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The Contribution of Enactments to Structural Family Therapy: A Process Study

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THE CONTRIBUTION OF ENACTMENTS TO STRUCTURAL FAMILY THERAPY: A PROCESS STUDY

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ABSTRACT

THE CONTRIBUTION OF ENACTMENTS TO STRUCTURAL FAMILY THERAPY: A PROCESS STUDY

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In an era where the effectiveness of many forms of psychotherapy has been thoroughly examined, the focus of many researchers has shifted from investigating outcome to exploring therapeutic processes. Process studies serve to identify the active ingredients of therapy – that is, those interventions that bring about in-session changes. This process study examines the relationship between the use of *enactments*, a structural family therapy intervention, and in-session change as observed over the course of the session. Change was measured by the amount of change that occurred in the *core problem dynamic*, that is, the most prominent pattern of dysfunctional family interaction. The sample consisted of ten videotaped family therapy sessions, representing ten families and four therapists. Clinician judges rated change on a seven-point Likert-like scale. Trained undergraduate raters rated successfulness of enactments and degree to which enactments and other meaningful moments addressed the core problem dynamic in each session. Pearson Product-Moment correlations were calculated to assess the relationship between change occurring in the core problem dynamic by the end of the session and several variables, including successfulness of enactments, and the extent to which enactments and meaningful moments addressed the problem dynamic. In addition, possible relationships between each of the variables were investigated, as well as relationships between the number of meaningful moments occurring within enactments

and successfulness of enactments and extent to which enactments addressed the core problem dynamic. Results suggest a positive relationship between successfulness of enactments and both change in the core problem dynamic at the end of the session and number of meaningful moments occurring in enactments. Implications and limitations are discussed.

This thesis is dedicated to my parents, Paul and Margret Fellenberg, who always encouraged me to reach for the stars.

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CHAPTER I

Introduction

Models of psychotherapy come to be known by the techniques that define them as different from each other. Bowenian therapy, for example, is associated with *genograms* and questions about family of origin, while structural family therapy is associated with the use of *enactments*. What often goes unnoticed is that, in addition to the defining techniques of various approaches, practitioners also use a number of techniques common to many of them. Therefore, the question arises, to what extent is the effectiveness of any particular approach based on the features unique to that approach? Are these defining techniques the primary active ingredients of those approaches, or are they just some of a host of interventions that contribute to the therapeutic process?

The present study attempted to answer this question for one family therapy orientation, structural family therapy. Structural therapists employ a number of techniques including *joining*, *unbalancing*, *making boundaries*, and *enactments*. While all of these techniques are important, enactments are at the core of structural family therapy, as structural therapists believe that only through interaction will the family change (Minuchin, 1974). Therefore, this investigation focused on the defining technique of structural family therapy, the enactment, in order to establish whether this technique is pivotal in bringing about change within structural family therapy sessions. The present investigation focused on whether enactments that address a family's core problem

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The following review explores the theoretical framework for structural family therapy, as well as the research supporting its effectiveness, and will consider some of the methodological implications associated with process research.

Structural Family Therapy

The Theoretical Framework of Structural Family Therapy

Structural family therapy grew out of necessity when Salvador Minuchin attempted to treat multiproblem, poor families at the Wiltwyck School for delinquent boys. Realizing that approaches used in treating middle-class families might not be suitable for the families whose sons were at Wiltwyck, Minuchin and his colleagues developed a different kind of family therapy. Now one of the most widely used models in the field, structural family therapy gained popularity and influence in the 1970s, due in part to its proven effectiveness, but even more so because of its charismatic principal proponent, Salvador Minuchin (Nichols & Schwartz, 2000).

As the name implies, structural family therapy is concerned with the structure of families, that is, the organized, predictable patterns in which family members interact. According to this view, families consist of various *subsystems*, determined by generation, gender, and function. These subsystems are protected and enhanced by *boundaries*, emotional barriers that regulate contact with others (Minuchin, 1974). Boundaries, which protect subsystems by managing closeness and hierarchical status, may be rigid, flexible, or diffuse. Structural family therapists believe that the structure of a family needs to be stable enough to ensure continuity, but flexible enough to accommodate changing circumstances. Therefore, families encounter problems when their structures do not adjust to changes (Minuchin, 1974). Structural therapists, then, help families move from

being stuck in their old ways of interacting to discovering new, more adaptive modes of interaction. In order to decrease disengagement, for example, the rigid boundaries that exist between family members have to be opened up. Likewise, when family members are enmeshed, firming up porous boundaries will increase their autonomy. To bring about these structural changes, therapists work with interaction, because only when a family is in action can its dynamics be directly observed and altered. The most prominent technique used to stimulate action, and the intensity that comes with it, is the enactment, a technique by which the therapist invites two or more family members to talk with each other about a topic of concern. Enactments are used not only to assess the structure of a family but -- more powerfully -- to modify that structure and help the family move to more productive ways of interacting. (Minuchin & Fishman, 1981)

Structural family therapy is now well established with an impressive body of research corroborating its effectiveness, and has moved into the new millennium as brief structural family therapy (Nichols & Minuchin, 1999) in response to the demands of a new healthcare climate. Let's review the evidence for its effectiveness.

Empirical Support for Structural Family Therapy

In several comprehensive reviews, researchers summarized the results of family therapy outcome studies and concluded that family therapy, regardless of the therapy orientation, was more effective than no treatment (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Pinsof and Wynne, 1995; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Dunn & Schwebel, 1995). Furthermore, investigators have concluded that family therapy is an effective mode of treatment for a variety of psychological problems and disorders, including schizophrenia (e.g., Goldstein & Miklowitz, 1995), alcoholism (e.g.,

Edward & Steinglass, 1995), drug abuse (e.g., Stanton & Shadish, 1997), dementia (e.g., Benbow, Marriott, Morley, & Walsh, 1998), conduct disorders (e.g., Chamberlain & Rosicky, 1995), autism (e.g., Estrada & Pinsof, 1995), aggression and non-compliance associated with ADHD (e.g., Anastopoulos, Barkley, & Shelton, 1996), adolescent obesity (e.g., Harkaway, 1987), anorexia nervosa (e.g., Minuchin, Roseman, & Baker, 1978), and childhood physical illness (e.g., Campbell & Patterson, 1995).

In addition, family therapy has been found to be more cost-effective than individual treatment options -- such as dynamic and client-centered therapies -- and more cost-effective than standard residential or inpatient treatment for certain psychological disorders, such as schizophrenia, severe adolescent conduct disorder, and delinquency (Shadish et al., 1995). This finding is particularly significant considering the current climate of managed care.

Once it was established that family therapy was an effective mode of treatment, investigators wondered whether that held true for each of the different orientations. Substantial evidence for the effectiveness of structural family therapy has accumulated over the past twenty years. While there exists no empirical proof of the superiority of one family therapy approach over the others, the following research certainly supports the effectiveness of structural family therapy in a multitude of settings and for a variety of disorders.

Some of the most convincing evidence for the effectiveness of structural family therapy comes from studies involving children with psychosomatic disorders (Minuchin, Roseman, & Baker, 1978) and psychosomatically complicated cases of diabetes (Minuchin, Baker, Roseman, Liebman, Milman, &Todd, 1975). There is also empirical

support that structural family therapy is instrumental in changing rigidly enmeshed patterns in families of chronic pain patients (Kunzer, 1986).

One study determined that structural family therapy was more effective than individual therapy or a placebo control group in reducing symptoms in families with drug-addicted members, and that the positive effects of therapy were maintained over a 12-month period (Stanton & Todd, 1979). More recently, structural family therapy was found to foster more adaptive parenting roles in heroin addicts (Grief & Dreschler, 1997) and to reduce the likelihood of African-American and Hispanic adolescents to initiate drug use (Santisteban, Coatsworth, Perez-Vidal, Mitrani, Gilles, & Szapocznik, 1997).

Research conducted by one of the experts on attention deficit/hyperactivity disorder (ADHD), Russell Barkley (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992), suggests that structural family therapy is at least as effective as communication training and behavioral management training in reducing negative communication, conflicts, and expressed anger between adolescents diagnosed with ADHD and their parents.

In a recent series of studies on multidimensional therapy, which is similar to the structural approach, Diamond and Liddle (1996, 1999) concluded that this type of therapy is effective in resolving conflicts between parents and their adolescents, when both parties have unresolved feelings and poor problem-solving skills. A shift in therapeutic focus from behavior management to difficulties in the parent-adolescent relationship enabled family members to articulate unexpressed feelings about the quality of their relationships and helped them to move beyond negative conversations that include blame,

accusations, and defensiveness to engage in more constructive discussions about their problems (Diamond & Liddle, 1996, 1999).

Finally, structural family therapy has been found to be effective in treating a variety of other disorders and problems, including conduct disorder (Chamberlain & Rosicky, 1995), delinquency (Alexander & Parsons, 1982), anorexia nervosa (Campbell & Patterson, 1995; Minuchin, Roseman, & Baker, 1978), protracted mourning (Fulmer, 1983), school problems (Carlson, 1987), and freeing chronically ill patients of considerable emotional suffering (Griffith & Griffith, 1987).

In summary, the empirical evidence clearly indicates that structural family therapy is an effective mode of treatment. Therefore, it is important, particularly for clinicians, to discover which specific ingredients -- or techniques -- make structural family therapy so successful in helping families heal. Structural therapists believe that the enactment is one of the most powerful tools they possess. Therefore, researchers have begun to investigate this pivotal technique. But before presenting a summary of their findings, it is important to understand exactly what an enactment is.

The Anatomy of Enactments

Minuchin describes an enactment as the "technique by which the therapist asks the family members to dance in his presence" (Minuchin & Fishman, 1981). The "dance" family members perform is the pas de deux of their daily interactions, their style of solving problems and communicating with each other. Usually, the therapist prepares an enactment by "joining" with each member of the family, asking for his or her point of view and empathizing with it (Minuchin & Fishman, 1981). Then, the therapist uses the information elicited from the family to identify the source of conflict and generate a topic

that specific family members are invited to discuss. The crucial characteristic of an enactment is the direct interaction between members of the family. Ideally, the therapist specifies who is to talk to whom and what they should talk about (Nichols, 1997). Once the dyad starts interacting, the therapist withdraws from the center and moves to the periphery of the therapeutic space (Simon, 1995). The clients are central, while the therapist slips into the role of observer. An enactment ends when the therapist closes it by summarizing his or her observations, giving advice on how to work on the problem at hand, and praising family members for their efforts (Nichols & Fellenberg, 2000).

Enactments are used to give family members a chance to deal directly with each other during a family therapy session and to open doors to explore new and more effective patterns of interaction. The therapist remains on the edge of the therapeutic space, but he or she slips in and out of the role of observer to direct the clients in order to help them find new options for communicating with each other (Simon, 1995). The therapist may do so by challenging the clients to express their point of view, taking sides to help the quiet member of a dyad to speak up, blocking interruptions of other family members, or keeping the dyad focused on the topic at hand. A well-trained therapist asks the dyad to talk about a subject in a way that gives them no choice but to communicate in a new and more constructive way. He or she also stays in control without moving back into the center of the therapeutic space (Simon 1995; Minuchin & Fishman, 1981).

As previously mentioned, enactments have been studied in some detail. The research conducted to investigate this and other in-session processes and techniques is known as *process* research, which can be differentiated from *outcome* research.

Therefore, before reviewing the findings on enactments, a review of family therapy process research will be presented.

Process Research in Family Therapy

In order to answer practical clinical questions about how to do therapy, researchers have turned to process research. In contrast to outcome research, which examines the overall efficacy of treatment, process research focuses on the specific interactions between therapists and clients in order to identify interventions that bring about in-session changes. This kind of research is designed to observe and then operationally describe the concrete events within a therapy session by investigating therapist, patient, setting, and treatment variables and their interactions (Hazelrigg, Cooper, & Borduin et al., 1987).

Researchers have studied in-session verbal statements in order to predict premature termination (Alexander, Barton, Schiavo, & Parsons, 1976; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Shields, Sprenkle, & Constantine, 1991), treatment context (Chamberlain, et al., 1984), and client change over treatment (Chamberlain, et al., 1984; Cline, Meija, Coles, Klein, & Cline, 1984; Laird & Vande Kemp, 1987). In addition, researchers have examined behaviors preceding and 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, Ford, Alden, & Johnson, 1993; Friedlander, Wildman, Heatherington, & Skowron, 1994).

However, in a comprehensive review of family therapy process research

Friedlander, Wildman, Heatherington, and Skowron (1994) concluded that published process studies were still few in number. Considering that family process research is generally labor intensive, access to audio- or videotapes of the work of experienced therapists is limited, and granting agencies are generally more attracted to outcome studies, the paucity of such research is understandable. Nevertheless, the lack of family process research is disappointing given the many benefits of such research.

In their review of family process research, Friedlander and colleagues (1994) discovered that in the 36 articles published on family therapy process at that time, generally three kinds of in-session processes were investigated: speech acts, change episodes, and the client-therapist relationship. Research on speech acts involves measuring the frequencies of clients' verbalizations in contrast to other client or therapist behaviors that occur during a specific segment of a session. Variables investigated have included a therapist's supportive or defensive comments on premature termination of client (Alexander, Barton, Schiavo, & Parsons, 1976), the effects of common and distinctive interventions of highly experienced therapists on client behavior (Friedlander, Ellis, Raymond, Siegel, & Milford, 1987), and changes in speech acts over the course of therapy.

A second group of studies has focused on change episodes, those moments that make a therapy session particularly effective or lead to observed in-session change in client behavior. In general, these studies focus either on characteristics of clients, such as expression of feelings or self-awareness (Greenberg, et. al, 1993), or characteristics of the therapist, such as reflective behavior or countertransference reactions (Garfield, 1990). An example of studies with a focus on the therapist-client relationship investigated the

therapeutic alliance, which was found to be most highly correlated with positive outcome in therapy, when compared to other process variables (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984).

Friedlander and colleagues (1994) concluded their review of process research in family therapy by delineating what we know and what we do not know about these processes. In particular, we know that (1) positive changes over the course of therapy can be described as affective, cognitive, and behavioral; (2) changes are observable in the way family members either relate to each other or to the therapist; (3) a family's level of cooperation and overall willingness to work in therapy are good predictors of effectiveness, continuation, and positive outcome; (4) family therapists tend to take an active and directive role; and (5) to use clever indirect communication, that is, they address another family member to communicate something to the person in question.

However, there are still many things we do not know about the process of change in family therapy, including (1) how specific interventions affect family members in an interpersonal context; that is, there has been little research on productive collaboration between and among family members and specific strategies to facilitate family members' engagement in problem solving; (2) details about individuals' behavior within the sequence of behavior and communication that occurs between client and therapist; (3) identifying sequences or patterns of behavior essential to understanding the interactional processes that make family therapy effective (Friedlander, Wildman, Heatherington, & Skowron, 1994).

In an attempt to shed light on the first of the three uninvestigated areas, Friedlander, Heatherington, Johnson, and Skowron (1994) conducted a qualitative

process study that focused on in-session change that was operationalized in terms of the movement of family members from therapeutic impasse to sustaining engagement. They argued that meaningful changes within family contexts are characterized by resolution of interpersonal impasses between family members. Therefore the investigators focused their qualitative process research on a change event that was divided into three phases according to Greenberg's (1986) task analysis. Friedlander and colleagues identified (1) a "marker" signaling that a particular type of impasse is present and that a shift is necessary, (2) a "task environment" or midsection of the change event that involves a series of activities in which the clinical task is negotiated, and (3) the "resolution" that follows a successful change event. In comparing detailed descriptions of 5 successful and 5 unsuccessful change events, the researchers identified 5 steps clients went through within the task environment of successful change events that were unique to the successful resolution. These steps were the recognition of personal contribution to the impasse, communication about the impasse, acknowledgement of the other's thoughts and feelings, building new constructions about the impasse and recognition of the motivation for engagement.

While the investigators described the steps that clients have to go through in order to resolve a therapeutic impasse successfully, they did not systematically investigate therapist interventions that might help clients complete those steps. The task environment described by Friedlander and colleagues (1994), however, included an enactment, because the two disengaged family members moved toward engagement by beginning to talk to one another about their thoughts and feelings regarding their relationship. Therefore, the enactment can be viewed as a specific change event that

occurs within structural family therapy, and the review of the process research of enactments will show that we now know fairly well how to implement enactments effectively.

Process Research on Enactments

The notion that enactments are the most powerful tool in structural family therapy has not yet been systematically examined. However, some studies show that the use of enactments can facilitate change in various settings. For example, enactments have been used to break the rigid nature of family roles in alcoholic families and to increase the likelihood that adolescents within these families will not re-enact maladaptive family patterns in relationships with friends, coworkers, and their own families (Perkins, 1989). Enactments have also been used to clarify individual family members' goals for establishing more positive relationships within the family (Mittelmeier & Friedman, 1993), and for facilitating the mourning process (Holmes, 1993). Furthermore, the technique has been utilized in group therapy to develop more adaptive ways of relating to one's family of origin (Collison & Miller, 1985).

Some of the most recent research has focused on the specifics of enactments. More concretely, researchers have attempted to uncover the elements of productive enactments. Nichols and Fellenberg (2000) conducted a discovery-oriented process study that focused on therapist and client behavior during enactments within family therapy sessions. They used judges' observations to determine the makeup of productive and unproductive enactments. The researchers concluded that enactments are a complex therapeutic phenomenon that may include as many as 35 possible therapist interventions, and they suggested guidelines for therapists to create productive enactments. Recently, in

a more carefully controlled extension of the Nichols and Fellenberg study, Cowan (2001) found an even larger number of interventions used by experienced therapists in producing enactments. Cowan also determined that an important element in enactments is the "pre-enactment" phase, the few minutes preceding the actual enactment in which the therapist lays the groundwork for a productive dialogue by tapping clients' motivation to address their unresolved conflicts (Cowan, 2001).

Other researchers have used a more quantitative approach to examining enactments. Fong (1999) attempted to produce the Family Therapy Enactment Rating Scale (FTERS) for both therapist interventions and client responses. While the reliability of the judges' ratings was generally low, the findings indicated that certain client and therapist variables were more closely associated with productive enactments and that certain key variables are essential to the general use of enactments (e.g., the therapist emphasizing the importance of family members talking, helping them select an important topic for discussion, gesturing and redirecting the participants to speak directly to one another, and providing the family with suggestions about how to improve their communication). Allen-Eckert (2000), who replicated Fong's (1999) study, developed a revised version the FTERS to produce a more reliable measure. The findings not only corroborated but also expanded on Fong's essential elements of enactments within a family therapy session.

This review of the literature suggests that we know relatively well what makes enactments successful. In order to produce effective enactments, therapists must first select a topic that both clients are equally invested in. Then, therapists must direct the clients by stating the topic of the conversation clearly and by specifying who is to talk to whom. It also is important for the therapist to direct clients on how the conversation

should go (e.g., by telling them to listen to each other). Furthermore, during the facilitation of an enactment, therapists should not interrupt the clients' conversation (even when the conversation pauses for a few moments), and they should also physically stay out of the conversation (e.g., by leaning back). If clients start talking to the therapist, he or she should redirect the clients to talk to each other. Finally, in closing an enactment, therapists should describe the specific nature of the problem dynamic, give suggestions about how the clients should continue to work on their communication or relationship, and praise them for having a good dialogue, if appropriate (Nichols & Fellenberg, 2000).

Besides enactments, structural family therapists also use a number of other techniques, including joining with family members, making boundaries around specific subsystems (e.g., the parents), unbalancing (taking sides with different family members at different points of the treatment), and challenging a family's assumptions (e.g., that the problem lies only with one family member).

Joining is one of the most important techniques utilized in the beginning of family therapy. For therapy to effective, the therapist has to challenge and confront family members about their usual ways of interacting. However, families will dismiss such notions and feel blamed, unless the therapist first shows acceptance and understanding. In talking to each family member -- especially in the beginning of therapy -- listening to each one's point of view and empathizing with it, the therapist conveys that he is caring and understanding, and thus confrontations later on in therapy are likely to be more productive (Nichols & Schwartz, 2000).

Structural family therapists often help reorganize families by strengthening diffuse boundaries or opening up rigid ones. A therapist may work on strengthening the

boundary between parents and children of an enmeshed family by asking the parents to tell their children to "butt out of their adult conversation." On the other hand, when family members are separated by overly rigid boundaries, the therapist may create an opportunity for those family members to reconnect, enforcing the boundary around them by blocking interruptions to open up the boundary between them. (Minuchin & Fishman, 1981).

Another technique that structural family therapists use is unbalancing. Here, the therapist takes sides with different people at different times. Taking sides, however, is not an expression of the therapist's judgment of the family members; it is used to help family members get unstuck from their habitual ways of interacting and to realign the system (Minuchin & Nichols, 1998).

At other times, family therapists may challenge the way families perceive reality. For example, families often come into treatment seeking help for the identified patient, most often a child. The therapist might challenge the family's assumption that the child is a troublemaker by commenting that he is behaving very well in the therapy room or by illustrating the circularity of the problem (Nichols & Minuchin, 1999).

All of these techniques could have an important impact on the outcome of a family therapy session. Some of them are actually used during enactments (e.g., boundary making). However, are enactments the most powerful technique and are therefore associated with more in-session change than other meaningful moments in the session? This question is the focus of the present study. More specifically, the present study was designed to take the investigation begun by Friedlander and her colleagues (1994) a step further and relate the successful completion of a change event (in this case,

an enactment) to the overall change that occurred in a session. A detailed description of the goals of the proposed study follows.

Purpose of this Study

As we have seen, structural family therapy is not only a popular mode of treatment, it has also been found to be effective in treating a multitude of disorders and problems across a variety of settings. However, we are relatively unclear about the reasons for its effectiveness. What specific ingredients or techniques used within the structural framework make this type of therapy successful? Therefore, investigating how specific techniques relate to the overall change achieved in each session may help to determine the potent ingredients of structural family therapy.

The most distinctive technique used by structural therapists is the enactment (Simon, 1995; Diamond & Liddle, 1996). Unfortunately, therapists often do not like to use enactments, partly because they may not know exactly how to implement them successfully and partly because during an enactment therapists must give up control to provide the opportunity for families to find their own new and more adaptive ways of interacting. Also enactments may lead to emotionally charged exchanges, which may be uncomfortable for clients and therapists alike. Some of the recent research has focused on determining how to implement enactments successfully (Fong, 1999; Allen-Eckert, 2000; Nichols & Fellenberg, 2000). Nichols and Fellenberg (2000) also determined that enactments are complex and difficult to implement successfully. So, while therapists may now know more about the effective use of enactments, they may still hesitate to employ such a complex technique. The literature to date does not link productive enactments to positive in-session change. Clinicians might be more willing to utilize

enactments if they knew that this intervention led to more change than other significant moments within family therapy sessions.

The present study was designed to answer some of these questions. More specifically, this investigation examined whether successful enactments that addressed the appropriate problem dynamic were associated with more change in the family's core problem dynamic than other meaningful moments in the session. The author hypothesized that (1) more change would occur in the family's core problem dynamic if the session's most meaningful moments directly addressed the problem dynamic, (2) even more change would occur if the enactments within the session were rated as successful, and (3) most change would occur when successfully rated enactments addressed the problem dynamic.

CHAPTER II

Method

The purpose of this study was to investigate the impact of successful enactments on in-session change. In the first phase, the clinical sample was selected. Phase two consisted of recruitment and training of undergraduate raters. In phase three, data was collected by raters. Finally, phase four consisted of the summary and analysis of data.

Phase One: Selecting The Clinical Sample

Data Pool

The clinical sample was selected from a pool of videotaped family therapy sessions obtained from the Minuchin Center for the Family in New York. The therapists conducting these sessions were experienced structural family therapists who received post-doctoral education in family therapy and had been practicing family therapy for at least fifteen years. The investigator believed that including only tapes of experts in structural family therapy would increase the likelihood that therapists used thorough knowledge of conducting this type of therapy and implementing enactments.

All of the clients consented to be videotaped during treatment with the understanding that the tapes would be used only for teaching and research and that the tapes would be handled with care and confidentiality.

The final sample included eight Caucasian families, one Hispanic family, and one African-American family. The sample consisted of two single-parent families, two blended families, two intact families, and four couples, all of varying socioeconomic status. These families were seen by a total of four different therapists: two Caucasian males, one Hispanic male, and one Hispanic female. Presenting problems included

parenting problems, adjusting to life as a blended family, addiction, schizophrenia, and marital problems.

Selection of Appropriate Sessions

Two doctoral students in the Virginia Consortium Program in Clinical Psychology with training in structural family therapy and one expert structural family therapist spent approximately forty hours prescreening tapes to decide whether the sessions were suitable for the present study. To be included in the study, the videotaped sessions had to be (a) complete and (b) include at least one enactment. We defined enactments as consisting of a clear initiation phase, a facilitation phase, and a closing. We ruled out sessions that included only spontaneous enactments,[1] because the purpose of these is not always clear and therefore they cannot be identified as a deliberate therapeutic intervention.

Justification of Small Sample Size

This type of research is very labor-intensive as judges have to study entire family therapy sessions before making their ratings. Approximately forty hours were spent selecting appropriate tapes for this study. Three clinicians spent another thirty hours completing clinical ratings. Undergraduate raters spent a total of thirty hours each on rating the tapes, in addition to spending a considerable amount of time in training sessions. The entire data collection process took approximately twelve months to analyze a sample of ten tapes. Researchers have pointed out that, because of the labor intensity required, a small sample size is justified in psychotherapy process studies (Greenberg &

[1] Spontaneous enactments are those not initiated by the therapist. Rather, two family members engage in a conversation without being asked to do so. Therefore, no therapeutic intent can be inferred.

Pinsof, 1986; Elliot, 1984). Furthermore, the difficulty of finding complete sessions that are considered to include the same type of elements has been discussed (Elliot, 1984). Therefore a sample size of ten videotaped sessions, while small, appeared adequate to study the clinical phenomenon under investigation.

Phase Two: Recruitment and Training of Undergraduate Raters

Recruitment

Raters were recruited from College of William and Mary undergraduate psychology classes. Interested individuals were invited to participate in ninety-minute orientation sessions at which the investigators explained the level of involvement required of the raters and showed a sample videotape (that was not used in the study) to familiarize potential judges with the material to be rated. These orientation sessions also served to screen volunteers for availability and to assess their general perceptiveness. Volunteers were instructed to keep all information about the tapes confidential and not to discuss them with anyone outside the study team.

Ultimately, three undergraduate students were selected as raters. Three alternates were also trained to safeguard against possible attrition. As it turned out, none of the original three judges dropped out, and therefore no replacements were necessary. All judges, including alternates, were female, which might not be surprising given the predominance of women undergraduate psychology majors.

Justification for Use of Undergraduate Raters

The reasons for using undergraduate psychology students with no clinical experience were both practical and conceptual. First, the easiest and least expensive way to acquire help was to ask students who were interested in being part of the study. Trying

to call on experts would have proved difficult if not impossible. Beyond such practical consideration, naïve raters actually had some advantages over experienced clinicians. First, the investigator could control for what these raters knew about structural family therapy. Second, naïve raters had few preconceived ideas about therapy and, the investigator hoped, were more open to observe videotaped therapy sessions with minimal preconception or bias.

Training of Undergraduate Raters

During the first four months of their participation in the present study, raters received twelve weekly training sessions of ninety minutes each. During the data collection phase, which lasted an additional four months, raters attended weekly booster sessions of 30-60 minutes in length to maintain the quality of ratings. Training sessions were conducted by the investigator and the expert in family therapy.

During the initial two training sessions, volunteers learned about the principles of family therapy, including systems theory, techniques, and the nature and purpose of enactments. These sessions resembled seminars, in which raters asked questions and were shown videotapes to illustrate family therapy theory and techniques. For example, after showing a segment of a videotaped family therapy session, the investigator asked raters about their view of the structural problem, and raters took turns discussing their observations.

The following seven sessions were used to explain to raters what they were to rate. During the first three of these sessions, enactments were the focus. The investigator talked about the difference between successful and unsuccessful enactments and illustrated them by showing videotapes of each. In addition, raters were given precise

descriptions of the seven points on the Likert-like scale to make the differences in ratings as clear as possible (see Appendix B). After discussing these rating scales, raters were shown practice tapes and asked to rate the successfulness of those sample enactments. Each rater wrote down her rating independently, and then disclosed her rating in the discussion that followed. In talking about the sample ratings, every rater first revealed her rating and then explained why she gave that particular rating. Subsequently, ratings were examined by comparing the sample enactment with the detailed descriptions of the scale points, after which the group -- led by the investigator and the expert family therapist -- determined the most accurate rating. During these discussions it became clear that subjectivity is sometimes hard to escape, even when trying to define ratings in as objective terms as possible. (See Appendix B for further details.)

Next, two training sessions centered around discussions of the extent to which enactments addressed a family's core problem dynamic. Again, the investigator showed videotaped family therapy sessions in order to illustrate the discussion. The investigator and the expert in family therapy pointed out how a therapist could focus on a core problem dynamic to varying degrees. Subsequently, raters were shown sample sessions and asked to independently rate the degree to which enactments addressed the problem dynamic. In order to complete their ratings, raters were given the predetermined core problem dynamic for each session segment. These dynamics were determined by clinician judges, as will be described below. Examples of a family's core problem dynamic include an enmeshed mother and disengaged father, and the demand-withdrawal pattern couples often display. Individual ratings were then discussed with the group, and

discrepancies were evaluated using the detailed descriptions of scale points. (See Appendix C for further details.)

After undergraduate raters mastered the task of rating enactments, the investigator introduced the notion of "meaningful moments." As raters were asked to rate the extent to which a meaningful moment addressed the problem dynamic, many of the things learned about enactments and core problem dynamic applied. Raters viewed several examples of meaningful moments, such as a therapist commenting on a couple's interactional pattern by stating, "She tries to pull you closer, and it pushes you away," or a daughter telling her mother that she has a lot of wisdom. Raters did not have much difficulty grasping the rationale behind rating such moments. Again, raters were provided with detailed descriptions of the scale ratings and then asked to rate sample meaningful moments. Thereafter, independent ratings were shared with the group and disagreements were discussed.

In the final three training sessions, the students practiced rating all three variables. During these sessions, more ratings were made, and discussions were shorter. Training was complete, when for each variable rated at least two out of three raters agreed exactly.

In the beginning of the following spring semester, two more refresher sessions were conducted before raters started rating the sample tapes of this study. These refresher sessions resembled the preceding sessions, in which ratings were practiced and only briefly discussed.

Booster sessions were conducted once a week during the data collection phase. These sessions were designed as a forum for technical and conceptual questions that surfaced while rating the sessions. They were also used to swap videotapes, collect

completed ratings, and monitor every rater's progress. When discussing conceptual problems, raters were asked to put their questions into general terms in order to avoid revealing specific details about their ratings or even which case they were working on. Most of the booster sessions were brief, and raters rarely had any conceptual problems to discuss. Often, the time was used to remind raters of the differences between rating scale points, and to discuss technical problems, such as different counter speeds of VCRs.

Phase Three: Data Collection

The collection of data was divided into several tasks. First, rating scales had to be designed for each of the variables to be judged. Next, the core problem dynamic had to be operationally defined. In addition, clinician judges rated change in the core problem dynamic at the end of each session included in the sample. Undergraduate raters recruited for a previous study in this series then identified the most meaningful moments within the session sample. Finally, undergraduate raters recruited for the present study rated success of enactments, and extent to which enactments and meaningful moments addressed the core problem dynamic.

In the following section, I will first describe the operational definition of a core problem dynamic and the process by which this dynamic was established for each session. Then I will discuss the different rating scales employed. Following that, I will explain data collection procedures for both clinician judges and undergraduate raters.

Defining the Core Problem Dynamic

As this study was part of a large-scale research project, some of the data was collected previously. During this earlier phase of the project, two doctoral students and one expert in family therapy independently described the family's core problem dynamic

in each session. These descriptions were tested for reliability using percentage of agreement, and only those sessions for which at least two out of three clinicians agreed on the description of the core problem dynamic were used. The core problem dynamic referred to the primary structural problem of a client family at the time of the session. Different families vary in their structural organization, and examples of organizational problems would be an enmeshed mother and disengaged father, both parents either enmeshed or disengaged with their children, families with an inadequate hierarchical structure, or couples who exhibit either a demand-withdraw pattern or some other form rigid complementarity. These organizational patterns may not be problematic in themselves, but when circumstances change, previously functional structures may become maladaptive (Nichols & Schwarz, 2000). Thus, the term core problem dynamic refers to the most prominent maladaptive structure of a family in treatment.

An example of a core problem dynamic would be a family with a mother enmeshed with her children and a disengaged father who comes to therapy because of their son's poor behavior. The family structure, that was adaptive for the family when their son was younger, has become problematic as the son grew older. Therefore, the core problem dynamic would be the pattern of the overinvolved mother and underinvolved father. This family's core problem dynamic might be modified by helping the father become more involved with his son, and helping the parents spent more time together as a couple.

Measuring Instruments

Four rating scales were designed to help raters quantify their observations. All scales were Likert-like, five- or seven-point scales, which were accompanied by

behavioral descriptions for each given point on a scale. These behavioral descriptions were an important training tool for judges and raters, and were distributed to both.

Clinician judges: Rating change in the core problem dynamic. In order to rate change in the core problem dynamic at the end of each session, a seven-point Likert-like scale was utilized, with one meaning "significantly destructive," four meaning "neutral," and seven meaning "significantly positive change" (See Appendix A). While differences between, for example, a rating of four (where there was no change in the core problem dynamic) and a rating of seven (where significant change was observed) might be easy to understand, distinguishing a six from a seven might be rather difficult. In order to make this task easier, each of the seven scale points was defined as clearly as possible using behavioral descriptions. For instance, according to these definitions, the observed change in a core problem dynamic earned a rating of six, when clients understood and accepted the therapist's formulation of the problem, seemed agreeable to altering their behavior, and accepted responsibility for the problem. However, the most positive change occurred (recognized with a rating of seven) when, in addition, clients began to make positive behavioral changes in the session (see Appendix A). For example, a rating of six would have been assigned when a couple, in which the husband pursued and the wife withdrew, understood the circularity of the problem, the husband agreed to not pursue his wife as much, and the wife agreed to be more available to her husband. In this scenario, husband and wife would not blame each other and would each assume some responsibility for the problem. In order for this couple's change to be rated a seven, the couple would also have to display the beginnings of behavioral adjustments in the session itself. For example, instead of pressuring his wife to spend more time with him, the husband might

have started a discussion about giving his wife two evenings a week to pursue her hobbies. Or the wife might have physically moved closer to her husband and held his hand while making the suggestion to start going on a date every Thursday evening.

While ratings of change in a family's core problem dynamic at the end of a therapy session would seem to indicate progress, it should be emphasized that no measures of actual therapy outcome were taken for this study.

Undergraduate raters: Rating the success of enactments. The successfulness of enactments was rated on a seven-point Likert-like scale, with a rating of one meaning "very counterproductive," four meaning "neutral," and seven meaning " very effective." Each of the scale points was defined using detailed descriptions. Research on enactments by Nichols and Fellenberg (2000) and Fong (1999) guided these descriptions. Again, making a distinction between a one and a four or a four and a seven might be rather straightforward, but it might take more training and practice to distinguish a five from a six or a six from a seven. More specifically, according to the scale's descriptions, a rating of five means that an enactment is "slightly effective" and should have been given when an enactment seemed slightly useful or productive, where the involved parties expressed some of their feelings or points of view without attacking even though there might have been disagreement, and they talked about issues, and said things that they usually hold back. In short, a slightly effective enactment was one in which family members broke the cycle of blaming and criticism, but where no significant breakthrough was achieved. In contrast, an enactment should have been assigned a rating of six (moderately effective), when family members not only talked about problems in a more constructive manner, but when there was also a clear, though perhaps not dramatic or

lasting shift in the way the family members interacted. For example, a reticent family member spoke up, a domineering one didn't do all the talking, family members listened to each other, or important feelings were shared. In a moderately effective enactment, participants seemed to understand what the therapist was driving at. Finally, an enactment should have been rated a seven, "very successful," when there was a visible shift of some kind, indicating that it might have a lasting effect; the involved parties not only acknowledged their own role in the problem, but also clearly showed their willingness to change.

Undergraduate raters: Rating the extent to which the core problem dynamic was addressed. Rating scales three and four were both five-point, Likert-like scales measuring the extent to which enactments and meaningful moments addressed the core problem dynamic. Definitions of the five rating points were the same for both scales, with one being "very destructive," three meaning "not on target," and five meaning "very much on target" (see appendix C). As with the other scales, descriptive definitions helped raters distinguish between the different points on these scales. For instance, while an enactment or meaningful moment that addressed one or more aspects of the core problem dynamic was rated as "somewhat on target" with a four, one that took into account all aspects of the problem dynamic was rated as "very much on target" with a rating of seven. For example, if an enactment of a family in which a couple were having problems because the husband did not participate much in family life and the wife was overly involved with her daughter, addressed the parents' relationship by inviting them to talk to each other and discouraged the daughter from interrupting, then it should be rated a four, as two aspects of the problem dynamic were addressed. If, in addition, an

opportunity would have been created for the father and daughter to move closer without letting the mother interrupt, all aspects of the problem dynamic would have been addressed and the enactment would deserve a rating of seven.

Data Collection Process

Clinician judges. After determining the core problem dynamic for each session, the clinician judges rated on a seven-point scale the overall change that occurred with regard to the problem dynamic in each of the sessions. As discussed previously, a seven-point scale was used for this rating, with one designated as "significant negative change" – a very destructive session which might threaten either the continuation of treatment or family relationships, or both. Four was defined as "neutral," meaning that things seemed to get no better or worse during the session. Seven was defined as "significant positive change," meaning that the clients understood the therapist's formulation of the problem, and actually began to make positive behavioral changes in the session in an attempt to interact more effectively. Appendix A will provide the reader with a more detailed description of each point on the rating scale.

First set of undergraduate raters. During the early part of the project, three undergraduate raters (selected and trained similarly to raters in this study) identified and then rank-ordered meaningful moments that occurred in each session. A meaningful moment was defined as a moment that significantly influenced or affected individuals in the therapy session. An example of a meaningful moment would be a mother's realization that she often sided with her son when he argued with his father. For the purposes of the previous study (Favero, 2002), those moments were described as therapeutically powerful. One could argue that significant negative statements or

interactions within a session could be viewed as meaningful moments; however, the investigator of this study was interested in positive meaningful moments only, that is those moments that were likely to contribute to a favorable shift in the core problem dynamic. The length of meaningful moments was variable as they lasted from just seconds to a few minutes. Meaningful moments could be initiated either by the therapist or by family members. Once the raters had noted several meaningful moments, they were asked to rank-order the three most powerful ones in the session. In order to make this task easier, the raters were asked to rate each of the meaningful moments on a 10-point scale, with one being "not at all powerful" and ten being "very powerful." Therefore, information about the problem dynamic, the amount of change in the problem dynamic in each session, and the most meaningful moments was obtained from this previous part of the project (Favero, 2002).

Second set of undergraduate raters. The raters recruited and trained for the present study rated (a) the successfulness of enactments, (b) the extent to which enactments addressed the problem dynamic, and (c) the extent to which the meaningful moments, which were identified in the first part of the research project, addressed the problem dynamic.

Raters were trained to rate success of enactments on a seven-point scale. In general, successful enactments (5-7) involved some kind of shift or breakthrough, unsuccessful enactments (1-3) involved a counterproductive hardening of positions, while a rating of four was indicated if the enactment did not lead to any change. Please refer to Appendix B for a more detailed description of the scale points.

In addition, judges rated the extent to which enactments addressed the family's

core problem dynamic. This rating was somewhat more dichotomous than the ratings previously discussed and therefore it seemed more reasonable to employ a five-point scale, with 5 meaning "very much on target," one meaning "very destructive," and a rating of three meaning that the enactment did not address the dynamic but also did not seem destructive. Again, Appendix C will provide more detailed descriptions.

Finally, raters were also asked to rate the extent to which meaningful moments addressed the family's core problem dynamic. The rating scale was the same five-point-scale as for the enactments.

In summary, clinician judges defined the core problem dynamic for each session, and rated the change in that dynamic for each session. One set of undergraduate raters identified and rank-ordered meaningful moments occurring in the sessions. Finally, a second set of undergraduate raters rated: (1) the successfulness of enactments, (2) the extent to which enactments addressed the family's core problem dynamic, and (3) the extent to which meaningful moments addressed the family's core problem dynamic.

For each tape, raters were provided with a description of the core problem dynamic, the times at which meaningful moments and enactments occurred, opening and closing phrases marking each meaningful moment and enactment, rating sheets (Appendix D), and instructions on how to proceed (Appendix E). Raters made their ratings independently and were instructed to rate one to two tapes per week. They were also asked to watch each session twice before making their ratings.

Phase Four: Data Summary and Analysis

Pearson Product-Moment correlations were used to assess three different relationships: (1) the relationship between the extent to which meaningful moments

addressed the problem dynamic and the overall change in the problem dynamic at the end of the session; (2) the relationship between the effectiveness of the enactment and the overall change in the problem dynamic at the end of the session; and (3) the relationship between the extent to which effective enactments address the problem dynamic and the overall change in the problem dynamic at the end of the session. While correlations are rarely used in clinical research, they may be beneficial in family therapy process studies because they do not imply causality and therefore do not violate systemic assumptions (Pinsof, 1989).

Cohen's Kappa is the statistic most often used to calculate interrater agreement. For this study an adaptation of the original calculations was used to enable a calculation of kappa for more than two raters (Fleiss, 1971).

CHAPTER III

Results

This section will present results for: a) interrater agreement of clinician judges in determining the core problem dynamic; b) interrater agreement of clinician judges in rating change in the core problem dynamic at the end of each session; c) interrater agreements among undergraduate raters in rating successfulness of enactments, extent to which enactments addressed the problem dynamic, and extent to which meaningful moments addressed the problem dynamic; d) all possible correlations between change in the core problem dynamic and each of three rating scales as well as between rating scales; and e) correlations describing the relationship between enactments and meaningful moments. An alpha level of .05 was selected for all statistical tests.

Scale Ratings

Defining the Core Problem Dynamic for Each Session

During the first study (Favero, 2002) in this series, two doctoral students, and an expert in family therapy each described the core problem dynamic of every session. Descriptions were made independently and then compared. Although the wording of descriptions varied slightly, it was easy to recognize when judges described the same problem dynamic. For example, one judge might say that the core problem dynamic was a "pursuer-distancer" relationship, while another might report that "the wife nags and the husband withdraws." The judges achieved 100% agreement for each of the ten sessions. Such an impressive result might be due to the fact that the presenting problems of the selected sessions were relatively clear and that the clinician judges shared a background in structural family therapy (Favero, 2002).

Change in the Core Problem Dynamic

After determining the core problem dynamic for each of the 10 sessions in the sample, the clinician judges (two doctoral students and one family therapist) rated its change at the end of each session on a seven-point, Likert-like scale. In order to determine the rating for each of the ten sessions, at least two out of three judges had to agree on the rating, which then was chosen as the rating of change in the problem dynamic. For example, if one judge rated change in the problem dynamic of a particular session as a five (slightly positive), but the two other judges rated it six (moderately positive), the rating for the change in that session was determined to be six, that is, moderately positive. Interrater reliability of the amount of change in each session was impressive with a significant kappa ($r_{.}$= .85, $p<.01$).

The mean of the ratings of change on a seven-point scale was 5.3 with a minimum of four, a maximum of six and a standard deviation of .67. The constricted range of these ratings suggests that sessions were fairly similar in the amount of change they produced in the core problem dynamic. These rather homogeneous ratings of change may be due to the fact that therapists included in the sample all had many years of experience.

Successfulness of Enactments

The ten sessions comprising the sample of the present study contained a total of 22 enactments. The number of enactments for each session varied from one to five. Enactments varied in length from 54 seconds to 18 minutes. Three undergraduate raters evaluated the success of enactments on a seven-point Likert-like scale. All three raters' scores showed complete agreement in 5 out of 22 enactments (22.7%), and two out of three raters (66.6%) showed agreement for the remaining 17 enactments (77.3%).

Interrater agreement yielded a kappa of .72 (r.= .72, P< .05). The mean rating for the successfulness of enactments was 5.45 with a standard deviation of 1.01 (n=22). The ratings ranged from 3 ("slightly counterproductive") to 7 ("very successful"). It is notable that raters did not make use of the full range of available ratings; however, the fact that all therapists in the sample were expert structural family therapists may explain the lack of variance. The undergraduates' ratings of successfulness of enactments suggest that on average, enactments were moderately successful, and that no enactments were significantly counterproductive.

Extent to which Enactments addressed the Core Problem Dynamic

In order to evaluate the extent to which enactments addressed the core problem dynamic, the three undergraduate raters employed a 5-point, Likert-like scale. Raters showed complete agreement on 12 out of 22 cases (54.5%), and two out of three raters agreed in the remaining 10 cases (45.5%). Interrater agreement yielded a kappa of .76 (r.=. 76, p<.05). The mean rating of the extent to which enactments addressed the core problem dynamic was 4.77 with a standard deviation of .53. The ratings ranged from 3 ("neutral") to 5 ("very much on target'). For a summary of descriptive statistics for each of the scales please refer to Table 1.

The restricted range of ratings across enactments again may be due to the similar level of expertise of the sampled therapists. The ratings also suggest that the enactments included in the sample on average addressed the core problem dynamic at least reasonably well, and that none of the enactments was therapeutically counterproductive.

Table 1

Descriptive Statistics for Each Rating Scale

Rating Scale	N	Min.	Max.	Mean	Standard Dev.
Change	10	4	6	5.30	.67
Successfulness of Enactments	22	3	7	5.45	1.01
Extent to Which Enactments Address Problem Dynamic	22	3	7	4.77	.53
Extent to Which Meaningful MomentsAddress Problem Dynamic	47	4	5	4.87	.34

Extent to Which Meaningful Moments Addressed the Core Problem Dynamic

In the sample of ten sessions, a total of 47 meaningful moments were noted. The number of meaningful moments per session ranged from 3 to 6. The meaningful moments varied in length from ten seconds to ten minutes. Undergraduate raters evaluated the extent to which each meaningful moment addressed the core problem dynamic using a 5-point, Likert-like scale. Raters agreed completely in 33 of 47 cases (70.2%), and two of three raters agreed in the remaining 14 cases (29.8%). Interrater reliability was established with a kappa of .83 ($r_{\cdot}$=.83, $p<.05$). The mean rating was 4.87 with a standard deviation of .34. Ratings on the five-point scale ranged only from 4 to 5.

These ratings suggest that the meaningful moments included in this sample always addressed the core problem dynamic to a certain extent. The constricted range of ratings may also indicate that meaningful moments are seen as such because they address the core problem.

Testing the Hypotheses

In order to investigate the hypotheses of the present study, all possible correlations were calculated between each of the rated items, including change, successfulness of enactments, and extent to which enactments and meaningful moments addressed the core problem dynamic. For this purpose, the raw data was summarized in the following fashion: First, ratings for each item were determined by assigning the value the majority of raters had assigned to the item. Then averages of ratings for all enactments and meaningful moments in each session were calculated. Those averages were used to calculate Pearson Product-Moment correlations.

Neither the correlations between the extent to which enactments addressed the core problem dynamic and change ($r.=-.397$, $p>.10$) nor the one between the extent to which meaningful moments addressed the core problem dynamic and change ($r.=.012$, $p>.10$) were significant. However, results showed a significant correlation between the successfulness of enactments and change in the core problem dynamic ($r.=.65$, $p<.05$). No significant correlations were detected between the extent to which enactments addressed the core problem dynamic and successfulness of enactments ($r.=.133$, $p>.10$), extent to which enactments addressed core problem dynamic and meaningful moments addressed core problem dynamic ($r.=.526$, $p>.10$), or successfulness of enactments and extent to which meaningful moments addressed the core problem dynamic ($r.=.178$, $p>.05$).

These results suggest that the success of enactments is associated with positive change in a family's core problem dynamic at the end of a session. However, the present

findings fail to show a relationship between addressing the core problem dynamic in either enactments or powerful moments and such change.

Table 2

Correlations between Change, Successfulness of Enactments, And Extent to Which Problem Dynamic Was Addressed

Rating Scale	1	2	3	4
1. Change	--	.646	-.397	.012
2. Successfulness of Enactments	--	--	.133	-.178
3. Extent to Which Enactments Address Problem Dynamic	--	--	--	.526
4. Extent to Which Meaningful Moments Address Problem Dynamic	--	--	--	--

Relationship Between Meaningful Moments, Enactments, and Change in the Core Problem Dynamic

In the previous study in this series, investigators found that twenty-two of the 47 meaningful moments were related to enactments (Favero, 2002). Meaningful moments were considered to be associated with enactments if they occurred during or within two minutes of the enactment. Moreover, of the numerous techniques employed, enactments were the technique most frequently associated with meaningful moments (47%), ranking

ahead of the technique of interpretation (30%). In addition, Favero (2002) found meaningful moments that were associated with an enactment to be positively correlated with change ($r.$=.663, $p<.05$). Furthermore, the overall number of meaningful moments and change at the end of sessions correlated positively ($r.$=.55, $p<.10$). Favero concluded that the greater the number of powerful moments in a session, the more change occurs in the core problem dynamic by the end of the session. Her findings also suggest that enactments are the technique that bring about the greatest number of meaningful moments in a session.

The present investigator was interested in examining further the relationship between meaningful moments and enactments, and therefore a Pearson Product-Moment correlation was calculated between the number of meaningful moments occurring during an enactment (including up to two minutes after the enactment) and the success of enactments, and it was found to be significantly positive ($r.$=.435, $p<.05$, $n=22$). No significant correlation was found between the number of meaningful moments occurring during enactments and the extent to which enactments addressed the problem dynamic ($r.$=.23, $p>.10$, $n=22$). In addition, the correlation between meaningful moments not associated with enactments and change was not significant ($r.$=.49, $p>.10$, $n=10$).

These findings suggest that success of enactments is associated with the number of meaningful moments occurring during that enactment; however, the number of meaningful moments occurring within an enactment is not related to the extent to which an enactment addresses the core problem dynamic.

Finally, this investigator examined the relationship between the sheer number of enactments in a session and change, but could not detect a significant one ($r.$= .08,

p.>.10). In addition to the fact that success of enactments was most strongly associated with change, this finding may suggest that the quality and not the quantity of interventions is related to change.

CHAPTER IV

Discussion

Research has shown that most types of psychotherapy have many common "active ingredients" such as empathy, trust, catharsis, reassurance, and a positive relationship (Lambert & Bergin, 1994). Therefore, clinicians may question whether those techniques that are unique to any particular psychotherapy orientation contribute significantly to its effectiveness. The most prominent technique in structural family therapy, which was the focus of the present study, is the enactment, and while previous studies have described some of the components of a successful enactment (Nichols & Fellenberg, 2000; Fong, 1999), the technique has not yet been linked to the outcome of therapy.

The present study was designed to examine the relationship between successful enactments and change observed at the end of a session. In structural family therapy, the objective is to help families restructure themselves by shifting from ineffective and rigid patterns of interaction to more productive ways of relating to each other (Minuchin, 1974). The ineffective pattern can be described as the core problem dynamic, which served as the measure of change in this study. In order to be able to compare the relationship between enactments and change with other interventions, the relationship between other meaningful moments and change was also examined. Furthermore, the relationship between the level to which an intervention addressed the core problem dynamic and change was studied. It was hypothesized that those meaningful moments

that addressed the core problem dynamic would be more strongly related to change than those that did not. In addition, this investigator theorized that successful enactments would be even more strongly related to change, and that successful enactments that addressed the core problem dynamic would be most strongly related to the change occurring in the core problem dynamic in the end of the session.

Summary of Results

The findings of this study suggest that successful enactments are indeed associated with change in a family's core problem dynamic. The more successful the enactments within a given session, the more change could be detected in a family's interactional patterns by the end of that session. However, the findings did not support the hypothesis that meaningful moments and enactments are more strongly associated with change when they address the problem dynamic, or that successful enactments that directly address the problem dynamic are most strongly associated with change in the core problem dynamic at the end of the session. The small sample size and limited range may have made it harder to see the nature of the relationships between these variables.

Nonetheless, additional findings suggest that enactments play an important role in structural family therapy. In particular, the number of meaningful moments that occurred within enactments was associated with change. Of course, the more successful the enactments were, the more meaningful moments they included, as the purpose of enactments is to create moments that are powerful enough to create change. Therefore, it is likely that successful enactments contribute to positive in-session change; however, studies exploring the nature of the relationship between enactments and change at the end of the session would have to confirm this hypothesis. Also, while change in a family's

core problem dynamic at the end of a family therapy session would seem to indicate progress, it should be emphasized that no measures of actual therapy outcome were taken for this study.

Although the findings of the present study suggest that the number of meaningful moments occurring outside of enactments is not related to change ($r.= .49$, $p>.10$), this investigator speculates that in a study with a larger sample size the relationship between those two variables might be found to be significant. What remains to be seen is whether successful enactments will continue to show the strongest relationship with change.

In sum, the findings of this study suggest that during enactments it is important for therapists to help clients to have a productive dialogue, although it remains unclear whether enactments are the intervention most strongly associated with change. Thus, it may be important for clinicians to learn how to push enactments to a successful conclusion by, e.g., blocking interruptions, redirecting clients to each other, stating how clients are to talk to each other, and so on (Nichols & Fellenberg, 2000).

Limitations of the Study

Small Sample Size

Unfortunately, the present study's sample of ten family therapy sessions – an adequate sample for many process studies – turned out to be problematic because of the quantitative nature of the analyses. Therefore, the most striking limitation of the present study is its small sample size. In future studies, this investigator would attempt to increase the sample size significantly. Specifically, a power analysis (Cohen, 1992) for this study suggests a sample size of at least 76 to for a medium effect size (or of at least 34 assuming a large effect size), in order to conduct a regression analysis. Using a more

sophisticated statistical analysis, such as logistic regression, would also eliminate another limitation of the current study. In particular, the analysis of the results of this study relied on multiple correlations, and only 2 out of 10 correlations were found to be significant. When conducting multiple simple correlations, the probability that correlations will be significant by chance increases. Thus, there is a possibility that those two correlations were found to be significant only by chance.

Homogeneity of Sample

Another problem with the sample was that it was homogeneous with respect to level of change in the core problem dynamic. As a result, ratings for change, success of enactments, and for the extent to which both enactments and meaningful moments addressed the problem dynamic lacked variability across cases. Most if not all ratings were within the upper half of the corresponding rating scales. The lack of variability made it more difficult to find significant correlations as these are easier to find when ratings are distributed over the entire scale.

Possible Contamination of Ratings

There may be a chance that the two ratings that were significantly correlated with each other – successfulness of enactments and change in the core problem dynamic – were contaminated. While these ratings were made by different sets of raters, the clinician judges who rated change might have seen enactments that appeared to be successful and this might have influenced their ratings of change in the entire session. However, I believe that this was not the case, as clinician judges strictly focused on a shift in the core problem dynamic and rating such change was clearly defined (see Appendix A).

Interpretation and Implications of Findings

The findings of the present study suggest that successful enactments are an important component of therapy sessions in which change can be observed in the pattern of family interaction. The results not only indicate that the more successful enactments are the more positive change occurs in family interactions, they also suggest that the most successful enactments include the largest number of positive therapeutic moments (i.e., meaningful moments).

These findings have several implications. First, while the present study is only the first step in exploring the contribution of enactments to in-session change in structural family therapy sessions, this study enhances our knowledge about this technique. Previous research has found enactments to be complicated and difficult to implement and has described those elements that make enactments successful (Nichols & Fellenberg, 2000; Cowan, 2002). In particular, Nichols and Fellenberg established that therapists create successful enactments when they select a topic to discuss that is relevant to both parties, specify who is to talk to whom, indicate how the two parties should talk to each other, avoid interrupting an enactment, remain physically removed from the conversation, redirect participants when addressing the therapist, and deliver a summary statement in the end of an enactment. The findings of the present study amplify the importance of implementing enactments in this manner. In other words, while previous studies shed light on how to implement successful enactments, the present findings are the first to suggest the therapeutic relevance of successful enactments.

Linking successful enactments to positive in-session change may be particularly important because many family therapists avoid using this techniques as it is difficult to

implement, often brings powerful emotions into the consulting room, and requires the therapist to give up some of the control as he or she moves to the edge of the therapeutic space (Simon, 1995). While the present findings do not directly compare successful enactments with other techniques, they suggest that successful enactments are associated with the largest clusters of therapeutically positive moments in therapy sessions. Although further research is needed, these results suggest that successful enactments are essential in creating opportunities for change.

The present findings are also relevant to the training of structural family therapists, especially if future research supports the current findings. It might be useful for teachers and supervisors to teach the implementation of enactments in more depth and with more care, not only to ensure that therapists are comfortable in using this complicated technique, but also to increase the likelihood that these therapists implement enactments that are successful. Nichols and Fellenberg (2000) discovered that therapists can push enactments to a successful completion by first selecting a topic in which both parties are equally invested in, defining who is to talk to who whom, stating how the conversation should go ("tell her in a way that she can hear you"), moving clients to face each other, blocking interruptions, redirecting clients to each other, and making a poignant summary statement, among other things.

Due to the limitations of the present study, the results, although encouraging, are preliminary. The possible clinical implications, as discussed in the previous paragraphs, may be significant if future studies confirm and extend the current findings

Future Directions

Some limitations of this study discussed earlier suggest how to improve the present design. The most important improvement would be to include more sessions, with a sample size of at least 30. Furthermore, the sample should be comprised of sessions with varying amounts of in-session change.

Subsequent studies might be designed to investigate the relationship between enactments and therapy outcome, especially if an improved version of the present design confirms the current findings. In addition, such studies focusing on the entire course of family therapy might examine events (or a sequence of events) that precede successful enactments. For example, how important is it that therapists successfully join with each family member before attempting to implement successful enactments? Is there a period of time in the course of therapy when it is too early to use enactments as therapeutic interventions? Under what conditions (e.g., level of rapport with clients, client level of motivation for change, etc.) are therapists most likely to implement enactments that are successful?

Other studies could focus on investigating a causal relationship between enactments and change in a family's core problem dynamic. Such studies would require different treatment conditions in which one group would receive traditional structural family therapy that included the use of enactments, and another group would receive structural family therapy without the use of enactments.

It might also be interesting to investigate whether positive change in a family's interactional patterns achieved at the end of a session would carry over to the next session. If the change achieved did not last until the next session, how many successful

enactments and sessions reinforcing the same change would it take to create lasting change?

All of these research questions have one goal in common. They are intended to examine the process of family therapy. Revealing and understanding the processes of therapy, including the role of its techniques, will help clinicians to become better healers.

Conclusion

The present study was a first step in examining the impact of the most prominent technique in structural family therapy, the enactment, on change in a family's core problem dynamic. The findings, while limited, seem to indicate that the continued study of the relationship between enactments and change will be a worthwhile endeavor. Furthermore, the present findings may stimulate interest in a more comprehensive investigation of family therapy processes.

The study is of importance especially for family therapists. Those who use enactments may need to work harder to bring them to a successful conclusion, as not the quantity but the quality of enactments seems to be important. Those who avoid using them, may be encouraged to start implementing them, as they may be associated with positive change in the patterns of family interactions.

REFERENCES

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

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

Allen-Eckert, H. (2000). A discovery-oriented process study of enactment in family therapy: Revision of the Family Therapy Enactment Rating Scale (Doctoral dissertation, Virginia Consortium Program in Clinical Psychology, 2000). *Dissertation Abstracts International, 61,* 1068.

Anastopoulos, A. D., Barkley, R. A., & Shelton, T. L. (1996). Family based treatment: Psychosocial intervention for children and adolescents with attention deficit hyperactivity disorder. In E. D. Hibbs & P. E. (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice.* (pp. 267-284). Washington, DC: American Psychological Association.

Barkley, R. A., Guevremont, D. C., Anastopoulos, A. D., & Fletcher, K. E. (1992). A comparison of three family therapy programs treating family conflicts in adolescents with attention-deficit hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 60,* 450-463.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting & Clinical Psychology, 66,*

53-88.

Benbow, S. M., Mariott, A., Morley, M., & Walsh, S. (1998). Family therapy and dementia: Review and clinical experience. *International Journal of Geriatric Psychiatry,* 8, 717-725.

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.

Carlson, C. I. (1987). Resolving school problems with structural family therapy. School *Psychology Review, 16,* 457-468.

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

Chamberlain P., & Rosicky, J.G. (1995). The effectiveness of family therapy in the treatment of adolescents with conduct disorders and delinquency. *Journal of Marital and Family Therapy, 21,* 441-459.

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

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155-159.

Collison, C. R., & Miller, S. L. (1985). The role of family re-enactment in group psychotherapy. *Perspectives in Psychiatric Care, 23,* 74-78.

Cowan, J. (2001). *Maximizing the effectiveness of enactments in structural family therapy: A qualitative analysis of productive and unproductive enactments.* Unpublished doctoral dissertation, Virginia Consortium Program in Clinical

Psychology, Virginia Beach, VA.

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

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.

Diamond, G. S., & Liddle, H. A. (1999). Transforming negative parent-adolescent interactions: From impasse to dialogue. *Family Process,38,* 5-26.

Dunn, R. L., & Schwebel, A. I. (1995). Using a cognitive family therapy model in conjunction with behavioral family therapy models. *American Journal of Family Therapy, 23,* 203-212.

Edward, M. E., & Steinglass, P. (1995). Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy, 21,* 475-509.

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.

Estrada, A. U., & Pinsof, W. M. (1995). The effectiveness of family therapies for selected behavioral disorders of childhood. *Journal of Marital and Family Therapy, 21,* 403-440.

Favero, D. (2002). *Structural Enactments as Methods of Cjhange in Family Therapy.* Unpublished dissertation, Virginia Consortium Program in Clinical Psychology, Virginia Beach, VA.

Fleiss, J. L. (1971). Measuring nominal scale agreement among many raters. *Psychological Bulletin, 76,* 378-382.

Fong, E. (1999). A discovery-oriented process study of enactments in family therapy: Development of the Family Therapy Enactment Rating Scale (Doctoral dissertation, Virginia Consortium Program in Clinical Psychology, 1999). *Dissertation Abstracts International, 60,* 1300.

Friedlander, M. L., Ellis, M. V., Raymond,L., Siegel, S. M., & Milford, D. (1987). Convergence and divergence in the process of interviewing families. *Psychotherapy, 24,* 570-583.

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.

Fulmer, R. H. (1983). A structural approach to unresolved mourning in single parent family systems. *Journal of Marital and Family Therapy, 9,* 259-269.

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

Garfield, S. L. (1990). Issues and methods in psychotherapy process research. *Journal of Consulting and Clinical Psychology, 58,* 273-280.

Goldstein, M. J., & Milkowitz, 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. (1986) Change process research. *Journal of Consulting and Clinical Psychology, 54,* 4-9.

Greenberg, L. S., Ford, C. L., Alden, L. S., & Johnson, S. M. (1993). In-session change in emotionally focused therapy. *Journal of Consulting & Clinical Psychology. 61,* 78-84.

Greenberg, L. S., & Pinsof, W. M. (1986). Process research: Current trends and future perspectives. In Greenberg, L. S. & Pinsof, W. M. (Eds.), *The psychotherapeutic process: A research handbook* (pp. 3-20). New York, NY: Guilford Press.

Grief, G. L., & Dreschler, M. (1993). Common issues for parents in a methadone maintenance group. *Journal of Substance Abuse Treatment, 10,* 335-339.

Griffith, J. L., & Griffith, M. E. (1987). Structural family therapy and chronic illness. *Psychosomatics,28,* 202-205.

Gurman, A. S., & Kniskern, D. P. (1992). The future of marital and family therapy. *Psychotherapy, 29,* 65-71.

Harkaway, J. E. (1987). Family intervention in the treatment of childhood and adolescent obesity. *Family Therapy Collections, 20,* 93-104.

Hazelrigg, M. D., Cooper, H. M., & Borduin, C. M. (1987). Evaluating the effectiveness of family therapies: An integrative review and analysis. *Psychological Bulletin, 101,* 428-442.

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

Holmes, P. (1993). The roots of enactment: The process in psychodrama, family therapy,

and psychoanalysis. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 45,* 149-162.

Horowitz, M.J., Marmar, C.R., Weiss, D.S., DeWitt, K.N, & Rosenbaum, R.L. (1984). Brief psychotherapy of Bereavement reactions: The relationship of process and outcome. *Archives of General Psychiatry, 41,* 438-448.

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

Kunzer, M. B. (1986). Structural family therapy with chronic pain patients. *Issues in Mental Health Nursing, 8,* 213-222.

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

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. Bergin and S. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change, 4th Edition,* New York: John Wiley & Sons, Inc.

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

Minuchin, S., Baker, L., Roseman, B., Liebman, R., Milman, L., & Todd, T. (1975). A conceptual model of psychosomatic illness in children. *Archives of General Psychiatry, 32,* 1031-1038.

Minuchin, S., & Fishman, C. (1981). *Family therapy techniques.* Cambridge, MA: Harvard University Press.

Minuchin, S., & Nichols, M. P. (1998). *Family Healing: Strategies for hope and*

understanding. Simon and Schuster

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

Mittelmeier, C.M., & Friedman, S. (1993). Toward a mutual understanding: Constructing solutions with families. In S. Friedman (Ed.) *The new language of change: Constructive collaboration in psychotherapy* (158-181). New York: Guilford Press.

Nichols, M. P. (1997). The art of the enactment. *Family Therapy Networker,6,* 23.

Nichols, M. P. & Fellenberg, S. (2000). The effective use of enactments in family therapy: A discovery-oriented process study. *Journal of Marital and Family Therapy,26,* 143-152.

Nichols, M. P., & Minuchin, S. (1999) Short-term structural family therapy with couples. In Donavan, J.M. (Ed.), *Short-term c;ouple therapy* (pp. 124-143). New York, NY: Guilford Press.

Nichols, M. P., & Schwartz, R.C. (2000*). Family therapy: Concepts and methods.* (5th ed.). Boston, MA: 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.

Perkins, S. E. (1989). Altering rigid family role behaviors in families with adolescents. *Alcoholism Treatment Quarterly, 6,* 111-120.

Pinsof, W. M. (1989). A conceptual framework and methodological criteria for family therapy process research. *Journal of Consulting and Clinical Psychology, 7,* 303-

313.

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.

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Mitrani, V., Gilles, M., & Szapocznik, J. (1997). Brief structural/strategic family therapy with African-American and Hispanic high-risk youth. *Journal of Community Psychology, 25,* 453-471.

Shadish, W. R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspectives from meta-analysis. *Journal of Marital and Family Therapy, 21,* 17-26.

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.

Simon, G. M. (1995). A revisionist rendering of structural family therapy. *Journal of Marital and Family Therapy, 21,* 17-26.

Stanton, M. B., & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122,* 170-191.

Stanton, M. B., & Todd, R.C. (1979). Structural family therapy with drug addicts. In *The family therapy of drug and alcohol abuse,* E. Kaufman and P. Kaufman (Eds.) New York: Gardner Press.

APPENDIX A

Guidelines for Rating Change in the Problem Dynamic

Change is defined on a seven-point scale:

1 – Significantly Destructive – Family relationships are threatened, continuation of therapy is threatened, or both.

2 – Moderately Destructive – A session which reveals a setback in relationships and noticeable anger.

3 – Slightly Destructive – Unresolved angry interchanges, slight hardening of problem dynamics.

4 – Neutral – Things seemed to get no better or worse during the session.

5 – Slightly Positive – Partial agreement with the therapist on the problem dynamic (Only one client seems ready to accept therapeutic formulation), clients seem ready to consider, yet not fully accept, therapeutic input.

6 – Moderately Positive – Clients understand and accept therapist's formulation; seem agreeable to altering behavior; accept responsibility for the problem.

7 – Significant Positive – Clients understand the therapist's formulation of the problem **and** begin to make certain behavioral changes in that direction.

APPENDIX B

Guidelines for Rating Successfulness of Enactments

Successfulness of Enactments is defined on a seven-point scale:

1 – Very Counterproductive – Destructive things get said; the enactment seems to have a significantly destructive impact on family relationships or the continuation of therapy, or both.

2 – Moderately Counterproductive – Quite a bit of arguing, attacking, or criticizing, not as an honest expression of feelings, but with a destructive and counterproductive sense that this made things worse.

3 – Slightly Counterproductive – Not only is nothing accomplished but positions seem to harden; participants are likely to be discouraged; participants don't listen to each other and it doesn't seem like just more of the same but also to confirm that things aren't going to change; quiet member(s) speak up, but dominant ones override them, etc.

4 – Neutral – Neither productive nor counterproductive

5 – Slightly Effective – Seemed slightly useful or productive, though not extremely so. Some expression of feelings or points of view without attacking (even though there may have been disagreement). They talked about issues. Things were said that are usually held back, etc. At least they talked about the issues, even if they don't achieve any big breakthrough; at least they don't simply repeat the typical blaming and criticism without allowing the other to have his or her say.

6 – Moderately Effective – Involves a clear, though perhaps not dramatic or lasting shift of some kind. Important feelings are shared; issues are addressed in a useful manner; reticent family members speak up; domineering members don't do all the talking; participants listen to each other; they seem to understand what the therapist is driving, etc.

7 – Very Effective – Involves a clear shift of some kind, which seems to have the potential to have a lasting effect. Participant(s) seem to recognize their own role in problems; quiet one speaks up and dominant listens, participants not only seem to understand what the therapist is driving at but also show signs of actually making changes, or being clearly willing to do so.

APPENDIX C

Guidelines for Rating Extent to Which Problem Dynamic was Addressed

1 – Very Destructive – The enactment/ meaningful moment does not address the problem dynamic and instead causes the problem dynamic to harden to a point that is very destructive (e.g., enmeshed teenage son and mother talk, with mother clearly viewing her son as incompetent and telling him that she will make all the decisions for him from now on without the therapist intervening).

2 – Somewhat Destructive – The enactment/ meaningful moment does not address the problem dynamic and instead encourages some hardening of the problem dynamic.

3 – Not on Target – Enactment/ meaningful moment does not address problem dynamic but is not destructive.

4 – Somewhat on Target – Enactments/ meaningful moments address most aspects of the problem dynamic, but may miss one or two aspects (e.g., son and distant father talk, mother is blocked from interrupting, but no opportunity is created for son to speak up for himself).

5 – Very much on Target – Enactment/ meaningful moment addresses the problem dynamic very much, when it takes all aspects into account.

APPENDIX D

Rating Sheets

Rater's Name:_____

Tape Name:_____

Enactment No.: ___

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1. Please rate the overall successfulness of the enactment.

Very Counterp.	Moderately Counterp.	Slightly Counterp.	Neutral	Slightly Successful	Moderately Successful	Very Successful
1	2	3	4	5	6	7

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2. Please rate the extent to which the enactment addresses the problem dynamic.

Very Destructive	Somewhat Destructive	Not On Target	Somewhat On Target	Very Much On Target
1	2	3	4	5

Rater's Name:_____

Tape Name:_____

Meaningful Moment No.: ___

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2. Please rate the extent to which the meaningful moment addresses the problem dynamic.

Very Destructive	Somewhat Destructive	Not On Target	Somewhat On Target	Very Much On Target
1	2	3	4	5

APPENDIX E

General Guidelines for Undergraduate Raters

1. Please remember that the information on the tapes is confidential and therefore should not be viewed in areas where others can see them.

2. Make sure that you use a VCR that has a real time counter.

3. Also, start the tape at the very beginning, view the entire tape, and rewind it after you have finished your ratings.

4. As you rate each of the instances to be rated, rewind the tape to view the enactment/ powerful moment at least 2 times, so that you are sure about what happened before you rate it.

5. Remember that the times that are indicated may vary from VCR to VCR. So, for enactments look for the starting and end points as provided (i.e., what the therapist says). For the powerful moments, look out for what the description is for the powerful moment. Powerful moments are usually the discrete period in which that occurs that is described as the powerful moment (e.g, it's just that sentence that the therapist said).

6. Record your rating on the appropriate rating sheets. Please make sure to indicate your name, the name of the tape and the enactment or powerful moment number. This is very important for keeping the data organized. You will find the numbers for enactments and powerful moments on each tape's info sheet.

7. When rating the enactments, please keep in mind that you have to record two different ratings. When rating the successfulness of the enactment, please remember to think about whether or not some kind of a shift has taken place in the way the two family members talk with each other, When rating the extent to which the enactment or the meaningful moment addresses the problem dynamic, remember to judge the therapist's set-up and his/her interventions throughout the enactment/meaningful moment.

8. Please keep in mind that a great enactment is not perfect. Rather judge it on what kind of change has occurred.

9. Remember that the guidelines are not the absolute answer to how to conduct the ratings. There are provided to give you some guidance, but ultimately you will have to use your best subjective judgment.

10. Finally, don't hesitate to call me with any questions. You may also call Dr. Nichols with any questions regarding the rating.

VITA

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