theoretical standpoint, structural family therapy views human problems as occurring within the context of problematic sequences of family interaction. By promoting enactments between different subgroups (e.g., parental dyad, parent-child dyad, child-child dyad) within the family, the therapist can support functional interactions and challenge dysfunctional ones. In using enactments as a therapeutic technique, the therapist keeps the hierarchical structure of the family in mind when supporting functional interactions or confronting dysfunctional ones.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In order to set up an enactment, the clinician begins by "joining" with each person in the family -- first eliciting and then acknowledging his or her point of view. Given a chance to express themselves, each of the family members will probably comment on the presenting problem and say something about other members of the family. In the process of joining, the therapist is likely to hear complaints which reveal conflicts that can then serve as topics of discussion in an enactment. The clinician next chooses a specific issue and gives explicit direction to a dyad of the family to "talk about it." Unlike traditional interrogatories, where the therapist obtains information about a family by direct question and answer, this request by the clinician allows specific subgroups in the family to demonstrate how they actually deal with a particular type of problem.

Enactments can accomplish several things at once. First, observing enactments allows a clinician to evaluate boundaries -- the conceptual dividers of family subsystems. Boundaries are evaluated by looking at how long two people can talk without being interrupted, whether or not the people in the dialogue bring a third person into the discussion, or whether the dialogue ends abruptly with the people failing to discuss the conflict at any length. Looking at boundaries also allows the clinician to see who plays central and peripheral roles in the family -- who speaks to whom and who does what to whom.

Enactments enable the clinician to develop a structural diagnosis of the family and its problems -- a process that involves broadening the presenting problem beyond the individuals to the whole family system. A structural diagnosis is constructed in the form of a conceptual map of the family portraying its subsystems and their boundaries. The

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

structural diagnosis describes the systematic interrelationships of the members in the present, derived from ongoing patterns in the past. When clinicians are able to make a structural diagnosis, they can move to intervene with specific strategies.

Another function enactments serve is allowing a clinician to highlight and modify problematic transactions that emerge. The clinician might choose to challenge the family's assumptions through confrontation or to join with one individual in order to realign the boundaries[1] or the clinician might help the enactment along and use strategies to suggest new options for family interactions. In other words, clinicians not only observe how enactments unfold, but also intervene to help families modify their interactions to develop more functional ways of relating.

In light of their conceptual definition, enactments should be used by therapists who believe one of the goals for a family in therapy is to promote dialogue about particular issues between various subgroups within the family. However, a conceptual understanding does not necessarily translate into the pragmatic ability to use enactments effectively.

Although I have delineated three clinical assumptions or tasks that enactments are thought to accomplish, such clinical assumptions are rarely put to empirical test. That is, clinicians often neglect to take a systematic look at whether or not a particular technique is useful in doing what it is presumed to do. But if we don't look at enactments

---

[1]Although therapists strive to maintain neutrality in the long run, in the short run a therapist might side with one family member either for strategic reasons -- to "unbalance" the system -- or because the therapist believes that in some cases one family member's point of view may be more useful than alternative points of view.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

systematically, we won't know whether our assumptions about their utility are valid. To study enactments, we must first develop a system that will yield reliable observations. With a reliable system at hand, studying enactments allows us to develop and validate a model delineating what elements make the in-session use of enactments productive or unproductive.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER II

LITERATURE REVIEW

The literature review section will provide a brief overview of process research, address past research methodologies relevant to this study, and provide a brief summary of related literature. Some concluding comments and the goals of the present study will also be addressed.

Overview of Process Research

Discovery-oriented or exploratory process research has been used in several areas within individual psychotherapy. In a review of this literature, Hill (1990) designated these areas to include therapist techniques, client behavior, covert processes, process models, interactions between therapists and clients, and therapy events. Although process research has been used widely in individual psychotherapy, its use in marital and family therapy research is still relatively uncommon. In a recent review of both traditional and discovery-oriented process studies of family therapy, Myrna Friedlander and her colleagues (1994) found 36 studies dating from 1963 that focused on the in-session verbal behavior of the participants or their self-reported perceptions of actual interactions.

Some family therapy process studies have been based on attempts at describing a particular aspect of the therapeutic process by analyzing in-session verbal statements. Aspects of family therapy process studied include premature termination (Alexander,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Barton, Schiavo, & Parsons, 1976; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Shields, Sprenkle, & Constantine, 1991), treatment context (Chamberlain et al., 1984), and client changes over treatment (Chamberlain et al., 1984; Cline et al., 1984; Laird & Vande Kemp, 1987; Munton & Antaki, 1988). Other family therapy process studies have focused on only those behaviors occurring during treatment that are presumed to be clinically meaningful. Investigators studied behaviors preceding or following important moments (De Chenne, 1973; Patterson & Forgatch, 1985), variables associated with effective sessions (Johnson & Greenberg, 1988; Gale & Newfield, 1992), and therapeutic tasks related to successful outcome (Heatherington & Friedlander, 1990; Greenberg et al., 1993; Friedlander et al., 1994).

The family therapy process literature mentioned above covers many components of family therapy but few of these studies utilize the innovative methodologies drawn from discovery-oriented research. Because the present study aims to investigate an intervention task presumed to create immediate in-session therapeutic change, the literature review will be limited to studies relevant to this line of research.

Discovery-Oriented Research Methodologies

Studies reviewed in this section will focus on in-session therapeutic tasks and discovery-oriented methodologies. Because of its relevance to the present study, Guy Diamond's (1992) dissertation at the California School of Professional Psychology will be discussed more extensively than others. The review's organization roughly follows the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

procedural steps proposed by Alvin Mahrer (1988) and the task analysis paradigm described by Leslie Greenberg (1984).

Step One: Selecting and Defining the Therapeutic Event

The first task in the change event (or task analysis) methodology, according to Mahrer (1988), is defining what are believed to be clinically "good moments" presumed to lead to therapeutic change. In this first step, a clinically significant therapeutic task is selected to be defined, located, and analyzed.

To accomplish this first task, researchers have used either a theory-driven or an empirical approach. Lester Luborsky and his colleagues (1984) used a theory-driven approach to select a change event by surveying various theories of depression and identifying behavioral markers of concepts (e.g., guilt, oedipal conflict, loss of self-esteem) from these respective theories. Mahrer and colleagues (1986) applied the theory-driven approach by surveying the literature for common therapeutic moments believed to be clinically significant. Similarly, Greenberg (1984) selected the integration of "splits" as the change event to be studied after exploring the assumptions and goals of experiential therapy. In his (1992) dissertation, Diamond employed theoretical ideas and clinical experience from strategic and structural family therapy to identify and describe the "shift event." Friedlander and her colleagues (1994) identified "sustained engagement" as an important change event in family therapy treatment across theoretical approaches. In applying an empirical approach to event selection, Elliot (1984) identified "helpful moments" by using client and therapist subjective reports, while Marmar and colleagues (1984) viewed video tapes to produce categories of "mind states."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Types of change events identified for study have included "shift events" (Luborsky et al., 1984; Elliot, 1984; Diamond, 1992), mental states (Horowitz, 1979), and therapeutic tasks or events (Rice & Greenberg, 1984; Diamond, 1992; Friedlander et al., 1994). In studying depression, Luborsky and colleagues (1984) defined the shift event as a decrease or increase in depression and analyzed therapist and client behavior preceding and following this central point. Behaviors identified in the study (Luborsky et al., 1984) were measured by a therapist-client checklist of 45 pre-defined therapeutic events or actions. Elliot (1984) defined insight as the shift event to be studied and had both therapist and client identify the point at which they achieved insight. Unlike Luborsky and colleagues (1984), Elliot (1984) did not use a pre-defined checklist in his study. Horowitz (1979) identified patterns of transition, or shifts, between clients' mental states during ongoing therapy. He divided the therapy sessions containing distinct shifts in clients' mental states, otherwise termed "ways of being," and analyzed them.

Another type of event is the "task" offered by Rice and Greenberg's (1984) task analysis. Here, the therapeutic challenge or task experienced by the client is seen as the change event. The task is defined as "the client's recognition of something puzzling going on and a willingness to explore it" (Rice & Saperia, 1984, p. 33). In order to operationalize the task environment, Greenberg (1984) identifies three components. First is the marker, which indicates the beginning of the task. Second are the interventions, which are used by the therapist to facilitate the task. Finally, there is the resolution of the task, where the intended goals of the therapist's interventions are accomplished. In Friedlander and associates' (1994) investigation of "sustained engagement," the family's

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

failure to sustain engagement (marker) required the therapist to facilitate collaboration during the session (working through) to achieve "sustained engagement" where members of the family take turns discussing the problem (resolution).

To further illustrate these three parts of a task environment, let us use Greenberg and Clark's (1979) research on the two-chair technique in experiential/Gestalt therapy. First, the marker is defined as the presence of an intrapsychic conflict appearing as a "conflict split," a "subject/object split," or an "attributional split." Second, the intervention is defined as the two-chair technique which allows the client to explore both sides of the conflict. The therapeutic elements of this technique are presented elsewhere (Greenberg & Clark, 1979). To deliver the therapeutic element, the intervention may contain many sub-tasks and be indeterminate in length. Finally, the resolution of internal conflict is defined either as the integration of the opposing sides, release of unexpressed feelings, or change of perspective lessening the conflict's pressure.

Diamond (1992) conceptualized the change or "shift event" as movement from a therapeutic impasse by shifting the content or affect of the discussion. In terms of content, the shift was from a focus on daily routines toward a focus on relationship problems. In terms of affect, the shift was from mutual hostility toward the expression of empathy on the part of the parents and the expression of sadness, disappointment, or resentment about the relationship. Hence, phase one of the task environment in Diamond's (1992) study was defined by unproductive discussions of daily routines (marker). Phase two consisted of therapists' attempts to implement the "shift strategy" (working through). Phase three began when at least one family member had begun to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

discuss relational problems with a more constructive tone (resolution). Thus, Diamond's (1992) identification and definition of the change event followed from Rice and Greenberg's (1984) task analysis paradigm.

Step Two: Selecting the Data Base

This step requires the researcher to select actual clinical examples of the event under investigation. In selecting a data base, Marmar (1990) has recommended considering such methodological issues as length, location, unit and context, and validity studies identifying the presence of the event. Also important is choosing the number of segments to be investigated.

Due to the labor-intensive nature of discovery-oriented research, studies have generally used small sample sizes. In Rice and Saperia's (1984) study on the resolution of problematic reactions, they identified and used six successful episodes. Luborsky and colleagues (1984) used nine episodes in a study on depression, while Elliot (1984) used only four segments of events of insight in his study. In a comparison of unsuccessful versus successful task environments, Friedlander and colleagues (1994) analyzed four unsuccessful and four successful "sustained engagement" change events. Elliot (1984) argues for the use of a limited data base by saying significant events should be put under intensive investigation due to their infrequent occurrence and complexity.

In Diamond's (1992) study, 160 family therapy sessions were viewed from the same pool of archival data used for the present study (described in the Method section). From these sessions, Diamond and a colleague selected ten examples that contained clear attempted shift events. Five of these episodes contained shifts that reached a resolution

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(successful shifts) and five contained attempted shifts that did not reach resolution (unsuccessful shifts). Clearly, the limited number of episodes used for studies (ten episodes) appear consistent with the claim that change event research is labor-intensive.

Step Three: Constructing a Performance Model

Model building is the essence of understanding how therapy and its sequences fit together to promote change. Rice and Greenberg (1984) spoke of this step as the development of an "idealized performance model." This "idealized performance model" is developed from a clinician's ideas about the order of events that lead to therapeutic progress. Task analysis allows a researcher to operationalize the implicit thinking that guides the process of therapy (Greenberg, 1984).

In order to construct a performance model, Rice and Greenberg (1984) have proposed three basic questions to guide the researcher in building a performance model:

1) What were the client markers that signaled there was something the client needed to tackle and was at that moment ready to do so?

2) Why did those therapist's interventions seem appropriate at that moment? In other words, what process was the therapist trying to stimulate and shape in the client?

3) What would be a successful resolution for the issues, that is, a successful in-session sub-outcome of therapy? (Rice & Greenberg, 1984, p. 291)

The result of answering these questions is an integration of the essential elements and pathways leading to therapeutic change. For instance, in Diamond's (1992) study, both theory and clinical experience helped the investigator identify and describe thematic

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patterns and repetitive interactions that occurred in the transcribed episodes. In constructing a performance model, Diamond (1992) described the structure of the event: family members' behaviors and their interaction and the therapists' strategies and techniques. The performance model resulting from this observational analysis included the family themes that occurred during the impasse and resolution phases, as well as the theory, operations, techniques, and family responses that occurred during the intervention phase.

In speaking of the essential elements of model building, there is a distinction to be made between client versus therapist performance components. The pathways talked about most often refer to client performances that lead to successful or unsuccessful completion of the task (Rice & Greenberg, 1984; Horowitz, 1979; Luborsky et al., 1984; Mahrer, 1986). By contrast, Elliot's (1984) study and Diamond's (1992) dissertation addressed the variations in therapist interventions that may contribute to the outcomes of the change event. Although the research by Friedlander and her colleagues (1994) addressed variations of therapist behavior, these variables were not accounted for in the conceptual model.

Greenberg (1984) has explicitly stated that the two-chair technique used by Gestalt therapists is similar across sessions. Greenberg and colleagues have shown that the two-chair technique has the power to create change by increasing experiencing and conflict resolution across different therapists (Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Rice, 1981). These studies failed to analyze, however, the degree of correlation between therapist variations and within-group outcome.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Therefore, other researchers have emphasized the importance of understanding a therapist's interventions in response to client changes (Pinsof, 1986; Shoham-Salomon, 1990).

Step Four: Quantitative Analysis

Greenberg (1984) used empirical instruments to collect descriptive data to refine an idealized performance model. He selected segments containing splits resolved by the two-chair technique and applied Klein and colleagues' Experiencing Scale and Rice and colleagues' Client Vocal Quality Scale (as cited in Greenberg, 1984). By graphing time and instrument scores on a X-Y coordinate system, the data revealed that two phases of the event were evident. In the first phase, the two chairs were shown to perform at "different levels," whereby different scores were obtained on the instruments. In the second phase, the scores obtained on the instruments became similar for the two chairs, indicating integration of the two parts of self and the occurrence of a resolution.

Elliot (1984) used the Interpersonal Process Recall (IPR) procedure introduced by N. Kagan (as cited in Elliot, 1984) to select the change event in each session. This procedure allows both the therapist and client to have input into what are considered "moments of helpfulness" (Elliot, 1984), because the two most helpful moments are selected for analysis. Three temporal phases (client pre-segment, therapist target intervention, client post-segment) were analyzed with a battery of process instruments which addressed content, action, style, state-experience, and quality.

In their 1984 study, Luborsky and colleagues used a symptom-context method of analysis. In this design, researchers identify the variable preceding and following the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

increase or decrease of a particular symptom. Unlike Greenberg (1984), they not only graphed changes in variables as they changed across the identified event but also validated their model through statistical analysis. In the study (Luborsky et al., 1984), the seventeen variables (e.g., hostility to self, guilt, loss of self-esteem, oedipal conflict, etc.) under investigation followed directly from four theoretical models of depression. These variables were extracted from the literature of these theoretical models. Quantitative analyses that reveal changes in these variables during the increase or decrease of depression either directly supported or challenged the theoretical models of depression.

In Diamond's (1992) dissertation, a macro-level coding instrument was used to track global relational patterns as the family moved through the phases of the task environment. Although The Beavers Timberlawn Family Evaluation Scale was originally designed by Lewis and colleagues (as cited in Diamond, 1992) to be used to assess healthy family functioning, the scale was adapted to Diamond's (1992) study to give additional information on families' interactional qualities. By using the Timberlawn scale, Diamond (1992) was able to tentatively compare family functioning on certain dimensions (e.g., overt power, permeability, empathy, etc.) based on the productiveness of the shift event and the phase of the shift event.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Summary and Concluding Comments

Many researchers have shifted from outcome to process research because psychotherapy, including family therapy, has been repeatedly and consistently shown to be effective. The general consensus in family therapy research appears to be that no one approach is better than others. However, among the many studies showing the effectiveness of family therapy, several have used structural family therapy. Structural family therapy is deemed to be at least as effective as the other approaches in family therapy. As such, psychotherapy research has turned to understanding exactly what components from the different approaches of therapy contribute to effective outcome. This line of research attempts to answer how and why therapy works.

From this shift in psychotherapy research, what has emerged as a useful methodology are strategies to study the conditions and interventions which lead to specific in-session changes. Discovery-oriented research strategies, such as task-analysis, seek to generate new hypotheses and understand clinical phenomena at a more specific level.

These discovery-oriented research paradigms have been applied to psychodynamic therapy, cognitive therapy, and experiential/Gestalt therapy. This type of research approach has recently been applied to understanding change in family therapy. The next section will briefly address the purpose and aims of the present study.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Purpose and Aims of the Present Study

The purpose of this investigation is to explore what happens in structural family therapy sessions to initiate, maintain, and resolve enactments. The specific aims of the study are: 1) to observe and identify therapist interventions and client responses in the use of enactments, 2) to develop a scale based on these observations, 3) to obtain reliability data for the scale, 4) to investigate which variables maintain and foster productive enactments, and 5) to propose a performance model delineating the elements necessary for the productive initiation, maintenance, and resolution of enactments.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER III

METHOD

Defining Enactments

Defining Enactment "Markers"

The investigator (Elizabeth Fong) and an expert in structural family therapy (Michael P. Nichols) observed 12 videotapes in which enactments were used. From viewing these samples of enactments, they identified verbalizations ("markers") that signified the beginning and end of an enactment.

Therapists began an enactment either by verbally directing family members to begin speaking (e.g.,"Tell him how you felt when...", "Talk to each other about...", "Let him know...") or giving them a hand gesture to begin speaking (e.g., if one of the family members had been previously prepared to talk to the other person). Given the nature of how enactments are initiated, the start of an enactment is usually very clear cut. On the other hand, the end of an enactment is more difficult to determine because it is often hard to decide whether an enactment is really over or whether there is merely a pause before continuing. Hence, the investigator decided that the "marker" for when an enactment ends is after the therapist summarizes and comments on the enactment (e.g., speaking about what happened and what could be improved). These markers served as criteria by which the sample of videotapes for the study was selected.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Defining Productive and Unproductive Enactments

Because one of the aims of this study was to address the effective use of enactments, definitions of productive and unproductive enactments were needed in order to select the sample. The investigator and the expert structural family therapist defined productive and unproductive enactments by observing the same 12 videotape sessions. A productive enactment leads to some form of meaningful breakthrough in communication--involving an emergence of some meaningful content or constructive shift in process. Whereas productive enactments bring about either a content or process breakthrough, unproductive enactments lead neither to a breakthrough in content nor a shift in process--it appears to follow the family's same interactional pattern with nothing new emerging. For a more detailed explanation of these definitions, please refer to Appendix A.

Selecting the Clinical Sample

A Note About the Clinical Sample

The sample selected for this study came from an archival videotape data base from the Center for Research on Adolescent Drug Abuse at Temple University. The archival data base was the product of a randomized clinical trials research project directed by Dr. Howard Liddle (Liddle, 1985). This project was funded by the National Institute of Drug Abuse to study the relative effectiveness of different treatment modalities (family therapy, group therapy, and multi-dimensional treatment) for adolescents with problems of drug abuse and conduct disorder. This study, which originated at the University of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

California, San Francisco, consisted of 250 families randomly assigned to 16 sessions of one of these treatment modalities. Family members completed individual and family measures during the following times: pre-treatment, post-treatment, 6-months, and then 12-months after treatment. All participants in the study consented to be videotaped during treatment, with the understanding that all the data resulting from the study would be used only for teaching and research.

Selecting the Sample for this Study

The selection of the clinical samples for the study was made by the investigator and an expert in structural family therapy (Michael P. Nichols, Ph.D.). These two evaluators observed videotaped sessions at the research center in Philadephia and independently rated whether or not an enactment occurred during the session. Only when both evaluators independently agreed that an enactment was present in the videotapes were they considered for the data sample for the study. All tapes selected for the study were drawn from the same population.

More specifically, the sample selection process took the following steps. The evaluators reviewed a total of 81 tapes and set a particular tape aside if they independently agreed that the taped session contained a "marker" of an enactment (refer to "Defining enactment markers" from the previous section). From this first review, 27 tapes were set aside for further consideration. Some tapes contained multiple enactments. In fact, there were 30 identifiable enactments within the 27 sessions.

These 30 enactments were again each reviewed with two intentions. First, the evaluators decided on when the enactment began and when it ended based on the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

beginning and ending "markers" (refer to the section "Defining Enactment"). The evaluators repeatedly reviewed these segments until they independently agreed on the beginning and ending points of the enactment. Second, the evaluators decided on whether an enactment was productive or unproductive using previously established definitions (refer to Appendix A). Only those enactments on which both evaluators agreed, on whether they were productive or unproductive, were chosen for the study.

In sum, 24 enactments were identified as usable. That is, they contained an enactment and the enactment was classified as productive or unproductive, and the beginning and ending points were identified. The remaining 6 enactments were not used because the evaluators could not reliably classify them as productive or unproductive. The therapists included in the samples were a Caucasian female, an African-American female, and a Caucasian male. All were trained in structural family therapy and were moderately experienced in the treatment of drug-abusing adolescents and their families. Nine enactments were selected from therapist A, four productive and five unproductive. Six enactments were selected from therapist B, four productive and two unproductive. Nine enactments were selected from therapist C, three productive and six unproductive. The evaluators discussed and arbitrarily agreed upon 12 segments included as the sample (two productive and two unproductive enactments for each of the three therapists). Three of the remaining 12 segments were used for training the raters.

Justifying the small sample size. In this type of study, where the goal is to build a model and formulate a category system for a clinical phenomenon, a sample size of 12 therapy sessions was considered adequate. A few reasons have been offered in justifying

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

a smaller sample size for this type of a study. First, researchers have agreed that this kind of study is labor intensive, therefore a smaller sample size is justified (Elliot, 1984; Greenberg & Pinsof, 1986; Luborsky et al., 1984). Second, a point has also been made about the difficulty of finding complete events which are considered the same type (Elliot, 1984). These points demonstrate the need to study in detail a selective smaller sample.

Developing the Enactment Rating Scale and Training Manual

Development of Scale Items

Based on observations (included as part of the Results section) recorded from their earlier viewing of sample enactments, the investigator and an expert structural family therapist (Michael P. Nichols, Ph.D.) constructed a comprehensive system of therapist interventions and client responses during the enactment. First, they listed all the therapist interventions and client responses (Appendix B) that were observed. Next, they separated these interventions and responses into categories considered to be different phases of the enactment. These four phases were determined to be pre-enactment preparation, enactment initiation, enactment facilitation, and enactment conclusion. Then, the evaluators decided on which items were to be measured as a judgment of presence or absence and which were to be measured as a 5-point scale.

In addition to the observation-based items, the evaluators also included several other items in the scale. They included items to assess the interpersonal and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

communication difficulty of the families. The evaluators thought these items were important because families and family members differ in terms of how well they can talk and listen to each other, and these variations would likely affect how successful therapists can be with enactments. In keeping with the discovery-oriented nature of the study, an open-ended question at the end of each checklist section asked raters to describe any additional unlisted therapist interventions as well as additional client responses that they observed.

Development of the Training Manual

The investigator constructed a manual that described the scale items in more detail (Appendix C). The investigator also described examples of what was considered the endpoints and midpoints of the 5-point items based on prior observations of the sample videotapes.

Training of Raters

Rater Selection

Six undergraduate psychology students from the College of William and Mary were selected and trained as raters. Announcements for volunteers were made in several sections of abnormal psychology courses. These volunteers were interviewed by the investigator to evaluate their commitment and availability for the duration of the project. They were selected if they could participate as raters for one academic year. Raters were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

told that they would be trained to rate particular behaviors from videotaped interviews. Raters were naive to the specific goals of the study.

Training materials

A sample of three videotapes, different from those used in stage five of the study, were selected for the purpose of training raters. The respective category systems developed in stage three of the study along with a copy of the training manual were provided to raters during the training. The investigator chose three enactment segments from three different tapes that illustrated a range of therapist and client behaviors. Each of the three segments either demonstrated a low occurrence, some occurrence, or high occurrence of scale items. All raters were trained on the same three segments.

Training Procedure

Three raters were trained to observe therapist behaviors, while three different raters were trained to observe client behaviors. The two groups of raters were trained separately to prevent ratings from being affected by expectancy bias. Raters received approximately 10 hours of training over the course of three weeks. The training consisted of the following components: 1) Review of the manual and scale items, 2) Practice ratings using the three segments, and 3) Discussion of ratings after the practice ratings. During the first training sessions, the investigator referred the raters to the Family Therapy Enactment Rating Scale-Training Manual for descriptions of the items and examples of the endpoints and midpoints of items. Thus, the manual was reviewed in its entirety with all raters.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In each of the next subsequent training sessions, raters independently rated three pre-selected practice segments. Raters were encouraged to make notes at the margins (of the rating scale) as to why they rated segments the way they did. After the raters had completed their ratings, the investigator led a discussion about the ratings. First, the investigator asked each rater how he or she rated a particular item. Second, the investigator asked the raters to support their ratings with concrete examples. If there were inconsistencies, the investigator rewound the tape to a particular point and showed raters specific therapist interventions and client responses. The investigator asked raters what on the scale should have been scored, and she referred raters to the descriptions in the manual. The discussion continued until the discrepancy was resolved by complete agreement by all raters. Raters were asked not to discuss the project outside of the training sessions, so as not to introduce outside influences on the training.

Setting Training Criteria

To determine whether raters had met the criterion (for being able to rate reliably), percent agreement was calculated for both groups (raters of therapist behaviors and raters of client responses) based on the ratings of the practice segments prior to the discussion. Criterion was considered met if percent agreement was equal to or above 75% on the final of the three practice segments. The following formula was used to calculate percent agreement: Percent Agreement = Agreements / (Agreements + Disagreements) x 100.

For the checklist items, acceptable agreement required that all three raters checked the item. For items rated on the five-point scale, agreement required at least two of the three raters having the same numerical rating, and that the third rater having rated within

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

one point of the other two raters. Under these conditions, the participants rating client responses reached 100% agreement on the last practice segment, with an average percent agreement of 93.7% across the three practice segments. The participants rating therapist interventions reached 97.1% agreement on the last practice segment, with an average percent agreement of 94.3% across the three practice segments.

Percentage of agreement was also calculated using more stringent conditions, where agreement was considered only when all three raters either checked the item or gave the same numerical rating. Under this condition, the participants rating client responses reached 87.5% agreement on the last practice segment, with an average percent agreement of 75% across the three practice segments. The participants rating therapist interventions reached 88.6% agreement on the last practice segment, with an average percent agreement of 85.7% across the three practice segments.

Rating the Clinical Sample

Materials for Rating

Each rater was provided with a three-ring binder that contained the following material: 1) Rater instructions (Appendix D), 2) Personalized sequence of the 12 segments (Appendix E), 3) Brief introductions to the segments (Appendix F), 4) Family Therapy Enactment Rating Scale-Training Manual (Appendix C), 5) 12 Blank copies of the appropriate section of the scale (Appendix B).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Procedure for Rating

Each of the six raters independently rated the 12 preselected clinical enactment samples. They followed the procedure outlined in the "Rater Instructions" (Appendix D). Since raters were allowed to rate the tapes based on their personal schedules, it took raters approximately two to ten weeks to complete their ratings.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER IV

RESULTS

The results are presented by first describing the observations that were the basis of the scale items, followed by the presentation of the reliability ratings of the scale items.

The Family Therapy Enactment Rating Scale

The Family Therapy Enactment Rating Scale is presented in Appendix B. The scale items are based on observations described below. Based on these observations, four phases were thought to be important in the course of an enactment: pre-enactment phase, enactment initiation phase, enactment facilitation phase, enactment conclusion or summarizing phase.

Pre-Enactment Phase

Therapist Interventions. In the pre-enactment phase, the therapist prepares family members to talk to each other. Therapists were observed to accomplish this in one of several ways. In the presence of the entire family, therapists often spoke to each member and inquired about what subjects or issues concerned or interested them. Without the entire family present, therapists were observed to use a different preparation strategy. That is, therapists prepared a certain family member individually, to help him or her verbalize personal thoughts and feelings, prior to bringing the family together. Examples of situations where this latter strategy was employed include an adolescent boy who had a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

difficult time speaking up, a mother who became angry when talking with her teenager, and a father who had been absent from his son's life for many years.

During the pre-enactment phase, there were a number of specific interventions therapists used throughout the tape samples to set up the enactment. Often, therapists began by stressing the importance of family members being able to talk to each other. That is, the therapist said something, such as "If you two don't talk, nothing will change," to imply that family members needed to communicate for progress to be made.

Some therapists were observed to prepare for an enactment by helping the family select a subject for discussion, asking, for example, whether they had talked about that particular subject. If the family had not talked about a certain subject or had been unsuccessful in discussing it, the therapist then spoke with each member and explored why it might be difficult to talk about that issue. Some reasons observed in the enactment samples of why it was difficult for family members to talk included an adolescent's fear that his mother wouldn't listen or his father would become angry, a father's worry that his disclosure would mean a loss of respect from his son, or a wife's fear that her husband would withdraw further from their relationship.

As a result of the pre-enactment preparation, families had a subject at hand to talk about. By the end of this phase, therapists had helped the family members select an issue where both parties involved in the discussion had something to say. Such subjects are important and of interest to the participants.

In contrast, therapists who did not adequately prepare for the enactment did one of several things. First, inadequate preparation for enactment occurred when therapists

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

arbitrarily selected topics that family members were only marginally interested in or that carried little or no affective charge. Here the discussants were observed to lack the motivation necessary to communicate, and enactments tended not to go anywhere. The other hinderance in preparing for enactments was when therapists failed to offer directions as to how the enactment should proceed. In this situation, a family who was ready and willing to communicate may not have the needed guidance to do so. While a therapist might have concluded that a certain enactment failed because family members were unable to communicate, a more accurate interpretation might have been that the enactment had little chance of success because of inadequate preparation.

These observations were represented as the four checklist items and two 5-point scale items under the pre-enactment preparation section in the Family Therapy Enactment Rating Scale for therapist interventions.

Client Responses. Prior to the actual start of the enactment, some family responses or family characteristics were noted from the tape samples. Some families were observed to have a certain dynamic or interpersonal style that revealed an eagerness to enter a discussion about a certain subject. Other families showed a reluctance to speak or to discuss certain hot or high-conflict topics. However, regardless of a family's eagerness or anxiety to begin talking about a subject, some families appeared to want to ventilate their feelings rather than engage in a dialogue about the issue at hand. When the primary interest seemed to be ventilating their feelings, family members engaged in what appeared to be a variety of unproductive interaction patterns.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Prior to the therapist-directed enactment, some examples of spontaneous discussions among family members appeared to indicate several unproductive patterns of interaction. The first unproductive pattern of interaction was a pursuer-distancer dynamic. In this type of interaction, it was observed that while one person in the conversation nagged and complained, the other person withdrew and was silent. With this interactional pattern, therapists often find that one member of the family dominates the conversation. They speak to the other family member in either a critical or patronizing tone. A common example observed in the tape samples involved a mother who complained about her son not doing chores, and the son not saying a word in response. For as long as this pattern of interacting continued, it appeared unlikely that the distancer would speak up or that the pursuer would listen. Another type of interaction that some families engaged in was the blaming-defending pattern. Here, one family member speaks in such a way as to cause the other member to be guarded. What results is a chaotic verbal confrontation, without resolution. An example of this pattern was an immature mother who accused her misbehaving daughter of not showing respect, and the daughter who attacked her mother with "you don't deserve respect--look at the men you date, they're half your age!" As long as there was this particular unproductive interaction, family members did not appear ready to calmly discuss a certain topic -- meaning that they speak, listen, and respond.

These observations were represented as a 5-point scale item under the communication difficulty section of the Family Therapy Enactment Rating Scale for client behaviors.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Initiation of Enactment

Therapist Interventions. Therapists were observed to begin enactments either by verbally directing or gesturing for the participants to start talking. The "marker," to direct the family to begin the enactment, was either expressed verbally or by hand gesture, or both. Some examples of therapist directions to talk included "Talk to him," "Tell her," "Why don't you two talk to each other," and "Discuss it with each other." Some therapists made some sort of hand gesture (e.g., pointing) in place of or in addition to the verbal request for the family members to talk.

In addition to directing family members to begin their discussion, the tape samples also showed therapists engaging in several other interventions to initiate enactments. Sometimes, therapists specified the members to participate in the enactment. One common and straightforward example was a therapist who requested, "Mom, tell [it to] John." Other therapists also specified the subject or issue for discussion by saying something to the effect of, "Talk about what makes you afraid." One request that certain therapists also used in initiating enactments was that they indicated that discussants should speak directly to each other. Therapists either gestured this request (by motioning both hands towards each other), or by saying "Don't tell me; talk to him directly," or both.

At certain times, therapists also performed a physical maneuver to facilitate direct conversation. For discussants who were physically blocked by a third person, therapists requested them to switch seats to move them in closer proximity. For those who were already in a position to talk, therapists simply turned their chairs towards each other in order to promote direct conversation.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In addition to these therapist interventions, several other aspects of the enactment initiation phase were observed to be important. For instance, the degree to which the therapist intentionally pulled back or stayed out of the dialogue once the conversation began appeared to increase pressure on the discussants to have a direct conversation with each other. Therapists' attempts to pull back included sitting back, looking away, and looking down with arms folded. Because we normally expect eye contact from the person we're speaking to, therapists also appeared to avoid being drawn in and promoted dialogue by making eye contact, not with the speaker, but with the family member being spoken to. Therapists also varied on the degree to which they were clear about the issue of the discussion. Therapists ranged from saying nothing about what the discussants should talk about, to using words like "this" or "that" ("Talk about that incident"), to overtly and precisely stating the subject ("Talk about what it felt like when he was not a part of your life").

Some therapists also initiated enactments by saying something about how the discussants should speak to each other. Such clarifications included something to the effect of "See if you can get John to tell you what he thinks."

Finally, there also appeared to be a range of subjects that therapists chose from. Whereas one therapist chose a one-sided subject that did not promote a discussion (e.g., why a mother wished her son didn't skip school), another therapist chose a subject that was interesting and promoted discussion (e.g., what it felt like for both father and son not to be a part of each other's lives).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

These observations were represented as the four checklist items and four 5-point scale items under the initiation of enactment section of the Family Therapy Enactment Rating Scale for therapist interventions.

Client Responses. Immediately after therapists directed the discussants to talk, discussants appeared to vary in the degree of ease that they started to talk and listen to each other. Whereas some discussants talked immediately after therapist directions without additional help, others did not start talking without repeated urging from the therapist. Somewhere in between these two extremes were cases in which discussants attempted an enactment and began to speak to each other but then turned to the therapist for clarification, or the therapist intervened to clarify either the subject for discussion or who was to speak to whom.

This observation, of how easily clients began talking, was represented as a 5-point scale item under the communication difficulty section of the Family Therapy Enactment Rating Scale for client behaviors.

Facilitation of Enactment

Therapist Interventions. Once therapists had given the initial request for the enactment to begin, and the discussants began to talk, the phase that followed involved the therapist as facilitator. Therapist interventions during this phase targeted enactment obstacles such as discussants changing the subject, discussants having difficulty opening up, discussants appearing to be not listening, or discussants starting to attack or make destructive comments.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

When discussants changed the subject, it was observed that therapists intervened in several ways. First, if the discussants talked about a multitude of subjects but did not focus on any one topic in a productive manner, sometimes therapists redirected the discussants back to the original issue. Second, if the discussants changed the subject but the new topic seemed emotionally relevant to the discussants, sometimes therapists chose to stay with the new topic so that the discussants remained engaged in conversation. As a result of this intervention, the discussants continue to talk meaningfully. Third, if the discussants changed the subject but none of the new subjects appeared emotionally charged to the discussants, therapists talked about a completely different issue that ended the initial enactment. That is, these therapists went back to the preparation stage by speaking individually with one or both discussants to uncover a new and more productive subject.

When one or both of the discussants had difficulty talking, therapists intervened in a variety of ways. The first and what appeared to be the most direct way was a request for one or both discussants to open up. Here, therapists encouraged disclosure by emphasizing the importance of the discussants expressing their points of view. Second, if one or both of the discussants stopped talking abruptly during their enactment, therapists verbally pushed them to continue talking or gave a hand gesture to encourage them to resume the discussion. Third, if one of the discussants had a difficult time opening up, therapists encouraged that discussant by repeating, clarifying, or rephrasing what the other one had said.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Another situation that required therapist intervention was when one or both discussants appeared to be uninterested or not listening. Therapists often chose to be direct in their intervention by requesting one or both family members to listen better (e.g., "Repeat what you said because I think he needs to hear it again," "Let's check to see if he heard you."). Sometimes, therapists also indirectly encouraged listening by talking about one of the discussants to the other one in the third person (e.g., "Wait, I think John is starting to open up. Let's listen."). Both of these strategies appeared to encourage better listening and usually promoted meaningful responses from one or both discussants.

In discussions that became heated and produced a situation where one or both discussants became blaming and hurtful towards each other, several therapist strategies were used. If one of the discussants designated the issue or problem as residing in the other person, therapists sometimes said something to convey that the problem was one involving more than just one person (e.g., "You cannot think that your mom is the only one responsible!" "I don't think that John is totally to blame."). At times, therapists decreased the blaming person's anger and emotional reactance by asking that person to talk about his or her related feelings or experiences of the blame.

During the facilitation phase, therapists tended to vary on how often they interrupted the discussion. While the discussants talked, some therapists frequently interrupted the enactment by talking about one member in the third person at some length. Both the number of times they interrupted and the length of the interruptions appeared to vary between therapists. Therapists also varied in the degree to which they intervened during the enactment. In one situation, a therapist stayed out of the dialogue

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

almost completely and intervened for a very brief moment when the discussants became stuck. In another case, a therapist made a lengthy speech even though the discussants seemed willing and able to continue talking to each other.

Control over who spoke and what they talked about also varied from case to case. When there were more than two family members present in a session and an enactment was set up to include only two of those family members, therapists sometimes needed to block interruptions from a third party entering the conversation. By doing so, therapists maintained control over who spoke during the discussion. Therapists also varied in terms of how much control they maintained over the subject of the dialogue. Control ranged from having no control at all over tangential subjects that discussants pulled into the conversation to exerting firm control in avoiding unnecessary tangential subjects.

In facilitating the enactment, therapists asked questions to probe deeper and to encourage discussants to elaborate on their conversation. Questions were either aimed at eliciting feelings or content, or both. Whereas a question eliciting emotion often took the form of "How did you feel when that happened?" a question eliciting content often took the form of "Tell me what happened next."

Therapists also varied on the degree to which they were interested in and responded to the content versus the process of the discussion. When therapists were interested in the content of the discussion, they focused on the information being conveyed. On the other hand, therapists who focused on process attended more to how the discussants were interacting than to what they were saying. Therapists who focused on process tended to respond to what was happening as it was happening, commenting on

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the characteristics of the interaction itself and not on what exactly was said. To illustrate this difference, consider a scenario where an adolescent who had been quiet and listening to a nagging mother's complaints finally spoke up and said "If only you had your own life, you wouldn't be always trying to run mine!" A therapist who focused on content was more likely to respond to what the adolescent meant by the mother having her own life, how this was to happen, and what she must do to make this happen. A therapist who focused on process was more likely to emphasize the fact that an angry adolescent spoke up and shared his views with his over-controlling mother and that voicing his opinion meant his wanting to become more like an adult.

These observations of therapist interventions were represented as the 10 checklist items and seven 5-point scale items under the facilitation section of the Family Therapy Enactment Rating Scale for therapist interventions.

Client Responses. During the course of the facilitation phase of enactments, several client responses were observed. The first group of responses included interruptions by a third family member. The second group included the extent and characteristics of talking, listening, and responding among the discussants. The final group of client responses included the quality of the discussants' enactment.

When more than two family members were present in the session and a third member intruded into what was meant to be a dialogue, two scenarios occurred as a result of the interruption. In the first case, the third member's interruption disrupted the dialogue and so the dialogue stopped or the subject of the conversation changed. In the second scenario, the third member's interruption did not result in the dialogue stopping or

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the subject changing. Instead, either as a result of the therapist blocking the third person or the two participants ignoring the third person, the conversation continued.

The next group of client responses covers the extent and characteristics of talking, listening, and responding that occurred during the enactment. In terms of talking, what the discussants talked about and how they talked seemed to vary.

First, discussants varied on the degree to which they spoke directly to each other rather than speaking through the therapist. Even some pairs who had much to say to each other did not engage in direct dialogue with each other but directed their conversation mostly towards the therapist. In doing so, they talked about the other discussant in the third person.

Second, discussants varied on what they talked about. Discussants talked about their own experiences or feelings or talked about something that has little or no direct personal relevance.

In terms of listening and responding to each other, discussants engaged in a variety of different responses. Sometimes, family members chose not to respond at all or responded minimally. At other times, family members chose to elicit a direct response by specifically asking the other member to share his or her point of view. Whereas these behaviors either occurred or didn't, the degree to which the discussants listened and responded to each other varied. In terms of listening, discussants ranged from appearing not to listen at all to listening carefully and overtly acknowledging what they'd heard. In terms of responding, discussants ranged from not responding or answering each other's

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

requests at all to always promptly and directly responding to each other's comments and questions.

The quality of enactments varied in several dimensions. First, the conversation varied in terms of whether the enactment was of interest to both discussants. That is, whether the conversation was two-sided. Conversations ranged from having or promoting only a one-sided view to having both sides presented. Second, conversations varied in the degree to which a resolution or agreement was reached. Conversations ranged from a total lack of conflict resolution or mutual understanding, to complete resolution or mutual understanding among the discussants about a particular issue. Finally, conversations varied in the extent to which they involved the expression of strong feeling. At the extreme ends of the continuum were situations where discussants stayed completely away from displaying emotion to where discussants overtly talked about or displayed their feelings to each other.

These observations were represented as the seven checklist items and seven 5-point scale items under the effectiveness-of-enactment section of the Family Therapy Enactment Rating Scale for client behavior.

Enactment Conclusion

At the end of some enactments, therapists offered commentary that summarized their observations of the enactment. Sometimes, therapists praised the discussants for being able to talk about the specified topic. A therapist's praise was conveyed as something to the effect of "I know it was difficult for you two to talk about something that's been hanging over you for so long, but you made a nice start today." Therapists'

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

praise was sometimes also followed by comments about what went wrong, something to the effect of "I think that you two weren't being very honest with your feelings." At times, therapists chose to close enactments by specifying what needed to happen in the future for continued progress. These comments either took the form of a request that something needed to happen differently (e.g., being honest) or simply of a statement that more of something needed to happen (e.g., an adolescent voicing his opinion like an adult).

These observations were represented as the three checklist items and one 5-point scale item under the summarizing commentary section of the Family Therapy Enactment Rating Scale for therapist interventions.

Client Responses. During this final phase of the enactment, client responses were observed to be limited. For the most part, while therapists gave their final comments, family members listened. In some cases, certain family members agreed with the therapists' comments by nodding their heads and commenting on their improvement from the last time they attempted to talk. In other cases, where families were locked into unproductive patterns of talking, critical comments by therapists were taken as an opportunity to further cast blame.

Because observations here were limited and sometimes an ending of one enactment lead to the beginning of another enactment, these observations of client responses to therapists' commentaries were not represented in the Family Therapy Enactment Rating Scale.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reliabilities for the Family Therapy Enactment Rating Scale

The reliability data for the Family Therapy Enactment Rating Scale are presented in two separate sections, reliability for the client behavior items and reliability for the therapist behavior items. For each set of itmes, the reliability data for the continuous variables are presented first, followed by the reliability data for the categorical variables.

An alpha level of .01 was used for all statistical tests. This alpha level corresponds to a Pearson r (10) = .708, which we considered to be a minimum criterion for acceptable reliability.

Reliability for Client Behavior Items

Continuous variables. Pearson correlation coefficients were computed for each pair of the three raters. Table 1 presents the coefficients for the variables, separated into items relating to the communication difficulty and items relating to the effectiveness of the enactment.

Reliabilities for all three pairs of raters were significant on two variables: responding and two-sided disclosure. Reliabilities for two of the three pairs of raters were significant on two variables: talking and content breakthrough. Reliabilities for only one of the three pairs of rater were significant on four variables: degree of ease, direct talking, listening, and affective breakthrough. For the remainder variable, family style, reliabilities approached significance (where r is significant at a level equal to or less than .05 but greater than .01) for all three pairs of raters. Reliabilities of r = .80 or greater

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 1

Continuous Variables of Client Behaviors: Reliability Coefficients among Three Independent Raters

Variable Name and Item Description	Pairs of Raters A-B	B-C	A-C
Communication Difficulty			
Family Style	.60	.60	.58
Degree of Ease	.46	.74*	.63
Effectiveness of Enactment			
Talking	.88***	.77**	.65
Direct Talking	.58	.59	.77**
Listening	.47	.84**	.54
Responding	.95***	.76**	.73*
Two-Sided Disclosure	.72*	.78**	.77**
Content Breakthrough	.83**	.67	.82**
Affective Breakthrough	.73*	.67	.62

Note. N = 12.
$*p < .01$. $**p < .005$. $***p < .001$.

were obtained for at least one pair of raters on four variables: talking, listening, responding, and content breakthrough.

To compare the range of ratings for these variables, Appendix G graphs the discrepancy distributions of ratings for pairs of raters. Each graph represents one of the continuous variables in the client behavior section of the Family Therapy Enactment Rating Scale. While the discrepancy distributions for some variables are very normally

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

distributed with great overlap between the three pairs of raters, other variables have more scattered distributions.

Categorical variables. Kappas were computed for each pair of raters. Table 2 presents the coefficients for the variables. With two variables, kappas could not be calculated and were replaced by values of percent agreement. A detailed analysis of the results revealed two reasons why kappas could not be calculated for these variables. In the first instance, the specified behavior was so readily and accurately observed that there was close to 100 percent agreement on the presence of the behavior in the sample. Specifically, on the variable Third Person Dialogue, there was 91.7 to 100 percent agreement that the behavior was present in all of the samples. On the other hand, kappas could not be calculated for behaviors that were not easily observed and there was close to 100 percent agreement on the absence of the behavior in the sample. For example, all three groups of raters obtained 100 percent agreement on the client variable Nonpersonal Dialogue, indicating that the behavior was not observed in any of the samples.

Excluding the variables for which kappas were not calculated, reliabilities for all three pairs of raters were significant on only one variable: encouraged disclosure. Reliabilities for two of the three pairs of raters approached significance (where kappa is significant at a level equal to or less than at the .05 level but greater than at the .01 level) on one variable: disruption 2 (continuation).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 2

Categorical Variables of Client Behaviors: Kappa Values among Three Independent Raters

Variable Name and Item Description	Pairs of Raters A-B	B-C	A-C
Effectiveness of Enactment			
Disruption 1 - no continuation	.625	-.091	.625
Disruption 2 - continuation	.800	.571	.750
Refusal of Participation	.438	.314	.063
Third Person Dialogue	(1.0)	(.917)	(.917)
Personal Dialogue	-.125	.250	-.143
Nonpersonal Dialogue	(1.0)	(1.0)	(1.0)
Encouraged Disclosure	1.00*	1.00*	1.00*

Note. $N = 12$. The notation ( ) is used where kappas could not be calculated and were replaced by values of percent agreement.
*$p < .01$.

Reliability for Therapist Behavior Items

Continuous Variables. Pearson correlation coefficients were computed for each pair of raters. Table 3 presents the coefficients for the variables separated into items relating to the four phases of the enactment: pre-enactment preparation, enactment initiation, enactment facilitation, and enactment summarization.

There were no variables for which reliabilities for all three pairs of raters were significant. Reliabilites for two of the three pairs of raters were significant on only one variable: preparation. Reliabilities for only one of the three pairs of raters were significant.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 3

Continuous Variables of Therapist Behaviors: Reliability Coefficients among Three Independent Raters

Variable Name and Item Description	Pairs of Raters		
	A-B	B-C	A-C
Pre-Enactment Preparation			
Topic Selection	.39	.32	.31
Preparation	.91***	.65	.77**
Enactment Initiation			
Withdrawal	.05	.76**	.04
Clear Topic	.74*	.80**	.60
Direct Conflict Topic	.15	-.38	.38
Specific Directions	.47	.59	.71
Enactment Facilitation			
Interruptions	.66	.76**	.59
Affective Probing	.16	.47	.03
Content Probing	.51	.60	.49
Dialogue Control	.36	.61	.69
Topic Control	.74*	.55	.70
Content vs. Process	.39	.75*	.29
Non-interruption	.39	.36	-.05
Enactment Summarization			
Comment Effectiveness	.47	.53	.82**

Note. $N = 12$.
*$p < .01$. **$p < .005$. ***$p < .001$.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on five variables: withdrawal, clear topic, interruptions, topic control, and comment effectiveness. Reliabilities for at least one of the three pairs of raters approached significance (where r is significant at a level equal to or less than .05 but greater than .01) on three variables: specific directions, content probing, and dialogue control. Reliabilities of r = .80 or greater were obtained for at least one pair of raters on three variables: preparation, clear topic, and comment effectiveness.

To compare the range of ratings for these variables, graphs of the discrepancy distributions of ratings for pairs of raters are presented in Appendix H. Each graph represents one of the continuous variables in the therapist intervention section of the Family Therapy Enactment Rating Scale. While the discrepancy distributions for some variables are normally distributed with great overlap between the three pairs of raters, others have more scattered distributions.

Categorical Variables. Kappa coefficients were computed for each pair of raters. Table 4 presents the coefficients for the variables. With three variables, kappas could not be calculated and were replaced by values of percent agreement. A detailed analysis of the results revealed two reasons why kappas could not be calculated for these variables: a behavior was either almost always absent or present. For the variables Topic Selection and Direction 1 (people), there was 91.7 to 100 percent agreement on the presence of the behavior in the sample. For the variable Explored Difficulty, there was 91.7 to 100 percent agreement on the absence of the behavior in the sample.

Excluding the variables for which kappas were not calculated, reliabilities for all three pairs of raters were significant on two variables: inquired about talking, direction 4

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 4

Categorical Variables of Therapist Behaviors: Kappa Values among Three Independent Raters

Variable Name and Item Description	Pairs of Raters		
	A-B	B-C	A-C
Pre-Enactment Preparation			
Importance of Talking	1.00*	.400	.400
Inquired about Talking	1.00*	1.00*	1.00*
Explored Difficulty	(.917)	(.917)	(1.0)
Topic Selection	(1.0)	(1.0)	(1.0)
Enactment Initiation			
Direction 1 - people	(1.0)	(.917)	(.917)
Direction 2 - subject	.571	.800[a]	.750[a]
Direction 3 - word/gesture	.000	.500	.000
Direction 4 - placement	1.00*	1.00*	1.00*
Enactment Facilitation			
Redirection of subject	.800[a]	.500	.667[a]
Third Person Discussion	.429	.308	.400
Encouraged Openness	.621[a]	.744[a]	.438
Switched Subject - continued	.077	.676[a]	.273
Switched Subject - discontinued	.250	.333	.167
Emphasis on "More than One"	.636[a]	.636[a]	1.00*
Encouraged Better Listening	.625[a]	.625[a]	1.00*
Repeated, Clarified, Rephrased	.556	.250	.250
Encouraged Continuation	.500	-.167	.314
Encouraged Openness - Critical	.556	.800[a]	.400
Summarizing Commentary			
Praised Family Members	.333	.333	1.00*
Stated Problems of Enactment	.750[a]	.571	.800[a]
Stated Methods of Improvement	.833[a]	.667[a]	.500

Note. $N = 12$. The notation ( ) is used where kappas could not be calculated and were replaced by values of percent agreement.
[a]$p \leq .05$. *$p < .01$.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(placement). There were no variables for which reliabilities for two of the three pairs of raters were significant. Reliabilities for only one of the three pairs of raters were significant on four variables: importance of talking, emphasis on "more than one," encouraged better listening, and praised family members. Reliabilities for two of the three pairs of raters approached significance (where kappa is significant at a level equal to or less than .05 but greater than .01) on seven variables: direction 2 (subject), redirection of subject, encouraged openness, emphasis on "more than one," encouraged better listening, stated problems of enactment, and stated methods of improvement. Reliabilities for only one of the three pairs of raters approached significance on two variables: switched subject (continued) and encouraged openness (critical).

Exploratory Analyses

Point-biserial correlations or chi-square analyses were computed to explore the relation between client and therapist variables and whether an enactment was productive or unproductive. These analyses were based on the original categorical judgments made by the investigators of whether an enactment was productive or unproductive. Significance levels were determinined by taking the highest 5% of those values with $p < .05$. Variables that were considered to approach significance included the remaining of the variables with $p < .05$ (not included in the highest 5%). Variables that approached significance also included those that obtained $p \leq .06$.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Continuous Variables and Productivity of Enactment

Point-biserial correlations showed that no client or therapist variables were significantly related to productivity of enactment. However, several client variables exhibited a tendency toward significance: direct talking ($r(12) = .64$, $p < .05$), listening ($r(12) = .61$, $p < .05$), responding ($r(12) = .56$, $p \leq .06$), two-sided disclosure ($r(12) = .57$, $p \leq .06$). Only one therapist variable had a tendency toward significance: withdrawal from enactment ($r(12) = .56$, $p \leq .06$).

Categorical Variables and Productivity of Enactment

Chi-square analyses revealed that no client or therapist variables were significantly related to productivity of enactment. Unlike the exploratory analyses for the continuous variables, no categorical variables exhibited a tendency toward significance. For variables that were almost always observed in the sample, and therefore had little variance, chi-square could not be computed: third person dialogue, direction 1-people. For variables that were almost always not observed in the sample, and therefore had little variance, chi-squares could not be computed: non-personal dialogue, stated problems of enactment.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER V

DISCUSSION

Overall, the reliability of the ratings of therapist interventions and client responses were generally low. These low ratings may be attributed to several factors, including factors having to do with the methodology, the training of raters, and the composition of the rating scale. Each of these factors are discussed in detail in this section. Due to low reliability, any conclusions that are drawn from these data are tentative. Despite the fact that few ratings were reliable, the present study yielded qualitative data that are deemed useful in offering some tentative conclusions.

Reliability of the Family Therapy Enactment Rating Scale

Ratings of client variables were found to be more reliable than ratings of therapist variables. Hence, more changes and additional training are needed on the therapist scale than the client scale. In demonstrating how much revision and/or training is needed, the scale items are divided in terms of whether they have excellent, good, or borderline reliability. Items with excellent reliability were those that obtained significance for all three pairs of raters. Items with good reliability were those that obtained significance for at least 2 pairs of raters. These scale items are perhaps acceptable as is but additional training of the raters would probably improve rater agreeement. Items with borderline reliability were those that obtained significance for one pair of rater or approached

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

significance for at least two pairs of raters. Items with borderline reliability would probably require some modification of the item, in addition to more thorough training of raters.

Reliability of the Client Variables

There were 16 client variables included in the Family Therapy Enactment Rating Scale. Eleven of these variables are included on the list of variables that are viewed as having excellent, good, or borderline reliability.

Excellent reliability. Raters were able to obtain excellent reliability on three client variables. They seem to be able to easily agree on how much family members are responding to each other, whether the conversation involved a two-sided disclosure, and whether one family member encouraged disclosure from another.

Good reliability. Raters were able to rate two of the client variables with good agreement. They were able to rate with good agreement how much talking was involved in the conversation and the extent that there was a breakthrough in content or new information during the course of the family's conversation.

Borderline reliability. On six client variables, raters obtained borderline reliability. These included the degree of ease with which the family began talking, the amount of direct talking that was involved, the amount of listening family members displayed, the extent to which there was a breakthrough in affect, the extent to which the family style was conducive to talking, and the whether or not a disruption in dialogue continued.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reliability of the Therapist Variables

Although there are fewer client variables than therapist variables on the Family Therapy Enactment Rating Scale, the number of therapist variables that were viewed as having obtained excellent, good, or borderline reliability are few. Of the 37 therapist variables included in the Family Therapy Enactment Rating Scale, only three variables were viewed as having obtained at least good reliability.

Excellent relability. Raters were able to obtain excellent agreement on only two variables: whether or not the therapist asked a family if they had talked about a specific topic, whether or not the therapist directed the family members to structurally move their seats.

Good reliability. Raters were able to agree with good reliability the degree that the therapist prepared family members for an enactment.

Borderline reliability. A great number of the therapist variables were viewed as having obtained borderline reliability. These variables probably lend themselves to some changes as well as additional training of raters. The following variables are the continuous variables needing change: extent to which the therapist withdrawals from enactment, extent to which a clear topic was presented, extent of interruptions, extent to which the therapist had control of the topic of conversation, extent of the effectiveness of the comments. Also needing change are variables asking whether the therapist did the following: stressed the importance of talking, emphasized the conversation as involving "more than one" person, encouraged better listening, praised family members, provided a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

subject for the discussion, redirected the family members to the subject, encouraged openness, stated problems of the enactment, and stated methods of improvement.

Variables without Variability

As presented in the results section, the five variables for which percent agreement instead of kappa were calculated include: third person dialogue, non-personal dialogue, topic selection, direction 1 (clear about who talks), explored difficulty. Since raters all agreed that two variables were not observed in the clinical sample (non-personal dialogue, explored difficulty), and therefore lack variability, these variables may not have been relevant to this clinical sample. As such, these variables may not be necessarily included in future revisions of the scale. Because raters all agreed that three variables were always observed in the sample (third person dialogue, topic selection, direction1 - clear about who talks), therefore lacking variability, these variables may be deemed as necessary elements to an enactment.

Variables Related to Successful Enactments

Although the exploratory analyses of the present study did not reveal any variables that were significantly related to productive enactments, several of the continuous client and therapist variables showed a tendency toward significance (direct talking, listening, responding, two-sided disclosure, withdrawal from enactment). What this begins to suggest is that these may be critical elements n the use of enactments. Hence, with an improvement in the Family Therapy Enactment Rating Scale and perhaps

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

a larger clinical sample, future studies might show that certain variables are indeed essential to the use of enactments. That is, in order for an enactment to be considered successful, the family members need to directly listen and respond to each other with a balance in self-disclosure, while the therapist needs to remain out of the family members' discussion.

Essential Elements of Enactments

Essential Therapist Variables in Enactments

Although many variables were observed within each phase of enactments, only certain variables were deemed as essential to the general use of enactment. That is, the investigator believes that these components must be represented in every enactment and serve as the umbrella for all other variables within that phase. In the pre-enactment preparation phase, the therapist must stress the importance of family members talking and help family members select a good subject for discussion. For instance, therapists might accomplish this task by exploring if family members have talked previously about a certain topic and what made it difficult to talk. As described in the previous section, the enactment preparation variable obtained "good" reliability (e.g., reliability coefficients for two of the three pairs of raters were significant).

During the initiation of enactment phase, therapists must direct the enactment by making clear who is to talk, specifying the subject of discussion, and then pulling back and staying out of of the conversation once the directive is understood. These three

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

variables obtained "borderline" reliability (e.g., reliability coefficients approached significance). In addition, one of these variables (withdrawal from enactment) showed a tendency toward significance in its relation to successful enactments. To help family members further understand the directive, therapists might also gesture that participants speak directly to one another, physically move them towards each other, and give specific directions on how they should talk.

If the therapist has done an adequate job preparing for and initiating the enactment, few, if anything needs to be done during the facilitation phase to move the enactment along. The primary task for therapists is to encourage family members to continue to speak to each other about the subject at hand. In order to accomplish this task, therapists may have to redirect family members to speak to each other, encourage better listening, and empathize with the angry member who inhibits the progress of the enactment. All these three variables had at least borderline reliability. These interventions are done with the general goal of getting family members to continue talking. The results suggest that when family members engage in direct talking, listening, and responding with a balanced two-sided disclosure, they may have a more productive enactment. Exploratory analyses of these variables showed that they approached significance in their relation to successful enactments.

In the final phase of enactment, therapists provide comments on the enactment that in turn closes off the enactment. Therapists may praise the family or give them constructive criticism about what went wrong and how it can be improved. These two

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

variables (summarizing the problems of enactment and stating method of improvement) obtained borderline reliability.

A Model Enactment Case Example

The following case excerpt illustrates the phases of enactment and the essential therapist elements that make the enactment go smoothly. The case is a sixteen year-old drug abusing adolescent male ("Tyler")whose father ("Mr. Jones") abandonned him at age 7. In the third session of the adolescent's treatment, the therapist invites the father to join the adolescent in therapy.

Therapist: One of the things we are trying to do for Tyler is to get him to talk about things that may be difficult for him to talk about. That's why you're here today, Mr. Jones. It's important that you two be able to talk about some things that may be interfering with your relationship [pre-enactment: importance of talking]. Tyler tells me that you've been out of his life for a while.

Father: Yeah, I've been gone for nine years...a long time.

Therapist: Have you two talked about why you left? [pre-enactment: attempting to select a topic]

Father: No. There was a lot going on with me.

Therapist: Tyler, is it important for you to know why he left? [pre-enactment: selection of topic]

Tyler: Yeah. I've thought about it some. I didn't know what was going on then...if it was me or whatever.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Therapist: Tyler, ask your father about why he left? Mr. Jones, try to explain to your son what was going on with you -- what kind of circumstances made you leave? [initiation: clear topic, clear that they are to talk to each other]

Tyler: Yeah, why did you leave? Was it me or something?

Father: No. It had nothing to do with you. I was just real confused back then...I was into a lot of things - drugs, booze. I had to leave. It was the best I could do for you. And your mom...

Therapist: Let's not talk about her because she is not here. Let's stay with why you left. You can tell Tyler how it felt to leave him. [facilitation: redirection]

Father (looking down): I didn't want to leave. But I just kept on thinking what a bad father I would be if I had stayed. I was ashamed to leave but I had to. Then I was ashamed to come back. (long pause)

Therapist: Okay, Tyler. Tell your dad how you feel about what he said. [facilitation: encouragement to open up]

Tyler: Well, I don't know. I guess I know why he left. But it didn't do any good 'cause I still had problems. I don't know. I just wished he was around. (pause)

Therapist: I think that we have made great progress here. Dad, you explained your reasons for leaving. Tyler, what I'm hearing from you is that, whatever dad's reasons, you wished he was around. Sounds like you both want to rebuild your relationship. That will take some time. [summarization: praised participation and offered future direction]

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Implications of Findings

Conceptual Implications

Enactment is a technique in structural family therapy used to observe, understand, and modify maladaptive sequences of family behavior. Although enactment is both a concept and a technique, no study is known to have delineated the essential elements that comprise the concept or technique. Without conceptually understanding enactment, one cannot begin to study what effect it has when used as an intervention in family therapy. A conceptual model of enactment (Figure 1) is delineated based on the observations made in the development of the Family Therapy Enactment Rating Scale. Conceptually, enactment is understood as comprising of four phases: pre-enactment preparation phase, enactment initiation phase, enactment facilitation phase, enactment summarizing phase. A tentative performance model for enactment is offered and illustrated on page 67.

The performance model of enactment takes into consideration that, during the enactment, the therapist may return to any previous phase if he or she feels that the enactment needs to be re-started. Although the therapist may return to a previous phase, illustration of the performance model suggests that enactments should follow the chronological order of the four phases. The model also suggests that a complete enactment involves following all four of the phases and its essential elements.

Pragmatic Implications

Often, it is difficult for therapists to work with families who have difficulty communicating or who have maladaptive ways of communicating. This study has begun

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

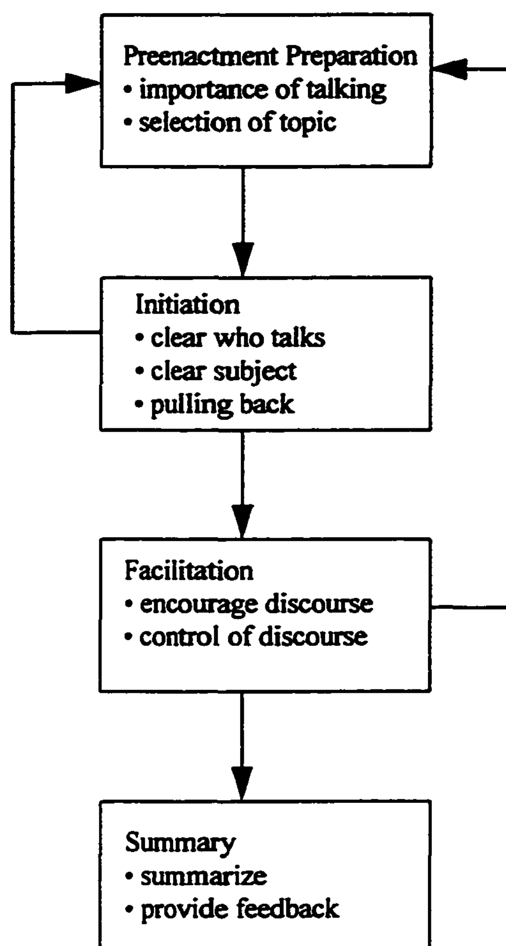


Figure 1. A Performance Model of Enactment: The Four Phases.

to delineate the phases and essential elements to get family members to communicate with each other. A model of performance for enactment has implications for training family therapists and affecting the amount and quality of communication within families.

Family therapy students learn a new concept better if they know what is involved in making an event happen in therapy. The performance model of enactment provides a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

stepwise approach for learning how to carry out enactment. If raters can reliably agree that a behavioral component of enactment is observed and also be able to clearly restate or repeat this behavior, it then becomes possible to teach these strategies. Hence, a family therapy student being taught how to direct an enactment can learn in phases how to prepare for, initiate, facilitate, and conclude the enactment. Within each of these phases, the novice student can be taught sample strategies and the essential elements necessary to accomplish each phase.

Having families be able to communicate effectively is perhaps one of the most difficult things to do in family therapy. The performance model of enactment allows the therapist to assess where the family is in terms of their communication difficulty. Families differ in how much they talk and what they talk about. For those families who have good communication styles, the therapist need only direct them to speak about something that he or she thinks has relevance for treatment. For those families who normally do alright with how they communicate but just have trouble with a certain topic, the therapist can push them to increase the amount of discussion of that topic which causes them difficulty. Still worse are those families whose communication style is maladaptive, and they are unable to approach any topic without getting stuck in this maladaptive pattern. For these families, the performance model offers therapists strategies within the facilitation phase to move them toward a more adaptive communication style.

Research Implications

The results of this study have several implications for research with enactment.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

First, the observational scale that is the result of this study provides an instrument for future studies of enactment. An instrument available for the study of enactment ensures that researchers can use the same language to promote the understanding of this concept and technique. For instance, when one researcher talks about enactment initiation strategies, researchers will know that these strategies include giving a clear topic, directing who is to talk, and pulling back from the family's dialogue. Second, the phases of enactment that are outlined as a result of this study allow researchers to either focus on enactment as a global technique or to focus independently on each of the phases. Finally, the scale also allow researchers to look at client responses to enactment separately or in relation to therapist interventions.

Limitations of the Study

Methodology of the Study

Arbitrary enactment ending points. The beginning of an enactment is much easier to identify than the ending point. For the beginning of enactment, the marker was clearly identified as the therapist's verbal or nonverbal direction of family members to talk to each other. On the other hand, the evaluators had a difficult time identifying the cut-off time marking the end of enactment, since, at times, the end of one enactment signified the beginning of another enactment. Hence, an end point of enactment was arbitrarily chosen for the purpose of telling the raters when to stop rating. This arbitrary selection of enactment end points may have made some of the scale items in the summary section (of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the Family Therapy Enactment Rating Scale) not applicable to some enactments in the clinical sample.

Small sample size. As mentioned in the methods section, the time-intensive and labor-intensive manner of the discovery-oriented nature of this study and others like it has justified for the small sample size. Athough one reason for the small sample size is the tremendous amount of time it takes in doing discovery-oriented research, one additional reason is that it was in fact more difficult to find clear-cut enactments than had been anticipated by the investigator. Hence, the small sample size of 12 in this study yielded less variables as being reliably significant. Statistically, there is a higher threshold to achieve significance for this type of sample size because some variables are expected to be reliable by chance. In certain cases, such as with the categorical variables, raters would have to have perfect agreement in order for a variable to be significant at an alpha level of .01.

Repetitive scale items. One of the aims in a discovery-oriented study is to be as comprehensive as possible, to make certain that no information is lost. Since the present study produced a comprehensive scale based on observations of clinical samples, items were repeated within phases and between phases of enactment. This repetition of items occurred particularly in the therapist scale items. For instance, the pre-enactment preparation phase asked raters to rate the presence or absence of whether the therapist "Helped family members select a subject to talk about" then asked them to rate "The degree that the therapist has helped family members select a subject that allows both sides a good opportunity to talk." Again, the facilitation phase of the scale, asked raters to first

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

rate the presence or absence of whether the therapist "Asked an angry or critical member to talk about his or her own experience or feelings" then asked them to rate "To what extent did the therapist attempt to probe deeper into family members' feelings?" When similar items are repeated, it makes the scale lengthy and difficult for raters to differentiate between the observations. If scales are lengthy and repetitive, raters may have been exhausted and confused during their observations.

Indequate training of raters. As stated in the methods section, raters were trained for approximately ten hours each. The problem here may have been that the training was all held prior to the start of the actual rating of the scales. Although raters were directed to refer back to the scale manuals during their rating sessions, raters varied on the degree to which they did this. Raters who referred back to the manuals in essence had more "training" than those who rated without referring back to the manuals. During the rating process, those who did not refer back to the manuals may have "lost" some of their understanding of the scale items, causing raters to be less accurate and less reliable.

Inappropriate training criteria. The training criteria used for this study were in terms of percent agreement. However, the statistics used for reliability were Pearson correlations and kappa. Although raters met criteria without much trouble using percent agreement, it may have required more training to meet criteria in terms of Pearsons or kappa. Pearson correlations and kappa are more stringent statistics and are different and more stringent than the percent agreement criteria used in the training phase.

Unstructured method of rating. After the training, raters were allowed to rate on their own whenever they wanted. As specified in the methods section, raters completed

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

their rating of the 12 clinical samples within anywhere from two to 10 weeks. With an unstructured method of rating, variations in ratings exists. For instance, with the time variation between two to 10 weeks, some raters may have forgotten more information from the training than other raters. Another way that reliability is affected is that without another person present, there is no way of knowing what the raters actually do in these rating sessions. Whereas one rater may watch the entire segment before rating, another rater may rate as they review the segment.

Generalizability of The Family Therapy Enactment Rating Scale

The Family Therapy Enactment Rating Scale, as it stands now, may have limited generalizability. This scale constructed for studying enactment was based on observations made of therapy sessions with a very specific type of clients, drug-addicted adolescents. With this particular group of clients, the drug treatment center adopted a stepwise approach to using enactment. First, therapists prepared the client (the adolescent) in prior sessions before actually attempting the enactment. Therapists also took some time to privately prepare the other family member involved in the enactment. Second, therapists brought the family members together and directed them to talk to each other. Sometimes, therapists did not need to say anything because the family members already knew what they were supposed to do. Third, the facilitation phase allowed the therapists to use certain interventions to get the family members to have a productive conversation. Finally, in some but not all cases, therapists had a resolution phase where they summarized the enactment and emphasized areas for future improvement.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

It is the third phase of the enactment depicted in the scale that may have limited generalizability. Because drug-addicted adolescents are so difficult for therapists to get to open up, they are observed to be doing many types of interventions in the facilitation phase. Therapists redirected members back to the subject, switched to a different subject, encouraged family members to talk, repeated and clarified the conversation. The facilitation phase of the scale listed numerous interventions perhaps because of the level of difficulty in working with drug-addicted adolescents. Hence, the faciliation phase of the scale may not represent what is needed to get a family, who comes to therapy with general problems in communication, to speak to each other.

Conclusion

Modifications of The Family Therapy Enactment Rating Scale

Since this study is a first attempt at constructing an enactment scale based on observations, modifications of the scale need to be made to make it a better scale and increase its reliability. Three areas of focus need to be considered when modifying the scale: length of the therapist scale, variables with low or borderline reliability, repetitive items.

As discussed earlier, the client response variables generally obtained better reliability than the therapist intervention variables. The investigator strongly believes that raters for client responses obtained better reliability because they were able to remain focused during their rating of the shorter section. Hence, one of the ways that this

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

difference in reliability can be resolved is to decrease the number of therapist intervention items, making both sections comparable in length.

Reliability can also be increased through eliminating or modifying those scale items with low or borderline reliability. While low reliability scale items are those that are generally not significant, borderline reliability scale items approached significance. For these items, several questions need to be considered when deciding whether to eliminate or modify the item. Is the item necessary in identifying what comprises an enactment? If not, can this item be eliminated and the scale still have what is considered essential in describing what goes on in enactment? If it is a necessary component of enactment, what modifications can be made to make it more easily observable?

One final way to make the Family Therapy Enactment Rating Scale a better scale is by eliminating or combining those items that appear repetitive. Currently, some items that are similar in composition are listed in both categorical and continuous form. For instance, therapist intervention items dealing with dialogue control, topic control, and whether or not the therapist attempted to switch topics may all be combined into one succinct scale item -- perhaps this "overall control of enactment" item is best listed as a scale item in continuous form. Several questions may help in deciding what items to combine or eliminate. What items appear to have overlap in their meaning? For instance, is there overlap in items dealing with clients' way of talking or therapists' way of encouraging dialogue? If there is overlap or repetition, how can these items be combined and explained to make it easy for raters to observe the behavior?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Future Studies

Several directions may be taken when considering to do a future study on the family therapy technique of enactment. First, studies may focus on how to modify the Family Therapy Enactment Rating Scale to make it a more concise and more reliable scale overall by repeating this reliability study. Second, studies may focus on applying the Family Therapy Enactment Rating Scale to a sample population besides drug-abusing adolescents (i.e., family mediations such as divorce). Third, future studies could also apply the scale to larger samples to show relationships between therapist interventions and client responses. Finally, outcome studies of enactment may include comparing the use of enactment as opposed to other techniques in changing the quality and quantity of communication within a family.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

REFERENCES

Alexander, J. F., Parsons, B. V. (1982). Functional family therapy. Monterey, CA: Brooks/Cole.

Alexander, J. F., Barton, C., Schiavo, R. S., & Parsons, B. V. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. Journal of Consulting and Clinical Psychology, 44, 656-664.

Benedetti, J. K., & Brown, M. B. (1978). Strategies for the selection of log-linear models. Biometrics, 34, 680-686.

Campbell, T. J., & Patterson, J. M. (1995). The effectiveness of family interventions in the treatment of physical illness. Journal of Marital and Family Therapy, 21, 545-584.

Chamberlain, P., Patterson, G., Reid, J., Kavanagh, K., & Forgatch, M. (1984). Observation of client resistance. Behavior Therapy, 15, 144-155.

Cline, V. B., Meija, J., Coles, J., Klein, N., & Cline, R. A. (1984). The relationship between therapist behaviors and outcome for middle- and lower-class couples in marital therapy. Journal of Clinical Psychology, 40, 691-704.

De Chenne, T. K. (1973). Experiential facilitation in conjoint marriage counseling. Psychotherapy, 10, 212-214.

Diamond, G. S. (1992). A process study of therapeutic impasses between parents and adolescents in family therapy. Unpublished doctoral dissertation, The California School of Professional Psychology, Berkley/Alameda.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Diamond, G. S., & Liddle, H. A. (1996). Resolving a therapeutic impasse between parents and adolescents in Multidimensional Family therapy. Journal of Consulting and Clinical Psychology, 64, 481-488.

Elliot, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal recall and comprehensive process analysis. In L. Rice & L. S. Greenberg, (Eds.), Patterns of change: Intensive analysis of psychotherapy process (pp. 249-286). New York: Guilford Press.

Falloon, I. R. H., Boyd, J. L., & McGill, C. W. (1982). Family management in the prevention of exacerbations of schizophrenia: A controlled study. New England Journal of Medicine, 306, 1437-1440.

Falloon, I. R. H., Boyd, J. L., & McGill, C. W. (1985). Family management in the prevention of morbidity of schizophrenia: Clinical outcome of a two-year longitudinal study. Archives of General Psychiatry, 42, 887-986.

Friedlander, M. L., & Heatherinton, L. (1989). Analyzing relational control in family therapy interviews. Journal of Counseling Psychology, 36, 139-148.

Friedlander, M. L., Heatherington, L., Johnson, B., & Skowron, E. A. (1994). Sustaining engagement: A change event in family therapy. Journal of Counseling Psychology, 41, 438-448.

Friedlander, M. L., Wildman, J., Heatherington, L., & Skowron, E. A. (1994). What we do and don't know about the process of family therapy. Journal of Family Psychology, 8, 390-416.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gale, J., & Newfield, N. (1992). A conversation analysis of a solution-focused marital therapy session. Journal of Marital and Family Therapy, 18, 153-165.

Garfield, S. L., & Bergin, A. L., (1994). Introduction and historical overview. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change, (4th ed.). New York: Wiley & Son.

Goldstein, M. J., & Miklowitz, D. J. (1995). The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. Journal of Marital and Family Therapy, 21, 361-376.

Greenberg, L. S. (1984). A task analysis of conflict resolution. In L. Rice & L. S. Greenberg, (Eds.), Patterns of change: Intensive analysis of psychotherapy process (pp. 67-123). New York: Guilford Press.

Greenberg, L. S., & Clark, D. (1979). The differential effects of the two-chair experiments and empathic reflections at a conflict marker. Journal of Counseling Psychology, 28, 288-294.

Greenberg, L. S., & Dompierre, L. (1981). Differential effects of Gestalt two chair dialogue and empathic reflections at a split in counseling. Journal of Counseling Psychology, 28, 288-294.

Greenberg, L. S., Ford, C. L., Alden, L., & Johnson, S. M. (1993). In-session change in Emotionally Focused Therapy. Journal of Consulting and Clinical Psychology, 61, 78-84.

Greenberg, L. S., & Rice, L. (1981). The specific effects of gestalt interventions. Psychotherapy: Theory, research and practice, 18, 31-37.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Heatherington, L., & Friedlander, M. L. (1990). Applying task analysis to structural family therapy. Journal of Family Psychology, 4, 36-48.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. Journal of Consulting and Clinical Psychology, 58, 288-294.

Horowitz, M. J. (1979). States of mind. New York: Plenum Press.

Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. Journal of Marital and Family Therapy, 14, 175-183.

Laird, H., & Vande Kemp, H. (1987). Complementarity as a function of stage in therapy: An analysis of Minuchin's structural family therapy. Journal of Marital and Family Therapy, 13, 127-137.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Fries, R., & Sturgeon, D. (1982). A controlled trial of social intervention in the families of schizophrenia patients. British Journal of Psychiatry, 141, 121-134.

Luborsky, L. Singer, B., Hartke, J., Crits-Critstoph, P., & Cohen, M. (1984). Shifts in depressive states during psychotherapy: Which concepts of depression fit the context of Mr. Q's shifts. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of Change: Intensive analysis of psychotherapy process (157-193). New York: Guilford Press.

Mahrer, A. R. (1988). Discovery oriented psychotherapy research: Rationale, aims and methods. American Psychologist, 43, 694-702.

Mahrer, A. R., Sterner, I., Lawson, K. C., Dessaulles, A. (1986). Microstrategies: Distinctively patterned sequences of therapist statements. Psychotherapy: Theory, research and practice, 23, 50-56.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Marmar, C. R., (1990). Psychotherapy process research: Progress, dilemmas and future directions. Journal of Consulting and Clinical Psychology, 58, 265-272.

Marmar, C. R., Wilner, N., & Horowitz, M. J. (1984). Recurrent client states in psychotherapy: Segmentation and quantification. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of Change: Intensive analysis of psychotherapy process (pp. 194-212). New York: Guilford Press.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Minuchin, S., Rosman, B., & Baker, L. (1978). Psychosomatic families: Anorexia nervosa in context. Cambridge, MA: Harvard University Press.

Munton, A. G., & Antaki, C. (1988). Causal beliefs amongst families in therapy: Attributions at the group level. British Journal of Clinical Psychology, 27, 91-97.

Nichols, M. P., & Schwartz, R. C. (1995). Family therapy: Concepts and methods, (3rd ed.). Boston: Allyn and Bacon.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. Journal of Consulting and Clinical Psychology, 53, 846-851.

Pinsof, W. M. (1986). The process of family therapy: The development of the Family Therapist Coding System. In L. S. Greenberg & W. M. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 201-284). New York: Guildford Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pinsof, W. M., Wynne, L. C. (1995). The efficacy of marital and family therapy: An empirical overview, conclusions and recommendations. Journal of Marital and Family Therapy, 21, 585-614.

Pinsof, W. M., Wynne, L. C., Hambright, A. B. (1996). The outcomes of couple and family therapy: Findings, conclusions, and recommendations. Psychotherapy, 33, 321-331.

Rice, L. N., Greenberg, L. S. (1984). Patterns of change: Intensive analysis of psychotherapy process. New York: Guilford Press.

Rice, L. N., & Saperia, E. P. (1984). Task analysis of the resolution of problematic reactions. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of Change: Intensive analysis of psychotherapy process (pp. 29-66). New York: Guilford Press.

Russell, G. F. M., Szmukler, G. I., Dare, C., & Eisler, L. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. Archives of General Psychiatry, 44, 1047-1056.

Shadish, W. R., Ragsdale, K., Glaser, R. R., Montgomery, L. M. (1995). The efficacy and effectivenes of marital and family therapy: A perspective from meta-analysis. Journal of Marital and Family Therapy, 21, 345-360.

Shields, C. G., Sprenkle, D. H., & Constantine, J. A. (1991). Anatomy of an initial interview: The importance of joining and structuring skills. American Journal of Family Therapy, 19, 3-18.

Shoham-Salomon, V. (1990). Interrelating research processes of process research. Journalof Consulting and Clinical Psychology, 58, 295-303.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Smith, M. L., Glass, G. V. (1977). Meta-analysis of psychotherapy outcomes studies. American Psychologist, 32, 752-760.

Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santisteban, D., Hervis, O., Kurtines, W. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. Journal of Consulting and Clinical Psychology, 56, 552-557.

Szapocnik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vasquez, A., Hervis, O., Posada, V., & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. Journal of Consulting and Clinical Psychology, 57, 571-578.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX A

DEFINITIONS OF PRODUCTIVE AND UNPRODUCTIVE ENACTMENTS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Productive Enactments

In family therapy, conversations that normally should take place at home but for some reason don't can occur. When a family has a productive enactment in the family therapy setting, a discussion leads to some form of meaningful breakthrough in communication. These breakthroughs may either involve an emergence of some meaningful content or constructive shift in process.

A breakthrough in process refers to some change or shift in a dyad's interactional pattern. For instance, a shift in process occurs when a reticent adolescent finally speaks up to a domineering parent, or a husband and wife continue a discussion beyond their usual threshold. In contrast, a breakthrough in content refers to a discussion of an important but previously avoided topic. For example, a breakthrough in content occurs when an adolescent is able to tell her mother that she has been molested, or when a son and father discusss how to be more a part of each others' lives.

Given these distinctions between productive enactments viewed in terms of either a content or process breakthrough, a productive enactment is hence defined as a dialogue occurring between family members that includes any or all of the following elements: acknowledgement and discussion of previously undisclosed feelings, productive discussion, active listening and responding, negotiating, verbal and controlled expression of strong feelings.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Unproductive Enactments

Families who come to therapy often have difficulty communicating effectively, especially about the conflicts and problems that bring them into treatment. These families bring with them to therapy their usual and unproductive ways of interacting. For these families, their familiar ways of communicating hinder progress and result in unproductive enactments -- either they fail to approach a previously avoided topic or approach a certain topic in the same conflicted manner as before.

Whereas productive enactments bring about either a content or process breakthrough, unproductive enactments lack meaningful content breakthrough or lack a shift in process. That is, it appears to follow the family's same interactional pattern with nothing new emerging. For example, an unproductive enactment due to lack of meaningful content occurs when one or both family members refuse to approach a "hot" previously undiscussed topic, such as a mother's suspicion that her son has been using drugs. An unproductive enactment due to unchanged process occurs when the family resorts to the same communication patterns as before, such as a mother continuing her domineering and lecturing style when speaking with her daughter about staying out late at night and doing poorly in school.

By viewing unproductive enactments as lacking of content or process breakthrough, unproductive enactments would occur when a dialogue contains any or all of the following more specific elements: minimal responding, discussants appear uninterested in the topic, discussants get off-topic or off-task, discussants talk through the therapist, discussants display sarcasm and/or blame.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX B

FAMILY THERAPY ENACTMENT RATING SCALE

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

FAMILY THERAPY ENACTMENT RATING SCALE
Part I: Therapist Behaviors/Interventions

Case Number__________________ Rater______________________
Session______________________
Segment_____________________
Date_______________________

Instructions: The following scales are designed to assess various aspects of therapist interventions during family interactions directed by the therapist. Rate therapist behaviors *independent of client responses*. With the exception of checklists, please *consider the entire range* of each scale when you make your rating. Score each scale only *based on what you see or hear*, NOT based on what you may infer.

I. Pre-Enactment Preparation

A. Check the behaviors that the therapist engaged in:

____ Said something about the importance of family members talking together.
____ Asked if family members have talked about a certain subject.
____ Explored why it might be difficult to talk.
____ Helped family members select a subject to talk about.

Specify any additional things the therapist did to lay the groundwork for an enactment:
____
____
____
____
____

B. Rate the following on a 5-point scale (1=not at all; 3=somewhat; 5=very):

The degree that the therapist has helped family members select a subject that allows both sides a good opportunity to talk.	1	2	3	4	5
How successfully did the therapist prepare for the enactment.	1	2	3	4	5

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

II. Initiation of Enactment

A. Check the behaviors that the therapist engaged in:

____ Made it clear who is to talk.
____ Made the subject of the conversation clear.
____ Indicated by word or gesture that family members should speak directly to each other.
____ Moved family members from one chair to another or turns them towards each other to facilitate direct conversation.

Specify any additional things the therapist did to get the enactment started:

____
____
____
____
____

B. Rate the following on a 5-point scale (1=not at all; 3=somewhat; 5=very):

Made a clear effort to pull back and stay out of the conversation as soon as the enactment begins.	1	2	3	4	5
The degree that the subject for the conversation was clear and specific.	1	2	3	4	5
The degree to which the subject of the conversation involved direct conflict between both sides of the discussion.	1	2	3	4	5
The extent to which the therapist gave specific directions for how family members should talk and/or listen.	1	2	3	4	5

III. Facilitation of Enactment

A. Check the behaviors that the therapist engaged in:

____ Redirected members back to the subject at hand.
____ Derailed the conversation by talking about a discussant in the third person.
____ Encouraged family member(s) to open up.

____ Switched to a different, more productive subject.
____ Switched to a subject that closes off the dialogue.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

____ Conveyed the subject as one involving more than just one person.

____ Encouraged family member(s) to listen better.
____ Repeated, clarified or rephrased what one person has said to the other.
____ Indicated by word or gesture that family members should continue talking.

____ Asked an angry or critical member to talk about his or her own experience or feelings.

Specify any additional things the therapist did to keep the enactment going:

____
____
____
____
____

B. Rate the following on a 5-point scale (1=not at all; 3=adequate; 5=very):

To what extent did the therapist interrupt the enactment by making a speech or sermon by talking at length about a family member in the third person?	1	2	3	4	5
To what extent did the therapist attempt to probe deeper into family members' feelings?	1	2	3	4	5
To what extent did the therapist attempt to probe deeper into the content of the discussion?	1	2	3	4	5
To what extent did the therapist have control over who speaks during the discussion, blocking interruptions?	1	2	3	4	5
To what extent did the therapist have control over the subject of the dialogue, avoiding tangential subjects?	1	2	3	4	5
To what extent did the therapist seem to respond to the content rather than facilitate the process of the discussion (1=mostly content; 5=mostly process).	1	2	3	4	5
To what extent did the therapist remain out of the conversation, except to intervene briefly as necessary?	1	2	3	4	5

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

IV. Summarizing Commentary

A. Check the behaviors the therapist engaged in:

____ Praised family members for being able to talk about a particular subject.
____ Made a critical comment about what went wrong.
____ Stated or clearly implied what needs to happen in the future for continued progress.

Specify any additional things the therapist did to keep the enactment going:

____
____
____
____
____

B. Rate the following on a 5-point scale (1=not at all; 3=somewhat; 5=very):

How effective was the therapist's comments of the enactment?	1	2	3	4	5

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

FAMILY THERAPY ENACTMENT RATING SCALE
Part II: Client Behaviors

Case Number__________________ Rater______________________
Session______________________
Segment______________________
Date________________________

Instructions: The following scales are designed to assess various aspects of the family's dialogue. Rate the family's interactions *independent of therapist interventions*. With the exception of checklists, please *consider the entire range* of each scale when you make your rating. Score each scale only *based on what you see or hear*, NOT based on what you may infer.

I. Communication Difficulty

A. ***Before the enactment actually starts***, rate the following on a 5-point scale (1=very unlikely; 5=very likely):

Considering both the interpersonal style and presenting problem of the family, how likely is it that family members will be able to talk, to listen, and to respond in a productive manner?	1	2	3	4	5

B. ***As soon as (one minute after) the enactment begins***, rate the following on a 5-point scale (1=very difficultly; 5=very easily):

With what degree of ease did family members begin to talk and listen to each other?	1	2	3	4	5

II. Effectiveness of Enactment

A. Check the client behaviors that occurred during the enactment:

____ A third family member intervened and disrupted the dialogue.
____ A third family member intervened but the dialogue continued.
____ One or more persons refused to participate in the dialogue or participated minimally.
____ Talked about the other participant in the third person (usually to the therapist).

____ One or more persons talked about his or her own experiences and feelings.
____ Talked about a subject not personal to the two people involved in the dialogue.
____ One or more member asked the other member to share his or her point of view.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Specify any additional things family members did that were not listed:

____
____
____
____
____

B. Rate the extent to which the family did the following, on a 5-point scale (1=not at all; 3=somewhat; 5=very much):

Talked.	1	2	3	4	5
Talked directly to each other (rather than through the therapist).	1	2	3	4	5
Listened to each other.	1	2	3	4	5
Responded to what each other is saying.	1	2	3	4	5

C. Rate the qualities of the conversation on a 5-point scale (1=not at all; 3=somewhat; 5=very):

Conversation was two-sided (where both sides expressed their point of view).	1	2	3	4	5
Conversation had a content breakthrough- reached a resolution, an agreement, or mutual understanding.	1	2	3	4	5
Conversation had an affective breakthrough- the participants displayed or talked about feelings.	1	2	3	4	5

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

FAMILY THERAPY ENACTMENT RATING SCALE TRAINING MANUAL

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Family Therapy Enactment Rating Scale
Training Manual
Part I: Therapist Behaviors/Interventions

I. Pre-Enactment Preparation

A. Said something about the importance of family members talking together. The therapist stated or emphasized that the family members needed to talk or discuss a certain topic.

Examples: "You need to say all the things you just said to me." "It's important that you two be able to talk about this."

Asked if family members have talked about a certain subject. The therapist asked whether family members have talked about a certain subject. The therapist asked whether one person thinks another knows how the first one feels about a certain subject or if a family member is curious about another person's actions.

Examples: "Have you and Mom talked about (this)?" "Does Dad know how you feel about (this)?" "Are you curious about why he did (that)?" Does Mom know you're upset?"

Explored why it might be difficult to talk. The therapist probed for reasons why talking is hard, a certain topic may be difficult to talk about, or directly asked for certain topics that are hard to talk about.

Examples: "Do you know what gets in the way of you talking to your father?" "What about this is hard to tell your Mom?" "Are there things that have been hard to talk about?"

Helped family members select a subject to talk about. The therapist has specified a topic or issue for family members to discuss. Score this item even if the therapist did not overtly name the issue. Sometimes, the therapist has individually prepared family members prior to the enactment and families knew exactly what to talk about.

Examples: "Do you remember what three things you thought would be important to tell Mom?" "Talk (to him) about your expectations." "Talk about how things might be different." "You want us to start?"

B. The degree that the therapist has helped family members select a subject that allows both sides a good opportunity to talk. Here, you should rate the degree that the topic is one that was relevant to both participants in the conversation. Rate this item a "1" if the subject appeared one-sided. That is, one participant was not at all interested and did not have an opinion about the subject. A rating of "3" would mean that the topic had some relevance to both, but more for one person than the other. A rating of "5" would indicate that there was two sides to the topic, a "hot" topic for them

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

both. Note: Rate this item based on the subject selected, regardless of whether or not the two people talked.

Examples: "1" subjects - Mom's worries that son is not attending school, Dad's expectations of his son, where to send son to live.
"3" subjects - Wife asking support from her husband, whether or not to come home after school, finding out what another's concerns are.
"5" subjects - Impact of dad's drinking on the family, wanting to be treated like an adult, negotiation of curfew, privileges, etc.

How successfully did the therapist prepare for the enactment? Rate this item base on the number of therapist behaviors you have scored in section "1A." If no items were checked, give a "1" rating and if all items were checked, give a "5" rating.

II. Initiation of Enactment

A. Made it clear who was to talk. The therapist verbally specified or gestured who was to talk. By gesture, the therapist pointed to one person and then the other or pointed to both simultaneously.

Examples: "Talk to Tom..." "Mom, talk to your son." "Dad, tell her how you feel."

Made the subject of the conversation clear. The therapist stated the topic for the discussion. Score this item only if the therapist clearly specified the subject for the discussion. Don't score this item from inferring that the therapist has specified the topic during prior preparation.

Examples: "Discuss your expectations of each other." "Talk (to your husband) about needing his support." "Help (your son) talk about what he's angry about."

Indicated by word or gesture that family members should speak directly to each other. If the participants direct their conversation towards the therapist, the therapist said or did something to indicate that they should direct the conversation to each other. The therapist may point to the person to which the conversation is intended. The therapist may also sit slightly back or look away (avoid direct eye contact) from the two participants.

Examples: "No, talk to him." "He needs to hear it." Points while saying, "Tell him that."

Moved family members from one chair to another or turned them towards each other to facilitate direct conversation. If the family wasn't already sitting in a way that facilitated direct conversation, the therapist did something and directed them to switch seats or turn to each other.

Examples: "Here, you move over here and get closer to your husband." "Turn toward him and tell him." "Let's switch seats so you can talk with him about that."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

B. Made a clear effort to pull back and stay out of the conversation as soon as the enactment began. The therapist either physically sat back or looked elsewhere so as to turn his or her attention away from the participants of the discussion, attempting to force the two to talk.

Examples: "Talk to him (sits back)." "Go at it (folds arms and sits back)." "You to need to talk about it (sits back and looks away)."

The degree that the subject for the conversation was clear and specific. The degree in which the therapist specified the conversation so that the participants had a good idea of what they are to talk about.

Examples: "1" Rating - Does not specify a topic at all.
"3" Rating - Mentions subject, but then uses words like "this" or "that" to refer to the subject.
"5" Rating - "Talk about expectations." "Talk about how you felt when..." "Ask him for his support of you."

The degree to which the subject of the conversation involved direct conflict between both sides of the discussion. The subject for the discussion had affective relevance for the participants. Another way to explain this would be to ask whether one would predict that the subject is a good enough subject so that participants would be equally interested in expressing their points of view.

Examples: "1" Rating - Subject has is not interesting to either participants.
"3" Rating - One member has at least some interest in voicing his or her opinion about the subject.
"5" Rating - Subject is equally important to both participants, both seem eager to express their point of view.

The extent to which the therapist gave specific directions for how family members should talk and/or listen. The therapist not only gave the participants a subject to talk about but also went on to say something about the way they should talk.

Examples: "Would you share some of what you told me with your mom? Talk to her so that she understands." "Can you talk to your son about (that situation) so that you're helping him tell you what happened?"

III. Facilitation of Enactment

A. Redirected participants back to the subject at hand. When the participants got off topic or became tangential, the therapist said something to get them back to the original topic.

Examples: "Let's stay with how you feel about (that)." "I'd like you to continue talking to your Dad about (this)."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Derailed the conversation by talking about a discussant in the third person. The therapist directed his comments at one of the participants using "he","she", or the participant's name. The comments were usually about the other participant.

Examples: "I think that George is listening, he is hearing you." "I think that he has some things to say about (that). Find out from him what happened."

Encouraged family member(s) to open up. The therapist directed his or her comments at the participant that is more silent and asked the participant to share his or her thoughts and/or feelings.

Examples: "How do you feel about what Mom has just said?" "She's saying that you have been different, what do you think about that?"

Switched to a different, more productive subject. The therapist saw that the original subject of the discussion as one that was not drawing enough affect or interest from the participants. Hence, the therapist directed them to talk about something else.

Examples: "Talk to him about what you found out...I see that you don't feel you have his support. Ask him for his support." "Maybe (this) is not helping. Is there something else that's on your mind? Something you would like to say to Dad?"

Switched to a subject that closes off the dialogue. The participants were either talking or stops talking, and the therapist introduced another subject that closed off the original discussion.

Examples: "(talking about needing support)...now you two need to come up with a plan before you leave today."

Conveyed the subject as a problem involving more than just one person. The therapist indicated that the problem is not just an individual problem, but one that the two participants or the family has to deal with.

Examples: "I don't think that J is totally to blame. I think that, as his parents, this is something that you also need to take responsibility for." "You cannot think that your mom is the only one responsible for what happened!"

Encouraged family member(s) to listen better. The therapist said or did something to indicate that one or more family members should listen better. The therapist may have said the person's name or gotten his attention by tapping on his chair.

Examples: "Why don't you ask your dad?" "Repeat what you just said. I don't think he heard you. I think he needs to hear it again." "Can you check to see if (someone) is listening?" "Wait, (someone) is starting to open up."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Repeated, clarified or rephrased what one person has said to the other. The therapist said something with the intention of amplifying what one person has said. By repeating, clarifying, or rephrasing what one person has said, the therapist placed emphasis on the statement.

Examples: "I think that what M means when he said (that) was..." "So, you're saying that it's hard for you." "You know what you've just said? You said it makes you mad when she treats you like you're a child."

Indicated by word or gesture that family members should continue talking. The therapist said or did something to urge the family members to prod or discuss a subject further. Score this item even if the therapist did not say anything and only motions her or his hand for the participants to continue.

Examples: "Go on. Continue." "Keep going." "Say more." "Go on with what you were saying."

Asked an emotional (or angry or critical) family member to talk about his or her own experience or feelings. The therapist encouraged a member to talk about his own experiences.

Examples: "Tell your son what you wished you would of had with your father. What did you miss out on?" "What was your life like when you were young?"

B. To what extent did the therapist interrupt the enactment by making a speech or sermon by talking at length about a family member in the third person? The therapist intervened by saying some things about one of the participants.

Examples: "1" rating - the therapist does not intervene to make a speech during the enactment
"3" rating - two sermons that are somewhat brief, "5" rating - three or more sermons that are lengthy.

To what extent did the therapist attempt to probe deeper into family members' feelings? The degree in which the therapist attempted to explore the affect that was in the room. The therapist directed one or both discussants to talk further about how they felt about something.

Examples: "Maybe you can tell Mom what you're mad at." "That's bullshit! Tell her how you really feel."

To what extent did the therapist attempt to probe deeper into the content of the discussion? The degree that the therapist attempted to explore deeper into what the participants were saying. The therapist asked questions to clarify or gain information.

Examples: "Tell me more about (that)." "What other expectations do you have?" "What were you mad about?"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

To what extent did the therapist have control over who speaks during the discussion, blocking interruptions? In a chaotic family whose members often interrupt each other, it is necessary for the therapist to stop the interruptions in order for the participants to resume their conversation. Therapists may do this verbally or by gesturing. Only score this item if their were more than two family members present.
Examples: "Let them talk." "Hold on." "Wait until they're finished."

To what extent did the therapist have control over the subject of the dialogue, avoiding tangential subjects? Sometimes, family members get off the topic at hand and talks about other subjects. When this happened, the therapist directed them back to the subject.
Examples: "Let's get back to talking about your relationship with your daughter." "I think we need to return to the original topic."

To what extent did the therapist seem to respond to the content rather than the process of the discussion? Content refers to the actual statements made in the session about subjects like curfew and school. The therapist responded to the information (what the discussants say) of the enactment.
Examples: "What happened?" "Say more about how you will do that." "What else do you expect from him in terms of school?"
Process refers to the therapist's response to family members' behaviors or affect that facilitate or hinder an enactment. The therapist responded to his or her observations about the interaction between the discussants.
Examples: "It seems like you two are not together on this." "Do you feel hopeless, right now?"

To what extent did the therapist remain out of the conversation, except to intervene briefly as necessary? Once the conversation has started, the therapist only entered briefly when the participants got stuck or got fixated on one aspect of the subject.
Examples: "1" Rating - interruptions were lengthy and frequent and when the conversation was going fine.
"3" Rating - intervened sometimes when necessary and sometimes when participants were still talking.
"5" Rating - intervened briefly only when the participants stopped talking or got fixated on an emotion or one aspect of the subject.

IV. Summarizing Commentary

A. Praised family members for being able to talk about a particular subject. The therapist offered some kind of statement to congratulate family members for their performance or efforts in the enactment.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Examples: "You did a nice job talking with your mother." "So, instead of slamming and kicking doors, you were able to talk to your mom today. I want to congratulate you."

Made a critical comment about what went wrong. The therapist pointed out things that the family did which hindered or didn't make the enactment go the way it should.

Examples: "I know it's difficult, but you weren't being honest with each other." "I think that things will go differently if you tried listening to each other a little better."

Stated or clearly implied what needed to happen in the future for continued progress. The therapist gave some direction or steps that the family needed to take in the future (may specify in the next session or in future treatment sessions).

Examples: "I think (that) is where we need to go next." "You were able to talk to Mom today like a 15 year old. We need to see more of that happening."

B. How effective was the therapist's comments of the enactment? Was the therapist clear and coherent in his or her comments to the family? Were these comments tied, in some way, into the family's progress? Rate this based on what you have scored in "A" of the summarizing commentary. A "1" would indicate that no items were scored in "A", the therapist did no summarizing. A "5" rating would indicate that the summarizing comments were both precise, detailed, and helpful for future progress.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Family Therapy Enactment Rating Scale
Training Manual
Part II: Client Behaviors

I. Communication Difficulty

A. Considering both the interpersonal style and presenting problem of the family, how likely is it that the family will be able to talk, to listen and to respond in a productive manner? Consider the likelihood that they will have a mutually meaningful conversation. In rating this item, please give a rating regardless of the skill level you think the therapist possesses.

Examples: "1" Rating - Given to families who are defensive and blaming (very unlikely that they will talk together).
"3" Rating - Families who are somewhat defensive and blaming.
"5" Rating - Families who are open and understanding and non-blaming (very likely to have a meaningful conversation).

B. With what degree of ease did family members begin to talk and listen to each other? Once the therapist has directed the family to begin talking (e.g., "Go at it.", "Tell him."), how easy was it for them to begin their conversation?

Examples: "1" Rating - Family members did not begin to talk at all, even when the therapist repeated the directions.
"3" Rating - One or both family members began talking, but either turned to the therapist for clarification or the therapist intervened to clarify.
"5" Rating - One or both family members began talking, without additional help from the therapist, and continued to converse.

II. Effectiveness of Enactment

A. A third family member intervened and disrupted the dialogue. While the two participants were conversing, someone else in the family had something to say about the subject. As a result of this interruption, the dialogue stopped or the subject changed. Only score if there are at least three family members present.

A third family member intervened but the dialogue continued. While the two participants were conversing, someone else in the family had something to say. However, the conversation continued either as a result of the therapist blocking the third person or the two participants ignoring the third person. Only score if there are at least three family members present.

One or more persons refused to participate in the dialogue or participated minimally. The conversation did not get off the ground because one person was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

silent or only answered whenever someone really pressed him or her to. Even then, the family member only provided "yes-no" answers.

Talked about the other participant in the third person (usually to the therapist). One of the family members used "he" or "she" to refer to the other participant and said something about her or him. Often, this came across as a complaint to the therapist.
Examples: "He won't say anything. It's the same as at home." "He's been staying out past 1 am."

One or more persons talked about his or her own experiences and feelings. The participants used the pronoun "I" to state how they felt and expressed their own concerns, wants, needs, etc.
Examples: "I need you to be more supportive." "I worry when you are out late, and I don't know where you are." "I was angry. It makes me mad when you treat me like a child."

Talked about a subject not personal to the two people involved in the dialogue. One or both participants talked about another person or a subject that was relevant elsewhere. This subject is not directly relevant to the discussants. Such subjects may have included: what someone else thought, the reason for a person not being in the session, what someone else did over the course of the week.

One or more member asked the other member to share his or her point of view. One or both participants encouraged the other to open up by directly asking or indicating that he or she is interested in hearing the response.
Examples: "I want to know. Tell me." "What do you think of that idea?" "Talk to me."

B. Talked. Rate the extent that family members talked or responded to each other, even if they had to talk through the therapist to do so. Ratings from "1" to "5" would indicate that family members talked minimally to talked a lot, respectively.

Talked directly to each other (rather than through the therapist). The dialogue was between the two participants and they did not try to engage the therapist ("5"). A "3" rating would indicate that they sometimes directed what they say to the therapist. A "1" rating is given in cases where the participants directed all or almost all of what they say to the therapist.

Listened to each other. The participants paid attention to and seemed to hear the "message" that the other one is expressing. The participants acknowledges what the other is saying. A "1" rating would indicate that the participants didn't hear and didn't acknowledge each other's messages at all and a "5" rating would indicate that the participants always got the message, by overtly acknowledging that they "understand" or "see" what the other is saying.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Responded to what each other is saying. The two people answered the other when asked a question/comment or when asked to open up and share their point of view. One person answered the other person's request for an opinion or answer. A "1" rating suggests that the two never responded to each other, while a "5" rating suggests that the two participants were prompt and direct in responding to the other's comments and questions.

C. Conversation was two-sided (where both people had a point of view). A "1" rating would indicate that the conversation was one-sided and one person did all the talking or lecturing. A "5" rating would indicate that the conversation was one in which the participants each had something of substance to say regarding the subject.

Conversation had a content breakthrough-reached a resolution, an agreement, or mutual understanding. Content breakthrough also refers to something new that emerged out of the conversation, something that one or the other participant did not know. A "1" rating would indicate that nothing emerged out of the conversation. A "3" rating would indicate that something seem to have emerged, but was not particularly significant. A "5" rating would indicate that some progress was made because the discussants overtly stated a resolution, an agreement, or overtly expressed mutual understanding.

Conversation has an affective breakthrough-the participants displayed or talked about feelings. Affective breakthrough refers to one or both participants admitting to or displaying some sort of emotion (e.g., mother crying, son displaying anger, dad expressing his disappointment). A "1" rating would indicate that no emotions were displayed and family members were very aloof. A "3" rating would indicate that some emotions were displayed but more by one family member than the other. A "5" rating would indicate that emotions were frequently and openly displayed by both members.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

RATER INSTRUCTIONS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

RATER INSTRUCTIONS

STEP 1: **Session Information**. Fill out the information at the top of the scale from the side panel of the tape (Case Number, Session, Segment, Rater, Date).

STEP 2: **VCR Preparation**. Make sure the tape is rewound to the beginning. Push the COUNTER RESET button. Then FASTFORWARD to the beginning time of the indicated "segment." (Example: If the "segment" is specified as 2:50-8:10, fastforward to 2:50.)

STEP 3: **Segment Introduction**. Read the introduction for the segment, so you have some context for the segment you are about to rate.

STEP 4: **Rating**. Pause and rewind as necessary, but not beyond where you originally started (Example: 2:50).
Remember! Take notes and refer back to the manual (as necessary) to ensure accuracy in your ratings.

STEP 5: **Stopping the Tape**. Stop at the time designated as the END of the segment (Example: 8:10).

STEP 6: **Review Ratings**. Make sure you have scored each of the items.

STEP 7: **Clean-Up**. Please, rewind your tape for the next rater.

PLEASE LEAVE YOUR FOLDER IN THE ROOM!!!

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX E

SEGMENT LISTS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 1

<u>Note:</u> **Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.**

CASE	SESSION	START TIME	END TIME	LENGTH
296	5	43:42	53:00	9m - 18s
265	4	1:15	13:30	12m - 15s
313	20	4:00	25:30	21m - 30s
421	14	13:30	23:30	10m - 0s
469	2	3:10	17:00	13m - 50s
577	5	3:00	9:30	6m - 30s
308	5	1:13	9:00	7m - 47s
360	12	0:30	9:30	9m - 0s
584	16	14:20	25:25	11m - 5s
577	5	22:30	31:00	8m - 30s
424	11	1:45	8:45	7m - 0s
524	3	5:30	18:30	13m - 0s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 2

Note: Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.

CASE	SESSION	START TIME	END TIME	LENGTH
524	3	5:30	18:30	13m - 0s
424	11	1:45	8:45	7m - 0s
577	5	22:30	31:00	8m - 30s
584	16	14:20	25:25	11m - 5s
360	12	0:30	9:30	9m - 0s
308	5	1:13	9:00	7m - 47s
577	5	3:00	9:30	6m - 30s
469	2	3:10	17:00	13m - 50s
421	14	13:30	23:30	10m - 0s
313	20	4:00	25:30	21m - 30s
265	4	1:15	13:30	12m - 15s
296	5	43:42	53:00	9m - 18s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 3

Note: Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.

CASE	SESSION	START TIME	END TIME	LENGTH
584	16	14:20	25:25	11m - 5s
360	12	0:30	9:30	9m - 0s
308	5	1:13	9:00	7m - 47s
577	5	3:00	9:30	6m - 30s
469	2	3:10	17:00	13m - 50s
421	14	13:30	23:30	10m - 0s
313	20	4:00	25:30	21m - 30s
265	4	1:15	13:30	12m - 15s
296	5	43:42	53:00	9m - 18s
524	3	5:30	18:30	13m - 0s
424	11	1:45	8:45	7m - 0s
577	5	22:30	31:00	8m - 30s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 4

Note: Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.

CASE	SESSION	START TIME	END TIME	LENGTH
577	5	3:00	9:30	6m - 30s
469	2	3:10	17:00	13m - 50s
421	14	13:30	23:30	10m - 0s
313	20	4:00	25:30	21m - 30s
265	4	1:15	13:30	12m - 15s
296	5	43:42	53:00	9m - 18s
524	3	5:30	18:30	13m - 0s
424	11	1:45	8:45	7m - 0s
577	5	22:30	31:00	8m - 30s
584	16	14:20	25:25	11m - 5s
360	12	0:30	9:30	9m - 0s
308	5	1:13	9:00	7m - 47s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 5

<u>Note:</u> Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.

CASE	SESSION	START TIME	END TIME	LENGTH
313	20	4:00	25:30	21m - 30s
265	4	1:15	13:30	12m - 15s
296	5	43:42	53:00	9m - 18s
524	3	5:30	18:30	13m - 0s
424	11	1:45	8:45	7m - 0s
577	5	22:30	31:00	8m - 30s
584	16	14:20	25:25	11m - 5s
360	12	0:30	9:30	9m - 0s
308	5	1:13	9:00	7m - 47s
577	5	3:00	9:30	6m - 30s
469	2	3:10	17:00	13m - 50s
421	14	13:30	23:30	10m - 0s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT LIST 6

<u>Note:</u> Please rate the segments in the following order. If it's a shorter segment, you may choose to start rating the next segment on this list. If you run out of time while you're rating a second tape, make note of where you've stopped (timer). In the next rating session, you can resume rating by fast forwarding to that point.

CASE	SESSION	START TIME	END TIME	LENGTH
308	5	1:13	9:00	7m - 47s
360	12	0:30	9:30	9m - 0s
584	16	14:20	25:25	11m - 5s
577	5	22:30	31:00	8m - 30s
424	11	1:45	8:45	7m - 0s
524	3	5:30	18:30	13m - 0s
296	5	43:42	53:00	9m - 18s
265	4	1:15	13:30	12m - 15s
313	20	4:00	25:30	21m - 30s
421	14	13:30	23:30	10m - 0s
469	2	3:10	17:00	13m - 50s
577	5	3:00	9:30	6m - 30s

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX F

SEGMENT INTRODUCTIONS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SEGMENT INTRODUCTIONS

Case	**296**
Session	**5**
Start Time	**43:42**
End Time	**53:00**

This case is of a father who has been absent from his son's life. Prior to the segment, therapist has been talking to each person individually about how they perceived their relationship.

Case	**308**
Session	**5**
Start Time	**1:13**
End Time	**9:00**

This is a mother who has a difficult time controlling her son. The adolescent has not been attending school.

Case	**469**
Session	**2**
Start Time	**3:10**
End Time	**17:00**

This is a session with the father, mother and son working on the father's relationship with his son. Prior to the segment, the therapist checked in with the family about what they thought of the previous session.

Case	**524**
Session	**3**
Start Time	**5:30**
End Time	**18:30**

This session is of a father, mother, and son. Prior to the segment, the therapist talked with the family individually about what they thought of the previous session. The therapist has also talked to the adolescent about his worries.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Case	**313**
Session	**20**
Start Time	**4:00**
End Time	**25:30**

This is a family where the father, mother, and son are present. Prior to the segment, the therapist has been talking with them about the past week.

Case	**360**
Session	**12**
Start Time	**0:30**
End Time	**9:30**

In this session, the mother and father are present. They are looking for a residential treatment program for their adolescent son.

Case	**577**
Session	**5**
Start Time	**3:00**
End Time	**9:30**

The mother and son are present in this session. Prior to the segment, the therapist has been talking with the adolescent about school.

Case	**577**
Session	**5**
Start Time	**22:30**
End Time	**31:00**

The mother and son are present in this session. Prior to the segment, the therapist has been reviewing the previous session with the family.

Case	**421**
Session	**14**
Start Time	**13:30**
End Time	**23:30**

The session begins with the therapist talking individually (and alone) with an alcoholic father. The mother and the couple's two sons enter 13 minutes into the session.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Case	**424**
Session	**11**
Start Time	**1:45**
End Time	**8:45**

The session started with the therapist talking to the parents alone about the adolescent. The adolescent enters about 2 minutes into the session.

Case	**584**
Session	**16**
Start Time	**14:20**
End Time	**25:25**

This is a session with the adolescent and his mother. Prior to the segment, the therapist and family have been talking about how they felt and the things they discussed in the previous session.

Case	**265**
Session	**4**
Start Time	**1:15**
End Time	**13:30**

This is a session with the adolescent and his mother. Prior to the segment, the therapist has done some individual preparation with the mother about her response to the son skipping school.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

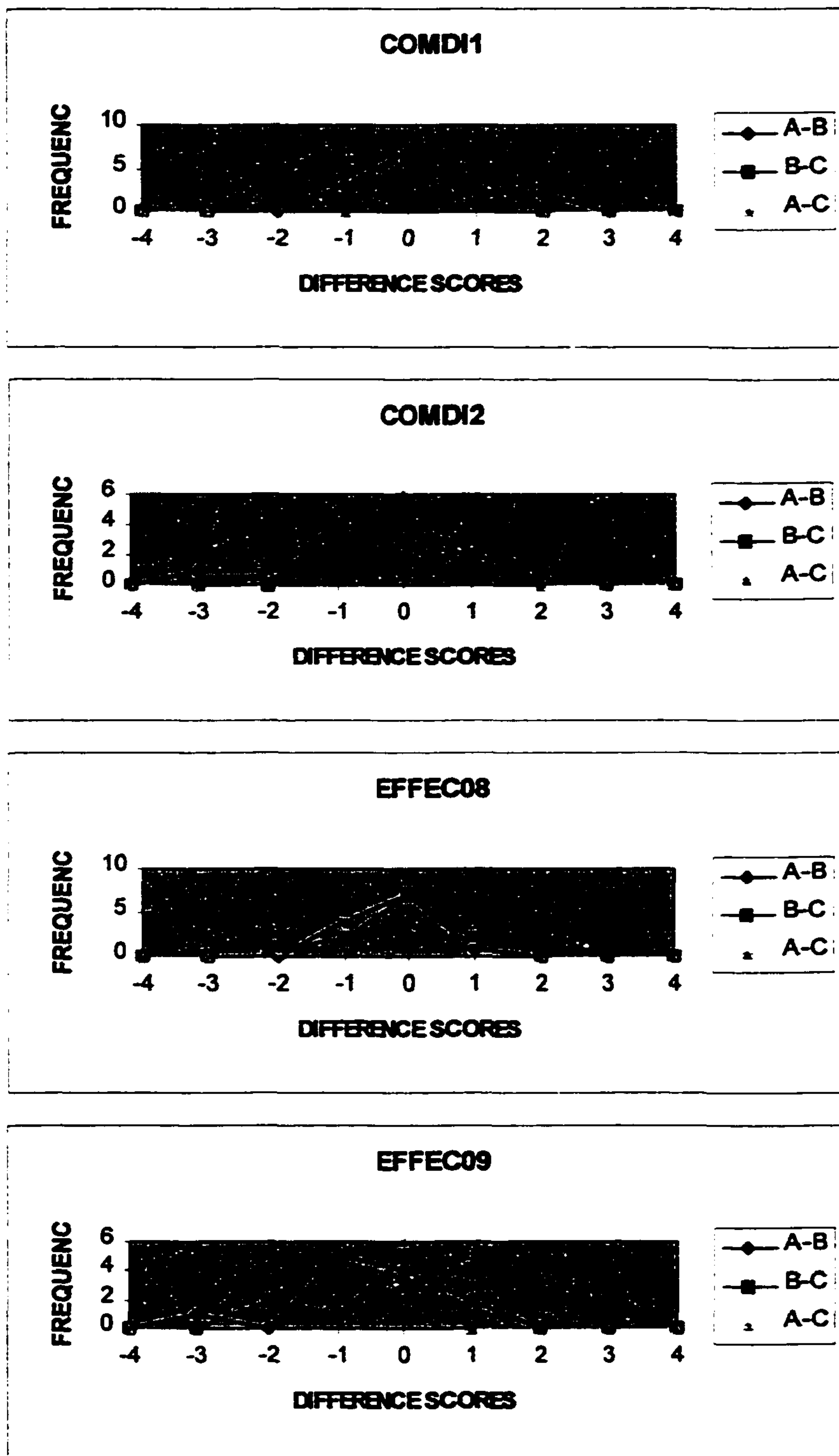
APPENDIX G

DISCREPANCY DISTRIBUTION GRAPHS FOR

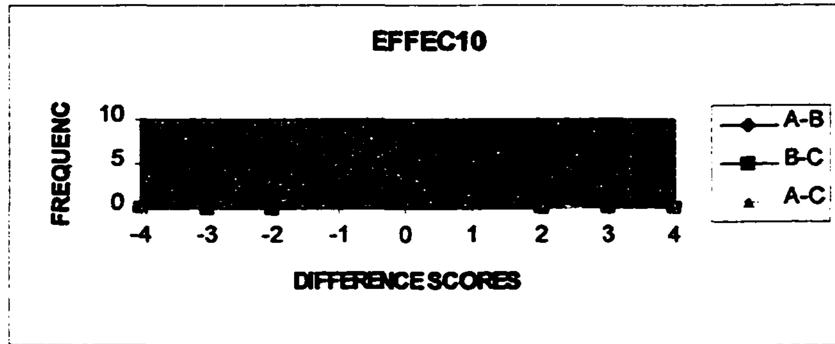
CONTINUOUS CLIENT VARIABLES

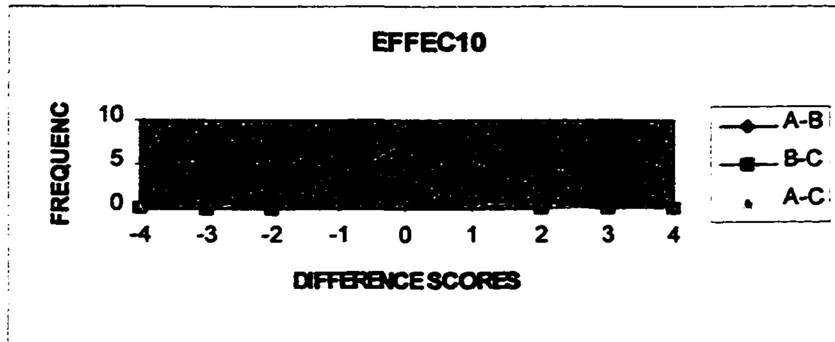
Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

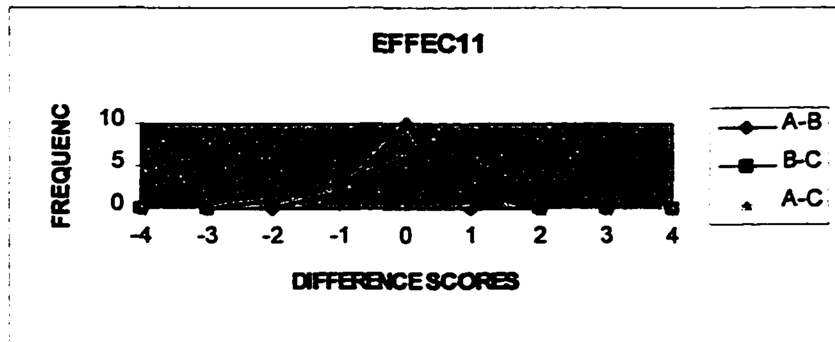
Continuous Variables of Client Behaviors: Discrepancy Distributions among Three Independent Raters.

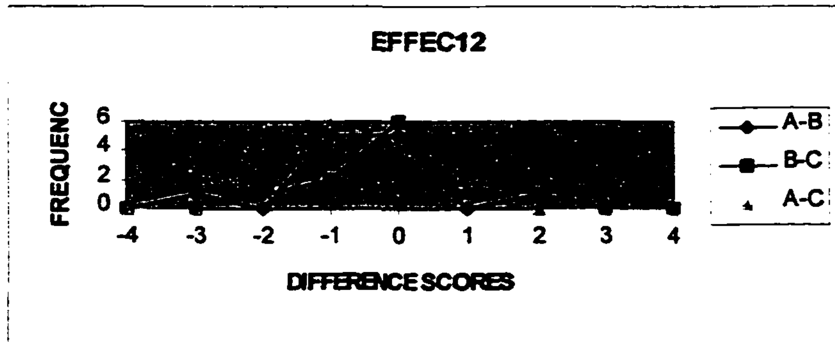


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

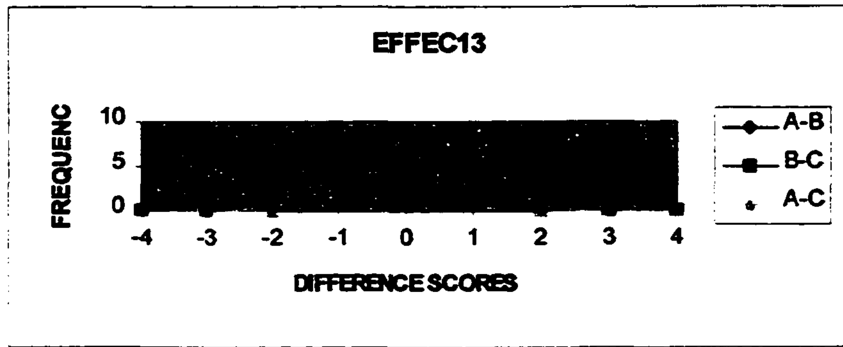


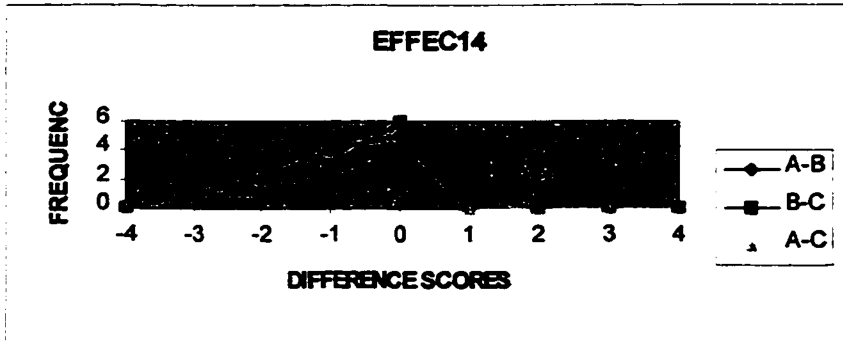






Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.





Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

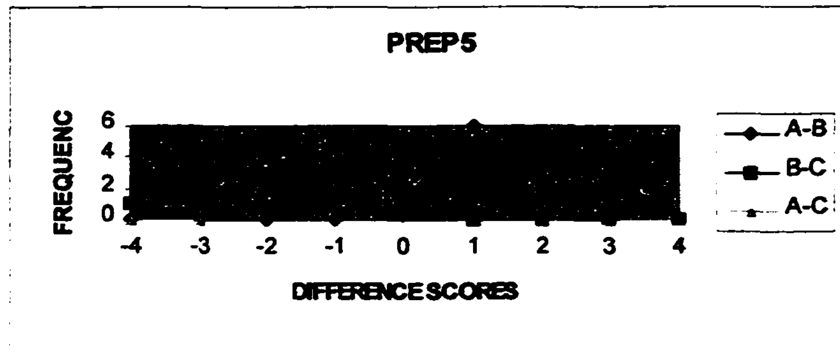
APPENDIX H

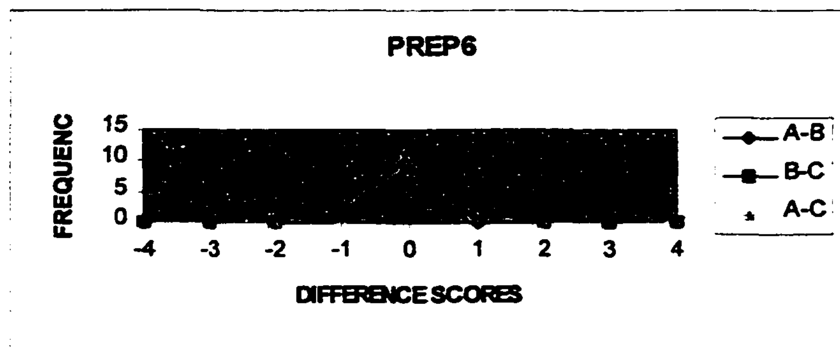
DISCREPANCY DISTRIBUTION GRAPHS FOR

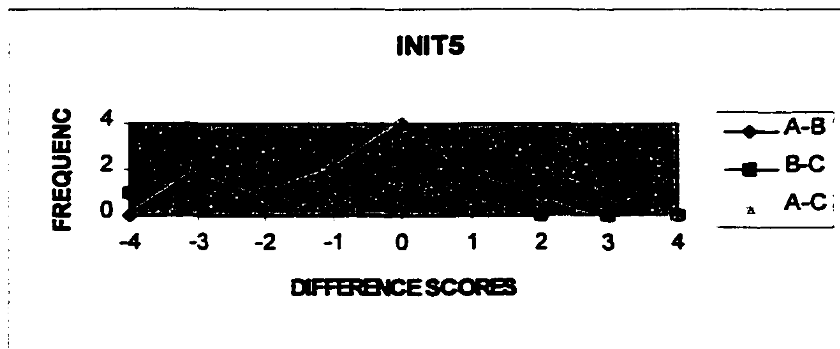
CONTINUOUS THERAPIST VARIABLES

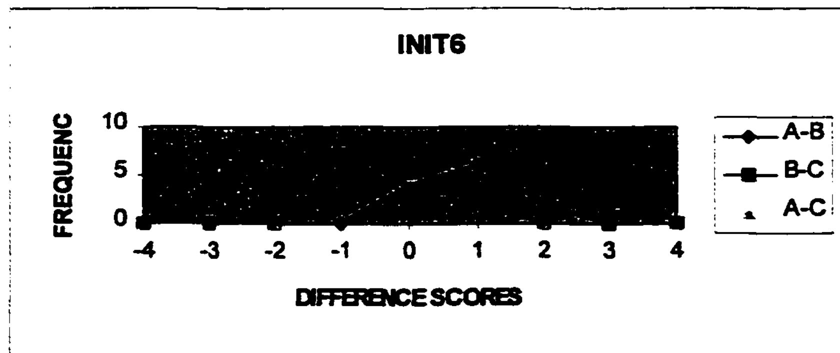
Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Continuous Variables of Therapist Variables: Discrepancy Distributions among Three Independent Raters.

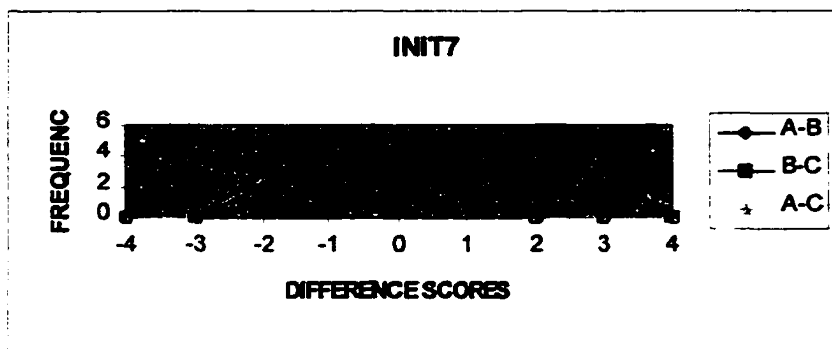


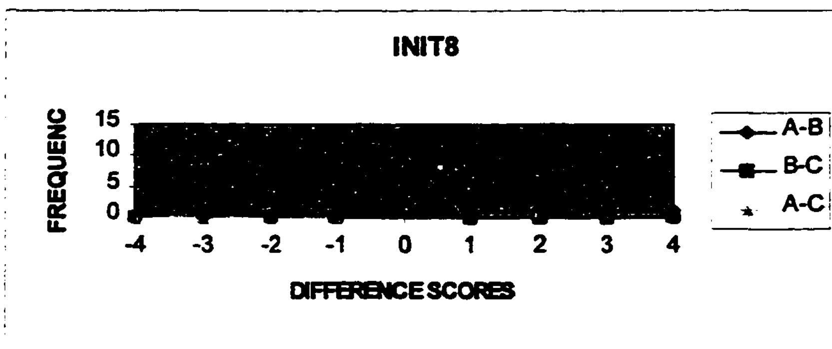


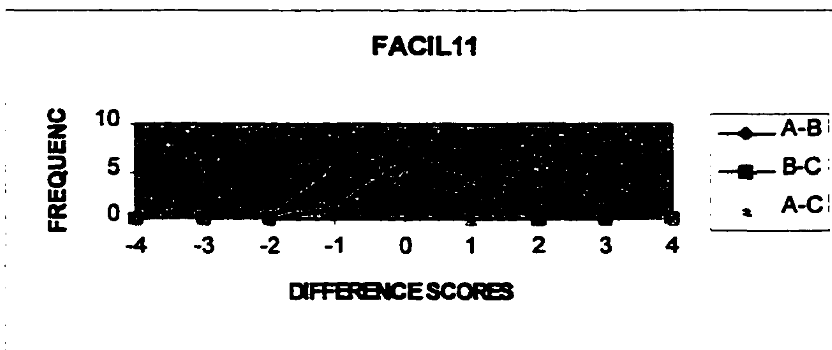


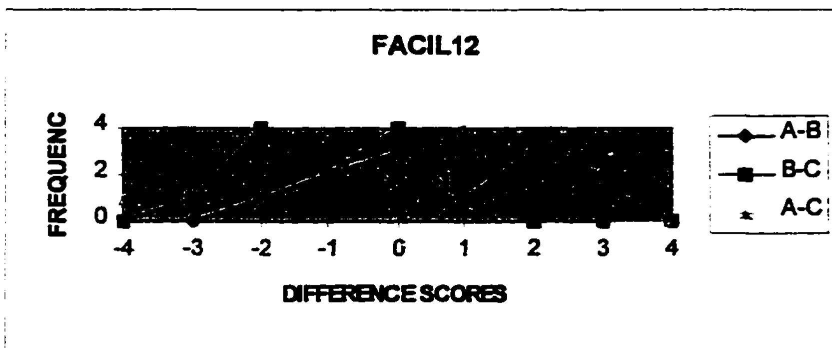


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

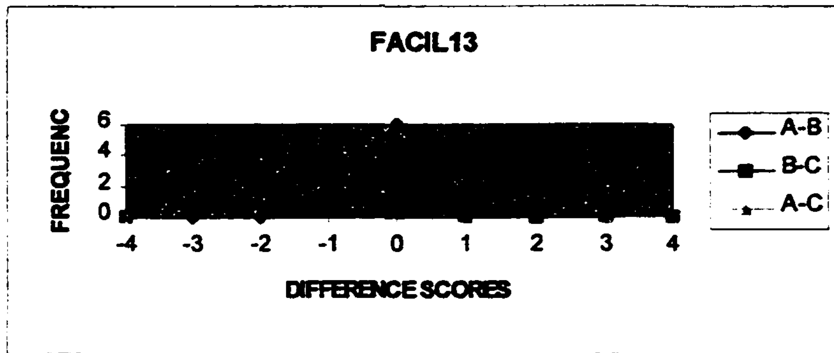


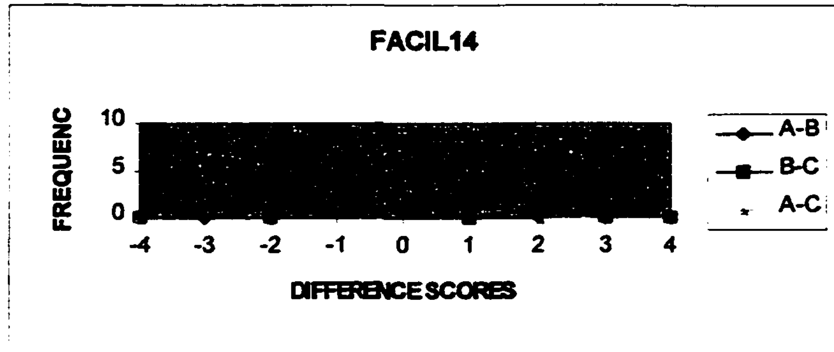


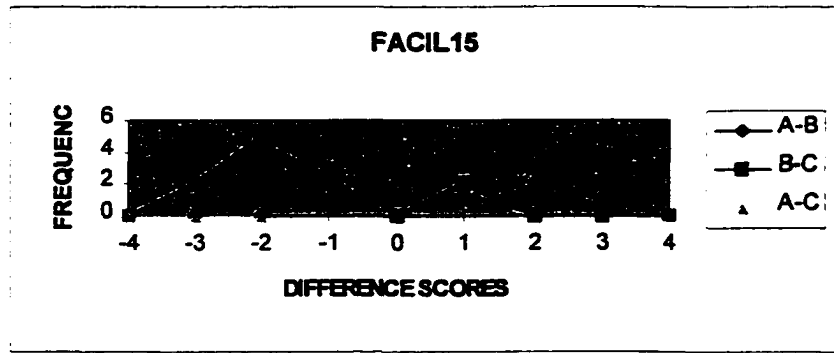


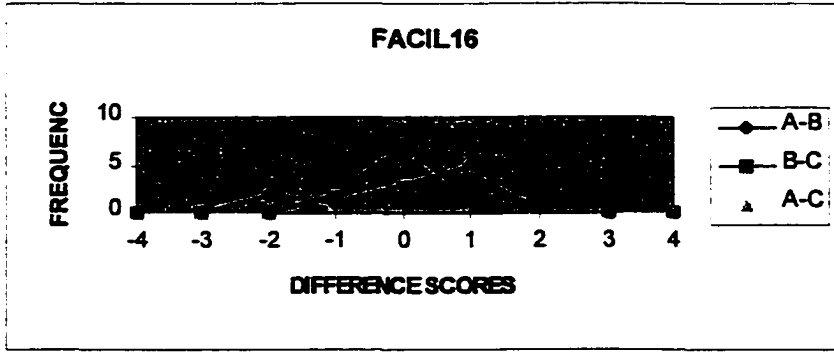


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

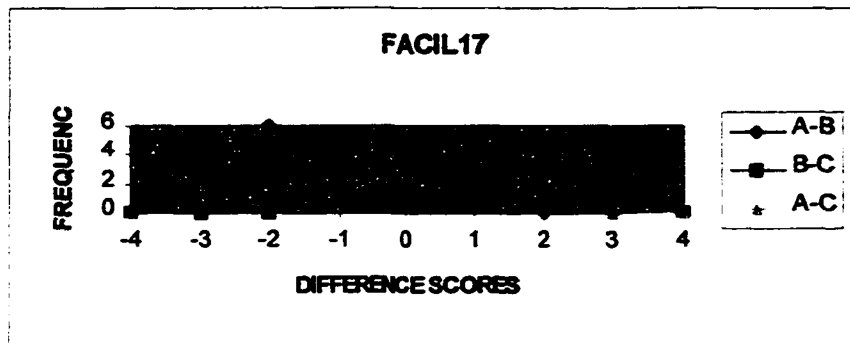


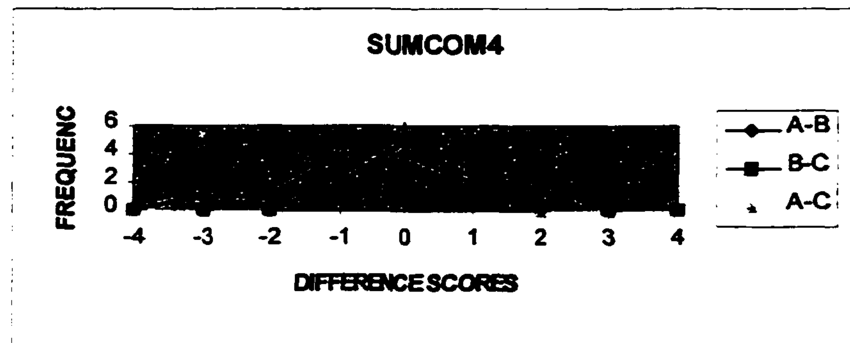






Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.





Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

VITA

Elizabeth Ong-Mythuan Fong
Virginia Consortium Program for Clinical Psychology
ODU/NSU Higher Education Center
3300 South Building/Room 201
397 Little Neck Road
Virginia Beach, Virginia 23452

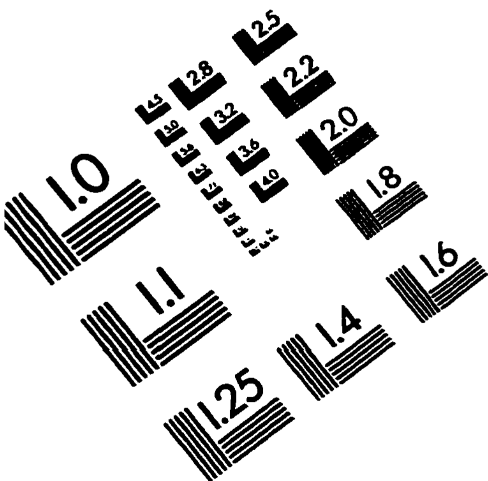
Elizabeth Fong graduated from the University of Virginia (Charlottesville, Virginia) in May of 1993 with a Bachelor of Arts degree. She majored in psychology and was a member of the Psi Chi National Honor Society in psychology. Elizabeth was a research assistant for the Laboratory for Infant Studies and the Department of Psychology at UVA.

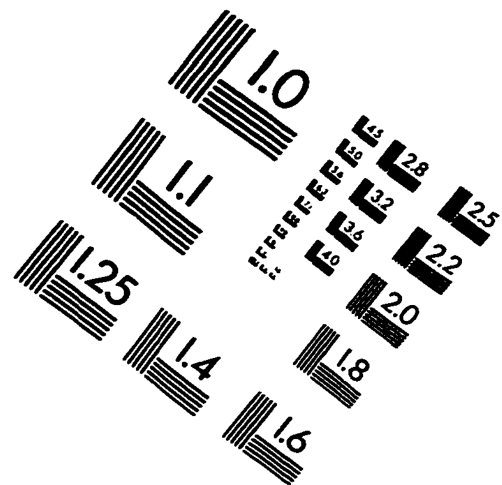
Elizabeth is currently in her fifth year at the Virginia Consortium Program for Clinical Psychology (VCPCP). This program is sponsored by the College of William and Mary, Eastern Virginia Medical School, Norfolk State University and Old Dominion University. The VCPCP has full accreditation from the American Psychological Association. Elizabeth is currently completing her clinical internship at the Alexandria Mental Health Center in Alexandria, Virginia. She is expecting to receive her degree as Doctor of Psychology in Clinical Psychology in December, 1998.

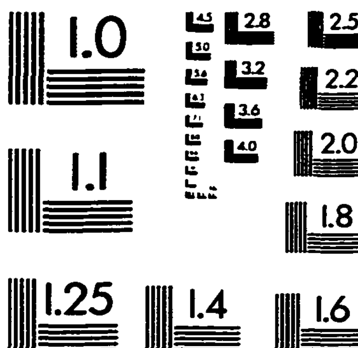
Elizabeth obtained advanced training during her studies at VCPCP in child, adolescent, and family therapy. Her dissertation title is "A Discovery-Oriented Process Study of Enactment in Family Therapy: Development of the Family Therapy Enactment Rating Scale." The director of her dissertation is Michael P. Nichols, Ph.D. During the course of her graduate training, Elizabeth also obtained clinical experience through the Williamsburg-James City County Public Schools, the Eastern Virginia Medical School Department of Psychiatry, the Barry Robinson Residential Treatment Center, the Virginia Beach Public Schools, and the Veteran Affairs Medical Center in Hampton, Virginia. She spent two years as a research assistant in the Department of Psychology at the College of William and Mary. She has also worked as a field interviewer for the Virginia Twins Project through the Department of Psychiatry at the Medical College of Virginia.

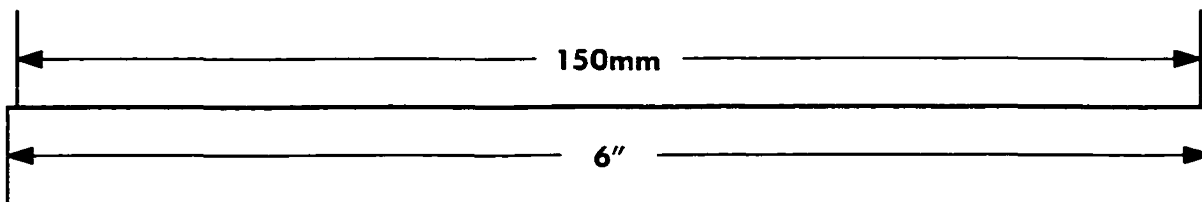
Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

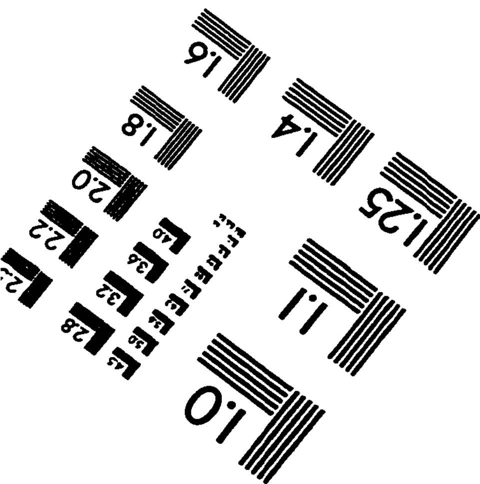
IMAGE EVALUATION TEST TARGET (QA-3)





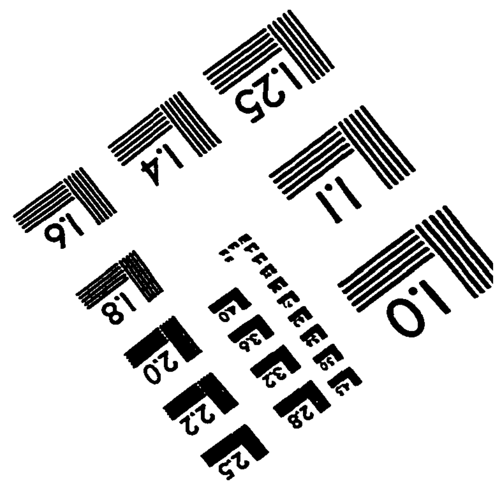






APPLIED IMAGE . Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.