Families on both sides of the mirror: a structural variation of the multiple family therapy model

Daniel Paul Wulff
Iowa State University

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Families on both sides of the mirror: A structural variation of the multiple family therapy model

Wulff, Daniel Paul, Ph.D.

Iowa State University, 1994
Families on both sides of the mirror:
A structural variation of the
multiple family therapy model

by

Daniel Paul Wulff

A Dissertation Submitted to the
Graduate Faculty in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY

Department: Human Development and Family Studies
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(Marriage and Family Therapy)

Approved:

Signature was redacted for privacy.

In Charge of Major Work

Signature was redacted for privacy.
For the Major Department
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For the Graduate College

Iowa State University
Ames, Iowa
1994

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To my parents,

Virgil and Gloria
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Thanks to the four families who participated in my study. Their courage to “leap into the dark” inspired me to do my best, to make the best possible use of their efforts. I am deeply indebted to them for their trust and faith.

To the two therapists in my study—Tim Heinrichs and Sally St. George—go my respect and undying gratitude. They generously opened up their therapy to let me get involved with their work and their clients. Not all therapists would be willing to do this, and they did it with creativity and excitement. Tim, your openness with your families is a pleasure to watch. Sally, you must have written the book on relationship-building with families. Thanks, Sally, for the pushes (gentle and not-so-gentle) when my writing was stuck.

A special thanks to Marilyn and Nathan who supported me through my return to graduate school despite the stress and strain that we knew would be involved. I needed your encouragement and you gave it.

In the final stages of my dissertation, Donna Vaughn and Don Baker from the School of Social Work at the University of Oklahoma “saved the day” by helping me get this dissertation on the computer. Donna found a computer for me that “spoke my language” and Don helped me organize in a couple of hours what
would have taken me a couple of infuriating weeks to do by myself.
ABSTRACT

A variation of the multiple family therapy model was designed that gave client families opportunities to observe each other's therapy and to provide feedback on their observations. This qualitative study allowed the participants to assist in the design, principally by deciding how to give their feedback to one another.

Using families as therapeutic teams behind a one-way mirror helped diminish the mystique often associated with such technology. This unique process also gave the families opportunities to be helpful and enjoy the benefits of that role.

The reactions and descriptions of the participants were analyzed using an organizing system devised by Tesch (1990), which was modified for this study. The Major Categories of responses included: Research Format and Procedure, Therapeutic Interaction, Similarities Between Families, Differences Between Families, Focus on Own Family, and Focus On Other Family. Minor Categories included: Focus on Therapist, Discussion of Problems in General Terms, and Distracting Behaviors.

The development of therapeutic interaction behind the one-way mirror was a significant finding. The observer families engaged the researcher in a therapy interview as the therapy interview with the other family was in process. These
simultaneous conversations on either side of the mirror were strikingly similar in content and tone.

The families formed strong relationships during the study protocol, an additional benefit of families participating in therapy together. The research requirements were coordinated with the therapy needs of the client families so that the research was accomplished without interfering with the therapy. In fact, the research enhanced the therapy. This study demonstrates that research and therapy can occur simultaneously and that both are enhanced in the process.
CHAPTER I

INTRODUCTION

First you must have the images, then come the words. And I begin to hear the words, begin to see them on pages of writing.

—Robert Waller, The Bridges of Madison County

One of the central themes in the helping professions is the importance of recognizing client capabilities and resources in order to utilize them in assisting the client to make life changes (Erickson, Rossi, & Rossi, 1976; Gordon & Meyers-Anderson, 1981; Richmond, 1917; Rogers, 1980; Szasz, 1965). Theories of human development share a belief that clients can make changes in their thinking and behaving that can lessen their pain/distress or achieve other desired outcomes (Maslow, 1968; Rennie, 1992; Sarason, 1966; Shands, 1960; Sullivan, 1954). Psychological and sociological theories and their accompanying therapeutic applications vary on how much reliance they place on the client's ability to change and the proper or prudent role for the therapist to take vis-à-vis the client/patient, but they all acknowledge change as fundamental to the human experience (Garfield & Bergin, 1986; Nichols & Schwartz, 1991).

This study rests on this tradition of valuing people's abilities to change themselves as well as the related belief that people possess the abilities or qualities to be helpful
to others (Gartner & Riessman, 1984; Gottlieb, 1981; Katz & Bender, 1976). In this study, families in family therapy spent some of their time behind a one-way mirror serving as a therapeutic team for another family in therapy. Families were given this more active role in the therapeutic process of family therapy based on two guiding principles. The first involved the demystification of the one-way mirror and the therapeutic team. The second belief was that families can contribute to family therapy in a variety of ways.

Demystification (diminishing the secretive or exclusive nature) of the one-way mirror and therapeutic teams does not reduce the contributions of those innovations to the therapy process. The use of one-way observation mirrors in family therapy has become a common practice in agencies and training facilities (Nichols & Schwartz, 1991). In this arrangement, other therapists and supervisors observe therapy interviews from behind a one-way mirror, occasionally consulting with the therapist in the room regarding analyses of the process and suggesting strategies or interventions (Boscolo, Cecchin, Hoffman, & Penn, 1987; Burbatti & Formenti, 1988; Hoffman, 1981; Madanes, 1984). Introducing families to the mirror and video technology and allowing them to occupy the observation position behind the mirror for another family should significantly reduce the mystique and anxiety associated with such therapeutic technology. Therapeutic benefits of
observing/interacting from behind the mirror are not diminished by including the client in that position—it is simply shared (Andersen, 1987, 1991).

Benefits can be derived from using the one-way mirror arrangement in family therapy without maintaining the secretiveness of those who are behind the mirror (Andersen, 1992). Some family therapists who use teams behind the mirror have the team meet the family before, during, or after the therapy interview (Brown, 1992). Others have the team enter the therapy room periodically to offer "reflections" on what they have been observing (Andersen, 1991). "The open-reflecting-team mode of working tended to move professional language towards daily language. This language contained only words and concepts we could all use in common" (Andersen, 1992, p. 58). The practice of using everyday language as opposed to technical jargon creates a more collaborative relationship with clients, one in which language does not pose a barrier to understanding. Therapeutic teams can be created without customary accouterments associated with professionalism—certified/licensed therapists and specialized language.

Families can contribute to family therapy in a variety of ways. Including families' voices in the process of therapy from the position of a therapeutic team enhances the therapy experience for the family in the therapy room. A family in
therapy, experiencing their own distress, is in a unique position to observe and comment upon the experience of another family in distress (Leichter & Schulman, 1974). Being part of a family in distress provides a location from which to view problems that differs from the therapist's position (Elliott & Shapiro, 1992). Utilizing a family in therapy in the therapy process for another family demonstrates a belief that families can help others in distress and that such help can be well received (Laqueur, 1973; Leichter & Schulman, 1974). In addition, the experience of offering help may enhance the self-confidence and self-worth of the provider of that help (Cowen, 1982).

This study employed a qualitative research methodology. Qualitative research allows access to the richness and complexity of individual lives. In a recent review of family therapy research, Lyman Wynne reports that many in the field recommend

... at the present state of development of the family therapy field, a strong emphasis should be given to exploratory, discovery-oriented, hypothesis-generating research, rather than primarily or exclusively to confirmatory research. ... In the study of most therapy issues, large-scale confirmatory clinical trials of family therapy were regarded as premature and likely to
be wasteful of funds and effort at the present stage of research development. (Wynne, 1988, p. 251)

Many voices in family therapy have been calling for the development of new research methodologies that are compatible with systems theory (Joanning, Newfield, & Quinn, 1988; Keeney & Morris, 1985; Pinsof, 1981; Tomm, 1983). Qualitative research shares many of the same theoretical bases that inform systems theory and family therapy (Moon, Dillon, & Sprenkle, 1990).

Qualitative research designs encompass a variety of specific methodologies (Tesch, 1990) and paradigms (Guba, 1990). Despite the divergences, agreement exists among the qualitative researchers that they share in "the process of making sense of narrative data" (Tesch, 1990, p. 4). Qualitative research promotes a contextualizing of research by clearly stating the purposes and assumptions that motivate the researcher in his/her procedural decision-making. Questions are open-ended to allow the respondents to express themselves as clearly and fully as possible. This design is emergent, meaning that the research has the flexibility to adapt to the exigencies of the study-in-context (Lincoln & Guba, 1985). The fluid design allows the participants to be involved in the inquiry process beyond simply giving answers to a priori questions formed by the researcher. Acker, Barry, and Esseveld (1990) consider the optimal conditions for
qualitative research to occur when "the object of research enters into the process as an active subject" (p. 136).

This study provided a format for the participants to experience family therapy in an innovative way. In addition, the design of the methodology stimulated the participants of the study to join in shaping the inquiry process itself.
CHAPTER II

REVIEW OF RELATED LITERATURE

.. every place can be reached from other places, by the most various roads and routes. ..

--Italo Calvino, Invisible Cities

The following review of related literature encompasses research, theory, and practice precedents for the research being proposed. "Related" refers to similarity but not necessarily "sameness." No studies were located that focused specifically on the use of families as "therapeutic teams."

Psychotherapy has long considered the client/patient to possess resources and capabilities. The therapist has the key to unlock that potential and is required to guide the client in the utilization of these resources. Without such assistance these resources are likely to remain unrealized potentials. There has been a prevailing tension between the role of the therapist and the role of the client as each seeks ways to work together or complement one another and to assess relative performances in those roles (Corsini, 1979; Hoffman, 1981; Nichols & Schwartz, 1984).

The field of family therapy began in the early 1950s in the United States with the idea of including families of patients in the therapy process. Families were included so that they could be more directly apprised of their "sick" member's situation or, in some cases, more "radically"
included by viewing family interactions as integral to the development and maintenance of individual behavioral problems/dysfunction (Bateson, Jackson, Haley, & Weakland, 1956). The therapist was a central figure in the process as had been the case in individual psychotherapy. He/she controlled what happened in therapy and directed the patient on how to proceed in the process of dealing with their problem(s).

Families Central to the Process of Change

Early in the development of family therapy, some practitioners focused heavily on client capabilities and responsibilities and placed less emphasis on the therapist as the principal factor in bringing about change. Notable among these therapists were Peter Laqueur, Robert MacGregor and his associates, and Ross Speck and Carolyn Attneave. Each of these therapists developed their models independently and in response to the particular exigencies of their locations and client needs.

Multiple Family Therapy

Organizing what were referred to as "Multiple Family Therapy" (MFT) groups, Peter Laqueur (1968) arranged meetings for groups of families who each had a hospitalized member in order to gain "a better mutual understanding of patients and their families for the purpose of assuring the patient's continued well-being after his discharge from the hospital"
Initially, these groups were brought together to pass information on to family members so they could better care for their family member when he/she returned home. The families were brought together in groups for the efficient dissemination of this information.

Once convened, the groups began to interact in ways that were supportive of one another (Leichter & Schulman, 1974). According to Laqueur (1968), the feeling of "having been there" in similar trouble helps immeasurably in learning new ways of dealing with conflicts and this feeling is more likely to occur in the MFT group with its many examples than in other forms of therapy. (p. 146)

Families began listening to each other. Subgroups formed within the larger group (e.g., fathers, mothers, adolescents, marital couples) that crossed family lines (Laqueur, 1968, 1973). The experience of being a father, a mother, or an adolescent served as a commonality for those in that category, which in turn created a supportive atmosphere and network. A father could see and hear another father react to circumstances that were meaningful to him by virtue of their common role as "father" (Sawin, 1979). Capitalizing on these cross-family connections,

new insights may be achieved through role-playing when the son of one family is asked by the therapist to play
the role of the father of another family. By acting "as if" he were that parent the actor may not only achieve for himself, but also transmit to the other children a greater understanding of the role of the parent in the given situation. (Laqueur, 1968, p. 146)

The MFT format brought families together in ways that relied significantly upon the families themselves to take the initiative beyond the therapy interviews. Laqueur (1973) put it this way: "We aim to let the families themselves discover such patterns with us, so that families may act as co-therapists and teach each other possibilities for change, for coping with problems in a new way" (p. 77). Although only hinted at in the literature (Leichter & Schulman, 1974; Strelnick, 1977), an additional value of MFT seemed to be its ability to structure a situation in which families came to consider themselves competent and possessors of valuable information, wisdom, or ways of relating that could be shared with others. In other words, the relationships of giving and receiving that were structured into MFT groups had value not only for the help that was "received" by the participants, but also for the feelings of competence and self-worth that accrued to those who extended help. Being considered worthy to help another family in this therapeutic context was viewed as a valuable therapeutic experience in its own right.
Multiple Impact Therapy

At approximately the same time though, in a different area of the country, another form of therapy with families called "Multiple Impact Therapy" (MIT) was evolving. "MIT . . . is a brief, usually two-day, intensive study and treatment of a family in crisis by a guidance clinic team" (Ritchie, 1971, p. 37) consisting of psychiatrists, psychologists, and social workers. Scheduling the therapy to be intensive and brief was an innovation born of the necessity to provide therapy for families who traveled great distances and could not make regular and repeated visits (MacGregor, Ritchie, Serrano, Schuster, McDanald & Goolishian, 1964).

One of the key elements in MIT was the "overlapping interview," a practice of informing families during the therapy process of the therapist's interpretations, with the option of having the patient or family critique the therapist's analysis (Ritchie, 1971). Trusting the patients and their families to participate in the therapists' ongoing development of understanding and meaning revealed a "confidence in the individual's or family's ability to find their own answers and solutions" (Ritchie, 1971, p. 38). In MIT, clients were afforded the opportunity to interact with the therapy process--not as just a subject, but as a participant. Notable was the therapist's courage to relinquish the hierarchical position vis-à-vis the client.
This openness to share more-or-less equally in the therapeutic process was highly unusual.

**Social Network Intervention**

Another model that utilized families' resourcefulness was the "Social Network Intervention" (Speck & Attneave, 1973; Rueveni, 1979). The following quote explains this model.

In social network intervention, however, we are experimenting with the idea of setting in motion the forces of healing within the living social fabric of people whose distress has led society, and themselves, to label their behavior pathological. We find that the energies and talents of people can be focused to provide the essential supports, satisfactions, and controls for one another, and that these potentials are present in the social network of family, neighbors, friends, and associates of the person or family in distress. So far as we can tell, most people have some contact with at least 40 or 50 people who are willing to be assembled in a crisis. In such an assembly, tribal-like bonds can be created or revived not only to accomplish the tasks of therapeutic intervention for the current crisis, but to sustain and continue the process. The retribalization we have been cultivating is not, therefore, a denial of the realities of today by a literal return to some distant past, but a way of restoring a vital element of
relationship and pattern that has been lost. The goal of network intervention is to utilize the power of the assembled network rapidly to shake up a rigidified system in order to allow changes to occur that the members of the system, with increased knowledge and insight into their predicaments, would wish to occur—and for which they are responsible. (Speck & Attneave, 1973, p. 7)

As in the MFT and MIT models, Social Network Intervention relies upon families' abilities to connect with others in positive ways. In the Social Network Intervention Model, "family" includes extended family and other significant social relationships. The role of the therapist (or "intervenor" as the role is called within this model) is to skillfully assist the group to revive or create a "healthy social matrix which then deals with the distress and the predicaments of its members far more efficiently, quickly, and endurably than any outside professional can hope to do" (Speck & Attneave, 1973, pp. 7-8). The therapist or intervenor has an important role, but the "forces of healing" reside in the extended family group/network.

Interpersonal Interaction in Groups

The three preceding models of working with families have elements in common with group therapy methods. From a somewhat different therapeutic tradition, group therapy with individuals has been a very influential form of psychotherapy,
relying on the interactions between biologically-unrelated individuals to achieve insight, understanding, support, and encouragement (Yalom, 1975).

Group therapies have developed a focus on process rather than content (Bion, 1961; Yalom, 1975). Concentrating on interpersonal interaction provided enough common ground among family-oriented therapists to encourage the blending of group therapy techniques with the structure of working with family units. The family is a group of individuals who have a biological or marital connection over time that exhibits regularized patterns of interaction. Interaction patterns can also be discerned among the participants in group therapy. Group therapists have championed the resourcefulness of group members and have depended on those interpersonal resources to create therapeutic moments in the therapy process. In a similar fashion, family therapists have focused their attention on the process of family interaction. The dynamics of intra-family interaction became the key ingredient in launching family therapy into its legitimacy as a unique and viable mode of psychotherapy (Bateson, Jackson, Haley & Weakland, 1956).

**Family Therapy**

Family therapy is a form of therapy that has built itself upon the concepts of behavioral change and therapist action, both occurring as parts of a systemic unit (Becvar & Becvar,
This active orientation assumes that clients (and therapists) are (a) able to make changes, and (b) willing to make changes, given the appropriate context.

**Strategic (Problem-Solving) Therapy**

In 1973, Jay Haley introduced Milton Erickson to the field of family therapy in his book *Uncommon Therapy*. Erickson's work revolved around the idea that clients have resources that they can use to effectively manage their problems and achieve their goals. Erickson used hypnotic techniques to assist clients in their efforts to counteract disrupting and unwanted behaviors. These techniques opened doors to the client's potentials that were often unknown or unaccessed. Erickson's skill was in showing clients how to access their resources now and in the future.

Haley (1976) incorporated Erickson's work into what he termed "problem-solving therapy." Client problems were viewed as more than substantive problems that needed solution/resolution—they also represented avenues whereby the therapist could help the client reorganize him/herself to be better able to handle future dilemmas or problems. These changes would serve to prevent future problems or at least better prepare the client to contend with the potential problems that may subsequently appear. The belief was that clients could reach levels of functioning whereby they could
deal effectively with their own problems without professional assistance.

**Collaborative Language Systems**

Other models of family therapy have, in recent years, joined and extended the notion of accentuating client competencies and abilities to make their own decisions. Notable among these practitioners have been Harry Goolishian and Harlene Anderson.

Garnering considerable attention in family therapy literature in recent years has been collaborative language systems approaches (Goolishian & Anderson, 1992), which have evolved through the work of Harry Goolishian and Harlene Anderson. Rather than working with families as distinguished by social organization or biological relatedness, Anderson and Goolishian (1988) work in therapy with those persons who are involved with the identified problems—those who are involved and invested in some way with the problem that has become the focus of attention. The therapist is viewed as "an expert in the management of the communicative process" (Goolishian & Anderson, 1987, p. 536) who hopes to create a context for a process "based on mutual understanding, respect, a willingness to listen and to hear, and an openness that is highlighted by seeking the 'rightness' of what is said rather than the pathology" (Anderson & Goolishian, 1988, p. 390). In this way, "clients demonstrate their own unique expertise regarding
their lives, their problems, and their social realities" (Anderson & Goolishian, 1988, p. 390).

Informal Therapeutic Interaction

Self Help Groups

The efforts by theorists and therapists to create models and techniques to accentuate and utilize the resources that clients possess have not taken place exclusively in family therapy and in psychotherapy generally. Self-help groups have emerged in the past several decades with the goal of bringing people together who have common backgrounds, experiences, or problems (Gartner & Riessman, 1984; Gottlieb, 1981; Katz & Bender, 1976). These meetings have been based on the assumption that people who have common life experiences or life situations/contexts can interact for their mutual benefit. Information, advice, support, and social activities can be shared within this group context to achieve positive results in addressing problems faced by the members. Through a process of sharing one's life experiences with others and hearing others tell their stories, insight and behavior change can result.

Non-Professional Psychotherapy

Most therapeutic interactions occur naturally, outside a therapy room. "The majority of 'psychological' problems people experience are never brought to mental health professionals or trained paraprofessionals" (Toro, 1986, p.
147). Good listeners and wise persons have always been consulted by people facing the trials and tribulations of life in order to receive help and guidance in resolving those issues. There is a common belief that people who have experienced problems or issues similar to our own are in a prime position to understand us and offer advice. They are believed to have the sensitivity to understand the issue at hand because they survived it and can reflect significantly upon it.

"Natural helpers" have provided interpersonal assistance to others throughout history. Behaving therapeutically is something all people do periodically as a natural part of living with other people. "Almost any human relationship (in a broad sense of the term) has the potentiality of making a significant change in human relatedness and so is similar to the psychotherapeutic relationship" (Shands, 1960, p. 228).

Carl Whitaker spoke of these "non-professional psychotherapists" as providing the bulk of all psychotherapeutic services in our society (personal communication, October, 1986). Hairdressers, bartenders, and family practice lawyers have been the focus of numerous studies, which determined that these individuals provided genuine help to people who requested their services (Cowen, Gesten, Boike, Norton, Wilson, & DeStefano, 1979; Cowen, McKim, & Weissberg, 1981; Doane & Cowen, 1981). In response
to the belief that help offered by non-trained helpers is inadequate, Whitaker (1976) responds:

There is no question but that a great many children headed for schizophrenia in their infancy happen to make contact with a loving-hearted lady next door, or even maybe with a friendly dog next door, and so learn how to love, learn how to be personal and intimate. This context is ordinarily just called friendship, but more honestly should be called social therapy. The grandmother who gives some little girl cookies whenever she comes to visit, the old carpenter who takes a neighbor's boy fishing, the boss who calls an employee in and rakes him over the coals, the supervisor who sits down to be straight with one of his workers may each be therapeutic (pp. 157-158).

Being therapeutic with others is not a mystical or esoteric experience reserved for a few. Therapeutic interactions are part of our daily lives.

**Technological Innovations in Family Therapy**

**One-Way Mirrors and Therapeutic Teams**

Family therapy has used various technologies to facilitate the process of seeing problems/issues systematically (i.e., video cameras, one-way mirrors, therapeutic teams behind the mirror). In particular, the one-way mirror affords the opportunity to view a family from a
vantage point different from that held by those who interact face-to-face with families. To watch a family in therapy without the responsibility of maintaining the conversation affords a unique perspective. More focus can be given to watching and listening without the usual imperative to respond to the speaker(s).

In family therapy, the purpose of using these teams behind the mirror is to inform and influence the therapy process in new ways. Originally the teams were kept isolated and secret from the family with only the therapist being in contact (and in collaboration) with them (Boscolo, Cecchin, Hoffman, & Penn, 1987). In recent years, Tom Andersen (1987) has experimented with what he calls the "reflecting team." The reflecting team watches the therapy session either from behind the one-way mirror or in the therapy room as it is occurring. The teams are not kept secret, providing the family with the option of meeting the team members. Periodically, the team behind the mirror may go into the therapy room and the therapist and the family may observe the team from behind the one-way mirror. Opening up the one-way mirror technology to varied uses that incorporates the family in significant ways conveys an appreciation of, and confidence in, the client's input and involvement in the course of treatment.
In this research project, families were placed behind the one-way mirror to serve as the therapeutic team for other families. This procedure embodies a belief that families (non-professionals) can be enlisted to help one another while at the same time achieving personal benefits themselves by being in the helping role.

**Qualitative Research**

Qualitative research methodologies are based on theoretical ideas that are resonant with the theoretical bases of systems theory. Systems theory has been a major contributor to the development of marital and family therapy (Becvar & Becvar, 1993). Family interaction (as well as interactions more generally) are complex and subjective and qualitative research methodologies are particularly well-suited to address these issues (Gilgun, Daly, & Handel, 1992). With qualitative methods, the focus is not on identifying structural or demographic trends in families, but rather on the processes by which families create, sustain, and discuss their own family realities. . . . Families are groups that construct individual and shared meanings. There is a concordance between families as a primary focus for the construction of meaning and the assumptions of qualitative research that focus on capturing that meaning. (Gilgun et al., p. 4)
Qualitative or naturalistic inquiry is based upon several assumptions regarding the nature of knowledge and how research can relate to that knowledge (Guba, 1981). First, the assumption is made "that there are multiple realities, that inquiry will diverge rather than converge as more and more is known, and that all 'parts' of reality are interrelated so that the study of any one part necessarily influences all other parts" (Guba, 1981, p. 77). Naturalistic inquiry is rooted in the complexity of social interaction and seeks to maintain that complexity or holistic nature rather than reducing the phenomena into raw data that lose their contextual time and place. According to Elliott and Shapiro (1992),

Therapy researchers do not yet know enough about therapeutic change processes to specify what to look for in advance. Therapy researchers have been particularly guilty of ignoring the role of context in understanding change processes. Careful, open-ended description of significant events is one way of generating knowledge about therapeutic change processes. (p. 164)

Qualitative methods are seen as "generative" in the sense that Gergen (1982) uses the term in reference to theory. He explains generative theory as "theory designed to unseat conventional thought and thereby to open new alternatives for thought and action" (Gergen, 1992, p. 27). Diverse responses
or "discrepancies between perspectives" (Elliott & Shapiro, 1992) are not seen as errors or indicators of invalidity, but rather treated as important data that must be encompassed methodologically.

Secondly, the inquirer (researcher) and the respondents are seen as interacting agents. As Stainback and Stainback (1984) explain, "the better the rapport developed and the relevance of the role assumed by the researcher, the greater the depth of understanding of the data that can be gleaned regarding the perceptions of the subjects" (p. 298). The instrument of qualitative research is the researcher and therefore the role is involved and active. This participatory method, whereby the researchers and subjects more openly interact, is frequently employed by feminist social scientists (Belenky, Goldberger, & Tarule, 1986; Maguire, 1987; McNamee, 1988; Roberts, 1981). According to Gergen and Gergen (1991),

The foremost feature of this type of work is the sharing of power between researchers and subjects in order to construct meaning. 'Subjects' become 'participants', and the number of interpretations (or theoretical possibilities) generated by the research is expanded rather than frozen. (p. 86)

Thirdly, with the view that multiple realities exist, truth or reality is a matter of perspective (Gergen, 1992). Different positions in time and space will yield different
views. The emphasis is more on validity issues than reliability. In the phenomenological tradition (Berger & Luckmann, 1967; Schutz, 1967), different people see events, situations, and contexts in various ways that indicate their unique vantage points or life experiences (Lawson, 1985). Our taken-for-granted assumptions or fore-structures (Addison, 1989) influence what we see and how we choose to talk about it. Examining basic assumptions is a key component of postmodern thought which invites the investigator to take account of the historical circumstances of his/her inquiry. What are the roots of the preferred discourse, what are its limits, what patterns of culture does it sustain, what does it discourage? Critical self-reflection is essential for the postmodern scholar. (Gergen, 1992, p. 24)

In naturalistic inquiry, reflecting upon how embedded assumptions impact our perceptual field becomes a critical element for all participants, including the research investigator.

Family process research invites the consideration of "client reflexivity" (Rennie, 1992), a concept that encompasses client self-awareness and action stemming from that self-awareness.
Unless research strategies are used that access this reflexivity, the researcher's understandings of clients' processing will be either incomplete or misguided. Although it has limitations, as we have seen, the technique of securing participants' reports of their covert (unspoken) experience of therapy is a considerable advance over the more conventional approach of simply analyzing discourse and/or its paralinguistic features. (Rennie, 1992, p. 227)

Studies have developed methods to give the participants' voices greater emphasis in the write-up of that research (Woodbrooks, 1991). Utilizing client feedback regarding how they experienced therapy and research was a significant source of information in this study.

Given the belief in multiple realities, qualitative research is seen as a useful mode of inquiry, as is quantitative research. The research question and the research context indicate in large measure which methodology and paradigm to use (Brotherson, in press; Ferguson, 1993; Stainback & Stainback, 1984).

**Assumptions**

Research (like theorizing or doing therapy) embodies assumptions regarding the way the world is and how it operates. The researcher makes certain choices about what topic(s) to investigate, what questions to ask, and which
systems of investigation to employ. These decisions are considered before the research activity begins. Goetz and LeCompte (1984) explain, "Although the influence of researcher role on the generation and refinement of theory thus is addressed occasionally, what commonly is ignored is how theory informs the investigator's choice from the range of roles available" (p. 57). We cannot get away from assumptions--nor should we. It is important that these assumptions be acknowledged so that the reader can examine the orientation of the researcher and the context of the research (Acker, Barry, & Esseveld, 1990).

This research is organized around the idea that families (and in particular, families who come to family therapy) have abilities to adjust their lives in ways that solve/resolve problems and that these families have abilities to assist others. Indeed, to build families into the therapy team format demonstrates a belief that families (even those in distress) have the ability to help themselves and others. In terms of this research, viewing the helper-helpee relationship as a one-way interchange whereby the helper gives something to the helpee and the helpee merely receives seriously oversimplifies the process; both parties in this interaction benefit. This research investigates the mutual benefit of this relationship. The relationship is more collaborative and mutual--each party gives and each party receives. This
research has assumes that people are capable and ready to extend help to others if the conditions are safe and secure. This research project was designed to gather information about social interaction, that is, the world of shared meanings among people. Mennell (1974) defines the phenomenological idea of "intersubjectivity" as "how we understand each other and how we come to have similar perceptions and conceptions of the world" (p. 46). Shared conventions of understanding, as well as the ongoing development of joint meaning and action, are primary sources of data. Working in the realm of meanings precludes an essentialist world view that incorporates analysis for the purpose of confirmation/disconfirmation. Expressions of participants in this study were elicited with a working understanding that such expressions are situated in contexts that have multiple meanings and interpretations. Data and analyses in this project were considered exploratory and generative of theory rather than reflective of essential and universal truths.

**Purpose**

Family therapy values clients' participation. Clients provide not only the content but also the context and texture surrounding their lives and dilemmas. They have an explicit voice in both the form and process of the therapy in which they are the central figures. This study structures a key
role for the families in the therapeutic process of family therapy, a role that has typically been reserved for trained psychotherapists. The purpose of this study was to allow families (nonprofessionals) to occupy roles or positions in therapy that were heretofore the domain of therapists and to elicit the participants' perceptions of that experience. This research seeks to answer the question: To what extent is this role useful and helpful for the family therapy process and for the participants themselves?
CHAPTER III

STUDY DESIGN

Freud employed a perplexingly simple way of finding out why people acted and thought or felt the way they did. He asked them.

--Renata Tesch, Qualitative Research

Sample

This qualitative study was designed to provide a structure for therapy that gave clients opportunities to contribute positively to the therapy experiences of other clients, while simultaneously providing new opportunities in their own therapy experiences. The families who participated in this study were facing serious interpersonal issues that merited careful attention to insure that the study did not impair their efforts to achieve their therapeutic outcomes. Beyond this basic concern to protect therapy interests, this study intended to expand their therapy experiences by allowing families to join each other in their processes of therapy.

The methods used to conduct this study were selected to facilitate the acquisition of descriptive data from the participants (Lincoln & Guba, 1985; Tesch, 1990). Providing structures that encouraged the participants to speak openly
and from their own experience were primary objectives (Apter, 1993; Williams, 1991).

The study protocol was designed as an adjunct to therapy that was already in progress. A "purposive" sampling procedure (Lincoln & Guba, 1985; Patton, 1980) was used to locate and enlist families engaged in family therapy. "Purposeful sampling is used as a strategy when one wants to learn something and come to understand something about certain select cases without needing to generalize to all such cases" (Patton, 1980, p. 100). The families included were those the researcher believed would provide significant information. Families who were facing serious problems at the time of the study were selected over those families who were not so urgently stressed. This study purposefully sought "critical cases" (Patton, 1980) to see if this therapy design (ongoing therapy in conjunction with the study protocol) would have a significant positive impact on cases that were therapeutically complex and difficult to create or stimulate behavior change.

Families chosen were matched with another family in terms of the types of problems they were experiencing and the structural configurations of their families. The study included two pairs of families who were matched on these qualities. The study design anticipated the need for the families to be significantly similar in order for the families
to see one another as credible commentators on their personal situations. If they were too different, they would not likely listen with interest or sincerity to one another. On the other hand, families who were too similar could be unremarkable to one another due to their not saying or might be perceived as not having anything new or different to contribute.

The combination of this multiple family interaction with the ongoing therapy was not done with the intent of testing the multiple family interaction component against the ongoing therapy or any other type of intervention. Rather, the format was designed to provide an additional experience in the context of family therapy that could be described by the participants. To do this with the therapy experience already in progress respected the clients' rights to therapy. At the same time, it provided valuable insights regarding the usefulness of this component.

Prior to the development of a study sample, approval for this study was obtained from the Iowa State Human Subjects Committee. Before the study, informed consents were obtained from each participant (see Appendix A). Since the participants included clients and therapists from a social agency, written permission from that agency was also secured.
The first step in the process of selecting the sample was to find a therapist (or therapists) who would be willing to participate in the study and include families from his/her caseload. The researcher was a supervisor of several in-home family therapy programs within a social service agency in a medium-sized metropolitan area in the Midwest. Two of the therapists who worked in these in-home programs had been colleagues of the researcher for three years, having attended the same doctoral program and then worked in programs under his clinical supervision. These therapists were invited to participate in the study with the understanding that to decline the offer would not be negatively regarded. Both therapists agreed to participate and were reasonably optimistic that they had families on their caseloads at that time who would likely consent to participate.

Using two therapists provided more variety of experience and feedback than using one. The therapists were also considered to be participants in this study. Their feedback regarding their perceptions of how this protocol affected their clients, the therapy process itself, and themselves as therapists were all important data that the study generated. With both therapists (and the researcher) working at the same agency, the facilities required for the study were readily available and easily accessed. The agency administration
agreed to participate in this study by providing their facilities (offices, therapy rooms, and videotape equipment) as well as allowing access to their clients. The use of the therapy room, observation room, conference room, and the videotape equipment were arranged during evening times and on Saturdays, which provided minimal disruption to the agency's functioning while providing maximal conditions for conducting this study. The times selected for the study were also convenient for the participating families and therapists.

**Therapist Profiles**

Therapist A had two years of experience in practicing marital and family therapy in a university family therapy training clinic, in a community-based group home, in an employee assistance program, and in his current position as an in-home family therapist working with multiproblem families. Therapist A had worked in an in-home family therapy program under the supervision of the researcher for four months at the time of the study. The specific program that he worked in provided in-home family therapy to families facing serious problems with their children, whether it was due to abuse, neglect, or behavioral disruption of another variety--problems that often lead to removal/placement of one or more of the children. The population of clients was diverse and the
families were usually court-ordered to participate. Therapist A's caseload included ten families and it was customary for him to spend one to three hours per week working with each of his families.

Therapist A had recently received his master's degree in Human Development and Family Studies and was completing his doctorate in the same department's Specialization in Marriage and Family Therapy (an American Association for Marriage and Family Therapy Accredited Program). His therapeutic style was systemic, with a particular interest in structural family therapy. He was eager to participate in the study, seeing a potential for the study protocol to help refocus his work with two families whom he felt were at an impasse in therapy.

Therapist B had five years experience doing marital and family therapy in university therapy training clinics, in an employee assistance program, and in her position as an intensive in-home family therapist at the time of the study. Therapist B had a master's degree in Counselor Education and was completing her dissertation for a doctorate in Human Development and Family Studies with a Specialization in Marriage and Family Therapy (an AAMFT Approved Program). Her therapeutic orientation was systemic, but she was also interested in narrative approaches to family therapy.
Therapist B strongly valued, and reinforced, the capabilities/strengths of her clients, which fit well with the research design.

Therapist B worked in an intensive in-home family therapy program designed for families with a child between the ages of eight and twelve who had been arrested for a first-time delinquency. The family was offered this in-home service at no charge to help address any problems that may have contributed to the child(ren) getting into trouble with the law. Therapist B had a small caseload of five families, which protected her ability to be available to the families as often as was needed (typically five to ten hours per week). She had been working in this program four months under the researcher's clinical supervision.

Family Profiles

After these two therapists had agreed to participate, two questions arose. First, did they have families on their current caseloads who would be willing to participate with the conditions of this study? In the development of the initial proposal for this study, the researcher was concerned about finding families who would be willing to have another family in therapy observe (and comment on) their therapy. The issue of privacy represented a tangible, real obstacle to getting a
sample for the study. This question would only be answered at
the juncture of the study when families were approached
directly. Second, if these families were willing to
participate, would their participation in any way jeopardize
their therapy process? Related to this second question, would
it be reasonable to anticipate that participation in this
study might enhance the on-going therapy? If it was possible
for the therapy process to be compromised in any way, those
families would not be included in the study.

Two pairs of families were built into the design. With
two therapists involved in the study, a pair of families from
each therapist were selected. Having the same therapist work
with each pair of families simplified the design and provided
the interesting situation where a family could see (and
comment on) their therapist working with another family.

*Therapist A* had two families on his caseload with similar
situations. He felt that the therapy process was at a virtual
standstill for each of them. He had been working with each
family for two months and he viewed the prospect of including
these two "stuck" families in the study as a potential means
of getting therapy moving on a productive basis again.

*Therapist A* had developed a good rapport with these two
families and they trusted his judgment. When he discussed the
possibility of enhancing therapy by participating in this study, they accepted the offer. The therapist discussed the study with the families prior to the researcher's involvement. After the initial positive response, the researcher talked directly with the families (see Procedures Section).

Each family had an adolescent male who was behaving in a defiant manner with his parents. One family was composed of a mother and a stepfather, with five children. The eldest son (age 14) had become unwilling to obey house rules, refused to return home at curfew, was failing school, and would leave home for several days without parental permission.

The parents were divided regarding how to handle the boy. The mother tended to be lenient and forgiving. The stepfather tended to be firm and unforgiving. A self-report questionnaire (FACES III) filled out by the mother and the stepfather as part of this study indicated considerable divergence of opinion on numerous marital and parental issues. The son's time out on the street by himself worried the parents. They feared for his safety, a point that they tried to impress upon him, to no avail. The therapist's efforts to reach agreements between the son and the parents regarding his behavior were only occasionally fruitful and a pessimism was setting in regarding whether or not any long-term success would/could be reached. In the other family, a 13-year-old
male (oldest child of four) was also increasingly defiant of his parents. His defiance over house rules and school performance was demonstrated by verbal and physical threats. His mother and younger siblings were afraid of him when he got angry. The father would respond physically, risking abuse charges. Their inability to get the boy’s behavior into an acceptable range was leading to significant dissension between the parents. A self-report questionnaire (FACES III) filled out by these parents showed considerable amounts of cooperativeness between them on a number of marital dimensions. This couple tended to work together successfully most of the time. The trouble with their son was an exception and consequently acted as a serious stress in their relationship. In both families, the parents and the therapist were feeling rather hopeless in their efforts to encourage appropriate behavior in the “problem sons.” In both families, the problems they were having with their sons had been gradually worsening for the last several years and the stress was high. The families’ coping resources were in short supply and the next step would likely be placement of the boys outside the home.

When Therapist A and the researcher discussed these two families and their appropriateness for this study, a significant issue emerged, that is, whether or not the problem
sons would be willing to participate in these sessions. Defying their parents seemed likely to show itself by not participating in this study (at least on any regular basis). Given this, the researcher suggested to the therapist that both families be represented by the parents only. The researcher had just secured two families (parents and children together) to participate from Therapist B's caseload. With a pair of families already enlisted, coupled with the situation with the often-absent-from-therapy problem sons on Therapist A's caseload, the researcher seized the opportunity to work with two pairs of families with differing configurations—a pair of families with children included in the study and a pair of families where the children were not included. The therapist was in agreement with this arrangement and the two sets of parents agreed.

Therapist B was working with two single-parent families whom she thought would be appropriate candidates for the study. One of these families had been working with the therapist for three months. This family of eight children was headed by a single mother in her mid-thirties. They were dependent on welfare for their financial support. Five of the children were male (ages 19, 18, 17, 13, and 4) and three were female (ages 16, 9, and 5). The mother was Caucasian and her
children were biracial (Afro-American and Caucasian). The identified child was the 13-year-old male. He had been caught stealing with some other boys, which brought him to the attention of the juvenile authorities. The mother had difficulties disciplining the children. A self-report questionnaire (FACES III) indicated considerable disagreement regarding leadership in the family, especially when it came to issues of rules and consequences. She had little or no adult support and no extended family nearby. She tried to improve her life and the lives of her children by getting her high school equivalency certificate, but found it hard to make time for that given all her other responsibilities.

The therapist worked primarily with the mother and the 13-year-old son. Some progress had been noted, particularly in his school behavior and the mother’s ability to try new parenting tactics. These improvements were in their infancy and tended to fade during times of stress. The magnitude and variety of pressures/stresses on this family were high and precluded any easy or brief style of intervention. Particularly troubling was the serious lack of financial resources.

Another family on Therapist B’s caseload was an Afro-American family consisting of a single mother of two boys, ages 9 and 8. The 9-year-old was the referred child; he had
committed a delinquent act with some other boys in his neighborhood. His 8-year-old brother had a muscle disorder and used a wheelchair. The mother had an abusive boyfriend who occasionally threatened and assaulted her. The sons were aware of this. Self-report questionnaires (FACES III) indicated some differences of opinion regarding who was in charge of this family. The children felt less sure that mom was in charge than she did. Therapist B had just begun therapy with this family but the similarity in family form (single mother, problem son, low income, mothers similar in age) provided the impetus to include them together with the other family. The therapist thought that if this family agreed to participate, the therapeutic process could be accelerated. It was hoped that the intense experience resulting from participation in this study would hasten rapport development and get them involved with the therapy faster than was typical. This family agreed to participate.

Discussions with the mother of the eight children, the therapist, and the researcher indicated that not all of her children would be interested and consistently cooperative in the study. It was decided to include her 13-year-old son and 9-year-old daughter. This provided a matching configuration with the other family—a mother with two children.
The children in these two families exhibited a sense of excitement and adventure regarding the study, especially the one-way mirror, the videotape equipment, and the idea of meeting another family in some ways similar to their own. The mothers had a sense of pride in participating, knowing that they had been chosen for this study. The researcher was acquainted with the family with eight children for several months prior to the study through his supervision of Therapist B.

The therapists continued to see the families in the clients' homes per their typical protocol. The study sessions were in addition to the therapy already in progress.

**Debriefer, Auditor, and Researcher Profiles**

A peer debriefer met with the researcher following each session. Initially this debriefer was an in-home family therapist at the same agency and in the same program as Therapist B. After the first such debriefing, time constraints made it impossible for him to continue these debriefings so Therapist B became the debriefer of the researcher following each session of both family pairs for the duration of the study.

This debriefer asked open-ended questions to elicit the researcher’s impressions of the preceding session, including
both content and process. These debriefings lasted 30 to 45 minutes and were videotaped. Given the debriefer’s connection to the study as one of the therapists, the debriefings of the researcher in regard to the families of Therapist B developed a quality of mutual debriefing—almost a case consultation. The researcher and the therapist mutually discussed that day’s session.

The researcher’s major professor served as a dependability auditor (Guba, 1981), overseeing the entire study. He was chosen because of his considerable experience in directing numerous qualitative research projects. He monitored the process of the research in terms of its conformity to generally accepted practice in qualitative research.

The researcher’s role in this study could be more aptly described as a set of roles. He organized and orchestrated the sessions, managed the conversation behind the mirror (much like a therapist), helped occasionally in the process of one family giving feedback to the other, ran the audio and video equipment, debriefed the families and the therapist after each session, transcribed the audiotapes (with assistance from Therapist B), and performed the qualitative analysis of the data. The performance of these various functions promoted a
continuity in how the sessions were conducted, which may not have been present if different people performed each task. Consequently, the families were only exposed to the researcher and the other family (in addition to their therapist), which minimized their anxiety of meeting many new people.

The researcher had been a marital and family therapist for 18 years, working in agencies, hospitals, and in private practice. Prior to this research, he participated in numerous research projects as a subject, an interviewer, and as an analyst of data. The researcher theoretically aligns with the tenets of social constructionism (Gergen, 1992), particularly the emphases on multiple realities of experience and the interpersonal configuring of realities. Hence, the study design is heavily weighted to highlight the clients’ experiences as they report/reveal them.

Procedures

The steps in this study are listed and discussed in detail below. See Figure 1 for an overview of the steps.

Meeting the Prospective Families

After a family was considered as a candidate for the study by the researcher and the therapist, the therapist discussed the idea with the family and gave them a handout
Procedure

Session 1

Family therapy interview with Family 1 while Family 2 observes from behind the mirror

Family 2 gives feedback to Family 1

Family therapy interview with Family 2 while Family 1 observes from behind the mirror

Family 1 gives feedback to Family 2

Debriefing of families and therapist

Debriefing of researcher

Session 2

Same protocol as Session 1

Session 3

Same protocol as Sessions 1 and 2

Follow-up Interviews

Figure 1. Procedure used to study families as therapeutic teams in family therapy.
that briefly described the study (see Appendix B). If the family was willing to participate, the therapist introduced the researcher to them and any further questions were answered. The four families chosen all consented to participate. After they consented to participate, the families were notified that a stipend of $50 would be given to them for their participation in the study.

For clarity in this narrative, the pair of families represented in this study by just the parents will be referred to as Family Pair A while the families in the study headed by a single-parent will be referred to as Family Pair B. (Note that Family Pair A worked with Therapist A and Family Pair B worked with Therapist B.)

The design within each session varied somewhat between Family Pair A and Family Pair B. The therapists and the families were given the prerogative to make adjustments within their sessions to best accommodate the needs of their therapy. If the exigencies of a therapy interview indicated alteration of how families gave feedback to one another, how long the interviews lasted, or other structural or procedural elements, the therapist was guaranteed the latitude to proceed as he/she saw fit. This also resulted in changes from session to session for each Family Pair. The term “session” refers to
both therapy interviews that took place sequentially with each family, the debriefing of the families following the therapy interviews, and the debriefing of the researcher. The term "interview" refers to each family's therapy experience during a given "session." There were two family therapy interviews in each session—one with each family. The phrase "behind the mirror" is used to refer to the observation room; the phrase "in front of the mirror" refers to the therapy room. The "observer family" is the family observing therapy from the observation room; the "therapy family" is the family in therapy in the therapy room.

Because there were adjustments made by each family pair within their sessions, between their sessions, and as compared to the other Family Pair, the following section will be a detailed description of the sequence of events that took place in each session with each Family Pair.

**Beginning the Sessions**

Both pairs of families started at the same time and their sessions ran concurrently. Each Family Pair's sessions were run independently of the other Family Pair's sessions. The families in Family Pair B did not have their own transportation so the therapist transported Family 1 and the researcher transported Family 2 to each session.
Family Pair A

Session 1

*Family Pair A* began with the two families being introduced to one another. The researcher, therapist, and the families engaged in small talk to diffuse some of the anxiety. The families were given a tour of the facilities--the therapy room, observation room, and conference room. Each participant read and signed the consent forms for participation in the study.

Participants were asked if they had any questions before beginning the session. Since no questions remained, the session began by having the families decide which family would be in the therapy room first. One family volunteered to begin and the other family joined the researcher behind the mirror.

The video camera was positioned in a stationary place in the therapy room and was activated by the researcher when the therapy interview began. The researcher started the audiotape situated behind the mirror when the family entered the observation room. The tape ran continuously until the observers left the observation room. A speaker was positioned in the observation room that allowed the observers clearly to hear the conversation in the therapy room.

The observation family was given instructions about how to listen and give feedback to the family they were observing.
The following is an example of what was told to the observation families.

The point is to try to understand things from their point of view. Then think of some things that you might be able to say in a positive way that might give them some encouragement or maybe even a new view. Try to frame your comments in a positive way rather than being critical. We’re looking to get some understanding from your point of view. Try to figure out some way to offer something that might be helpful. Whatever that is--it’s up to you. You know your situation--what’s similar about theirs and what’s special about yours.

They were encouraged to phrase their feedback in positive language--to express their ideas in ways that, if they were on the receiving end, they would understand and accept. This was not designed to be a critical or negative review of each family, but rather a supportive/hopeful process that conveyed respect (Andersen, 1987). The families were free to comment on whatever they were thinking about behind the mirror as they watched the other family’s therapy. This did not need to be limited to what was going on in the room, content-wise--it could include any thoughts, feelings, or reflections that occurred (Andersen, 1987). In actual practice, the observer families stayed focused on the content of the other family’s
situation as indicated by the feedback they provided to the therapy families.

No plan had been prearranged between the researcher and the therapist regarding how or when to switch the families from one side of the mirror to the other. It was generally understood that the therapy session would run between 30 and 45 minutes. The researcher decided to have the observer give feedback after 30 minutes to allow time for these comments before the second therapy interview. The therapist discussed with the family in therapy, as well as with the observer family, some possible formats for the observer family to give their feedback. The participants requested that the observer family speak directly to the therapy family in the therapy room. The researcher wanted to give the families decision-making responsibilities regarding the specific format used to give their observations/feedback in order to facilitate their giving of feedback. The structure of how they gave feedback was a crucial element in this process. The researcher anticipated that several different formats would be used in the course of the three sessions, given the changing circumstances of therapy. The observer family made some comments based upon what they heard/observed. The family in therapy received the feedback regarding their therapy interview and responded to the feedback, and a discussion
ensued. The researcher operated the video camera during this discussion process, moving it to capture the discussion better than if it were fixed in one position. After 10 minutes, the researcher stopped the conversation (and the videotape) for all to take a short break. All the participants left the therapy room and some refreshments were served.

The families switched positions. The family who had observed, went into the therapy room with the therapist while the other family went behind the one-way mirror with the researcher. The videotape in the therapy room and the audiotape in the observation room were started. After 30 minutes, the family behind the mirror and the researcher went into the therapy room and the observer family offered their observations and engaged in a dialogue with the therapy family and the therapist. While these families and the therapist talked, the researcher controlled the video camera. Occasionally the researcher would ask questions of the participants from his position as video camera operator. After 15 minutes of conversation, the researcher closed the discussion and the participants took a brief refreshment break.

The participants reassembled in a conference room adjacent to the therapy room. All participants (both families, their therapist, and the researcher) sat around a
table and discussed what the experience of that night's session was like for each of them. This debriefing conversation was audiotaped. The researcher focused the conversation on the participants' perceptions and feelings about the process of the study as they had just experienced it. Occasionally, the conversation centered on the specific situations that led them to therapy or discussions that were continuations of the kind of dialogue that had taken place in therapy, but the researcher steadily refocused the discussion onto the particulars of how they felt about the format of the therapy experience that they had just completed. After 20 minutes, the researcher brought this debriefing process to a close and arrangements were confirmed for the next session, one week later.

The therapist continued to see the families as he normally would throughout the intervening week until the next session. He usually met with the families two or three times per week in their own home.

Session 2

*Family Pair A* returned the next week as had been pre-arranged. One of the families brought three of their children because their baby-sitter canceled at the last minute. The children played in an adjacent conference room (which had hastily been transformed into a play room), but periodically
the children, squabbling with one another, interrupted the session. This distraction irritated the parents who occasionally stopped their therapy (or their observing behind the mirror) in order to attend to the children's arguments.

The family who started in the therapy room first at the last session began as the observer family for the second session. After 30 minutes, the researcher and the observer family came into the therapy room. The researcher requested that the feedback be given in a specific format—one in which the observer family discussed their observations with the researcher while the therapist and the family in therapy watched from behind the mirror. Providing a different format for giving feedback presented the families with two different feedback formats to compare. The families and the therapist agreed to this format. The family in therapy along with their therapist went into the observation room while the observing family and the researcher talked in the therapy room about what they had just observed. The therapy family and the therapist listened from the observation room with no pressure or mandate to respond to the comments of the observer family. This format more closely resembles Andersen's (1987) "reflecting team" process. After 10 minutes of this reflecting format, the participants switched back to their starting positions (with the therapist and the first family
back into the therapy room, and the observer family once again
behind the mirror with the researcher). The therapist and the
family in the therapy room then discussed the reflections that
they had just heard. They gave their “feedback-of-feedback”
while the family behind the mirror listened. This lasted 10
minutes followed by a short break.

The family who had been observing then met with the
therapist for their therapy interview while the other family
moved behind the mirror with the researcher. After 30
minutes, the observer family and the researcher entered the
therapy room and joined the therapist and the other family.
The families requested that feedback be given face-to-face,
with all participants together in the same room. This
feedback discussion took 15 minutes after which a short break
was taken. The debriefing interview took place in the
adjacent conference room in the manner outlined in the first
session debriefing process.

**Session 3**

A third session took place one week following the second
session. The family in Session 2 who started their therapy
interview first also started first in Session 3. The other
family was behind the mirror with the researcher. As before,
after 30 minutes the observer family went into the therapy
room and discussed their observations with the family in the
therapy room for 15 minutes. After a short break, the families switched places. After 30 minutes of the second therapy interview, the observer family came into the therapy room to offer 10 minutes of feedback. When this ended, the families and the therapist joined the researcher for a debriefing of this session. This lasted about 30 minutes and the stipend for the study was given to each family. The families were asked to be available in about a month for a follow-up session to discuss the entire study from their perspectives. The day and time for this follow-up was finalized in a few weeks by communication through their therapist.

Follow-Up Interviews

The follow-up interview was scheduled to take place approximately one month after the third session. Each family was seen separately because of scheduling difficulties. These separate interviews provided an opportunity to say things that might have been uncomfortable to say (and maybe were therefore unsaid) in front of the other family. There was no indication that there were such items but the format of seeing each family separately provided the opportunity for such comments, should there be any. In each follow-up interview, their therapist was present with the researcher. One of the families was interviewed for the follow-up session in the
conference room where the study debriefings had taken place while the other family was interviewed in their own home. These interviews lasted 45 minutes and were audiotaped. At the end of this follow-up interview, the families were asked to be available for further questions from the researcher as needed. These questions were asked by phone or were written. Both families agreed.

Family Pair B

Session 1

The first session with Family Pair B had to be postponed due to a sudden crisis in one of the families. The session was re-scheduled and took place later in the week.

Similar to the process with Family Pair A, the two families in Family Pair B were introduced to each other, some casual talk occurred in order to help the families relax with each other, and the families were shown the therapy room, observation room, and other facilities on the premises. The children were particularly intrigued by the one-way mirror and the video camera. All participants were reminded of the study’s protocol and given informed consent forms, which they signed. The two families were allowed to decide which of them would start behind the mirror and which would start in the therapy room with the therapist. The family with the son and
daughter present volunteered to begin in the therapy room. The family with two sons went behind the mirror with the researcher. After 30 minutes, the therapist stopped the interview, and had the two families switch places—the therapist and the family in therapy went behind the mirror and the observer family and the researcher came into the therapy room to give their observations. After 10 minutes, the families switched back to their original positions and the therapist and the family in therapy discussed the comments on their therapy offered by the observer family. After 15 minutes of discussion, the therapist halted the interview and a short break with refreshments was taken.

After the break, the family who had been observing behind the mirror went into the therapy room with their therapist and the other family took the position behind the mirror with the researcher. After 30 minutes, the therapist asked the observer family to come into the therapy room, and at the request of both families, the feedback by the observer family was given directly to the family in therapy. (The therapist agreed to this, as did the researcher.) The feedback led to a conversation between the two families that lasted 20 minutes until the researcher suggested a break. The families had some refreshments and then all participants reconvened in the conference room adjacent to the therapy room for a debriefing
interview. This interview was audiotaped. The next session was scheduled for a week later.

On the scheduled day for Session 2, one of the mothers was very ill and the session was postponed. When the session took place a few days later, both mothers were mildly ill, but they agreed to meet. Baby-sitting problems meant one of the mothers had to bring two of her younger children (ages 4 and 5). The children's attention span was short and they were a distraction for part of the session.

Session 2

The family who began Session 1 in the therapy room began Session 2 in the same position. After 30 minutes, the families switched positions, with the observer family talking with the researcher while the therapy family and their therapist listened from behind the mirror. After listening for 10 minutes, both families met together in the therapy room to discuss the feedback just given. This conversation lasted 20 minutes and then a break was taken. The session resumed with the family who had been observing taking their position in the therapy room with the therapist, and the other family joining the researcher behind the mirror. After 30 minutes, the observer family joined the therapy family in the therapy room and gave their feedback directly. The feedback to the other family evolved into a discussion and then into a
debriefing conversation. The families moved so smoothly into a debriefing discussion of this session that the researcher did not insist on breaking into the adjacent conference room as had been previously done. The videotape captured this debriefing process. A third session was set for one week later.

**Session 3**

Session 3 occurred as scheduled, but the family with two sons did not bring the son who was disabled. The reasons given for his absence were his failure to do his homework combined with his not wanting to come. The session started with the family with one son present in the therapy room with the therapist and the other family behind the mirror. After 30 minutes, the observer family and the researcher came into the therapy room to discuss their observations. After 10 minutes of this discussion, a short refreshment break was taken. The families switched positions and the therapy interview began. After 30 minutes, the observer family came into the room and a discussion occurred among all the participants. This conversation lasted 15 minutes, followed by the participants' move into the conference room for a debriefing conversation. The stipends for the study were given to the mothers.
Follow-Up Interviews

A follow-up interview was scheduled for four weeks following the final therapy session. The researcher and therapist had a follow-up interview with each family separately. These sessions were held at the office where the research sessions were conducted. They were audiotaped and each lasted 30 minutes. Pizzas were served as perceptions of the experiences in this study were discussed. Permission was requested to have further contact with the families, by phone or in writing, to help clarify the write-up of their experiences. Both families agreed.

Data Collection

Data were collected from conversations behind the one-way mirror while watching the therapy interviews in progress, the family therapy interviews, debriefings at the end of each session, researcher debriefings, and follow-up interviews after the sessions were completed.

The behind-the-mirror conversations, the debriefings at the end of each session, and the follow-up interviews were audiotaped. The audiotaped conversations were all transcribed. The behind-the-mirror audiotapes included the conversation that went on behind the mirror as well as a background conversation of the talk in the therapy room, which was broadcast behind the mirror for the observers to hear. At
times, it was difficult to separate the two conversations so the researcher, assisted by a Therapist B, transcribed all the audiotapes rather than relying on an outside transcriber. The researcher’s presence when the audiotaping occurred provided sufficient knowledge to distinguish the various speakers and what they were saying. The context and non-verbal dimensions of the behind-the-mirror conversation that were remembered by the researcher further aided in the transcription process. The debriefings following each session were transcribed by the researcher and Therapist B due to the multiple voices and conversations on the audiotape.

The therapy interviews were videotaped, but those videotapes were not transcribed. Instead, the therapist and the researcher reviewed each videotape independently and made notes throughout regarding what was being discussed in a paraphrased fashion. This process allowed the notes to reflect not only the words spoken but many analogical (non-verbal and contextual) markers that are more defined on a videotape than an audiotape (Acker, Barry, & Esseveld, 1991; Angus & Rennie, 1988; Bottorff, 1994).

The researcher debriefings were videotaped for later review and provided perceptions of the sessions at the time they were happening. These debriefings were reviewed by the
researcher to detect larger themes and patterns of the sessions.

Conversations with the therapists that occurred throughout the study were recorded in notes made by the researcher. A slightly modified version of Tesch's "Steps for Developing an Organizing System for Unstructured Qualitative Data" (1990) was used to analyze the transcriptions and videotapes (see Analysis).

**Analysis**

The analysis of qualitative data is an ongoing process (Erlandson et al., 1993) that begins in the data gathering phases and continues throughout the write-up (and beyond). Marshall and Rossman (1989) explain data analysis as "the process of bringing order, structure, and meaning to the mass of collected data" (p. 112).

Tesch (1990) describes the common ground shared by qualitative researchers to rest on "the process of making sense of narrative data" (p. 4). Analysis seeks to locate themes within the narrative information.

The value of narrative data stems from the phenomenological approach to studying social interaction. A key assumption in phenomenology is the notion of "subjectivity" in human interactions. Subjectivity focuses on "how those concerned with objects--subjects--come to see and
confront aspects of experience as things separate from themselves" (Gubrium & Holstein, 1993, p. 654). The emphasis is on treating "all persons, common and celebrated, as epistemologists" (Gubrium & Holstein, 1993, p. 654).

Understandings of the therapy experience vary between people, between therapist and client (Caskey, Barker, & Elliott, 1984). Applying this approach to research, Tesch (1990) portrays phenomenological researchers as "interested in the way people experience their world, what it is like for them, how to best understand them" (p. 68).

Once collected, these narrative data were analyzed according to systems of analysis designed to capture themes or general statements that help to understand the respondents. This study incorporated an organizing scheme (Tesch, 1990) that is straightforward in its approach to organizing "unstructured qualitative data" (narrative data). The steps for developing an organizing system for unstructured qualitative data are briefly outlined:

1. Familiarize yourself with the data as it arrives.
2. Select a data document and pick out the main ideas or topics (don't try to capture everything).
3. Make a list of topics for each data document and compare topics across the documents. Compose three new lists:
   (a) Topics that are similar.
(b) Topics that are unique.
(c) Leftover topics.

4. Form a preliminary organizing system from the list of similar topics and the list of unique topics. Create code words for these topics and place these codes by the appropriate sections in the original documents. See if the codes cover things adequately, make necessary changes, and use this coding system on new data.

5. Make three new lists:
   (a) Topics that have occurred in all data documents
   (b) Unique topics in terms of your research purpose
   (c) Least important topics
Relate topics to each other (if possible) to form categories.

6. List topics within each category (topics can appear in more than one category). Code the text by category codes.

7. Pull out all text fitting under each given category. Summarize the content for each category. Look for commonalities, differences, contradictions, or missing information.

8. If recoding is necessary, make those revisions and apply to new data.

Patton (1980) states that "each qualitative analyst must find his or her own process" (p. 299) and in this regard, this research was no exception. Tesch’s steps for developing an
organizing system were modified to fit this study (St. George, 1994). The topics were grouped into categories that fit into two broad classifications: Major Categories and Minor Categories. Major Categories were those that occurred consistently in all the data and were influential in the interactions examined in this study. Minor Categories were less influential in the study or limited to certain data documents.

The data were in the form of audiotapes and videotapes. The researcher was present when all of these tapes were recorded. In addition to the recordings on tape, the researcher also had first-hand experiences of the material/activities that were recorded. This was a factor when the researcher was involved in working with the tapes. He recalled thoughts/feelings associated with those events that may or may not have been captured on tape.

The researcher (with the assistance of Therapist B) transcribed the audiotapes following the third sessions. In terms of the tapes of the behind-the-mirror conversation, the researcher was the only person who could reliably discriminate the voices on the tapes as to whether they were part of the talk behind the mirror (of which he was a part) or part of therapy room conversation that was broadcast into the observation room through a speaker. The complication posed by
separating the two conversations was offset by the rather serendipitous good fortune of having the two conversations linked on one tape. The simultaneous conversations could be examined precisely as they occurred in time. The videotapes of each therapy session were reviewed independently by the researcher and by the therapist involved, with notes being taken that captured the process and content of the video.

The researcher became familiar with the data as he (a) listened to and recorded the data as it was presented, and (b) transcribed the audiotapes and made notations from the videotapes. After the transcriptions were made, the researcher, as suggested by Tesch, read through each transcription and noted in the margins what the passages or narrative sections were about. Rather than the precise content, the "topic" of the content was noted. This process of streamlining the text did not remove ideas or content, but rather arranged the data into groups that clearly represented what that section of narrative was saying. For example, a section of transcript that revealed a mother and son arguing could be transformed into a topical statement that says "mother and son arguing." Unless the researcher was searching for a particular nuance of the argument, the topic "mother and son arguing" captured that passage.
In the case of the videotapes, topics were also generated, but in a somewhat different manner. Topics were generated while viewing the videotapes, not from reading the transcriptions of the interviews. Each therapist and the researcher performed this function independently. The lists of topics generated by the therapist and by the researcher were then compared and contrasted.

These lists of topics were arranged according to the document from which they were derived (see Appendices C, D, E, and F). A search was done to discover the relatedness of topics across documents. Similar topics were gradually grouped into clusters of relatedness and a phrase was chosen to represent the members of that “category.” These category names/phrases were applied to the original data documents to determine if they sufficiently captured the actual data. Refinements were made in the category names/phrases to better reflect the data that were members of that class or category of topics (See Appendix G). Because the data were collected from four families, two therapists, on ten separate occasions over a two month period, analysis also compared the data between the two family pairs, from session to session, and sequencing patterns of the data.
Trustworthiness

Qualitative research develops its trustworthiness by providing "truth value through credibility, applicability through transferability, consistency through dependability, and neutrality through confirmability" (Erlandson et al., p. 132). Each of these areas of trustworthiness will be addressed within the context of this study.

Credibility

Credibility refers to "the compatibility of the constructed realities that exist in the minds of the inquiry’s respondents with those that are attributed to them" (Erlandson et al., p. 30). The data in this study were collected in a continuous process of rechecking the meaning of that data with the respondents themselves. The conversations with the researcher behind the one-way mirror, the debriefing interviews at the end of each session, and the follow-up interviews constantly refined the researcher’s understandings and interpretations. In addition to these "member checks," all conversations were audiotaped (and some were videotaped as well) to provide mechanisms with which to check researcher interpretations. The researcher was debriefed following each session by a peer debriefer, which also provided a check on the researcher’s interpretations.
Transferability

This aspect of trustworthiness has to do with the applicability of research findings to other contexts or with other respondents (Lincoln & Guba, 1985). Naturalistic inquiry does not believe that true generalizations are possible and therefore establishes what is referred to as “transferability,” a process of scrupulously describing the context of the inquiry. “Thick descriptions” of the study’s content, process, and context allow would-be consumers of the inquiry to judge the applicability of the study for their purposes. In addition to thick description, this study included purposive sampling, which contributed to presenting a clear picture of the respondents who provided the data for this study. Through the analysis, care was taken to describe in detail the process of analysis and the findings of that analysis.

Dependability

Dependability seeks to establish consistency in its data. This concept includes the concept of reliability (error management) as found in the conventional science paradigm along with what Guba (1981) calls “trackable variance,” meaning those “variabilities that can be ascribed to particular sources (error, reality shifts, better insights, etc.)” (Erlandson et al., 1993, p. 34). An “audit trail” was
kept that outlined each step of the study’s process, including the analysis. An external “dependability auditor” monitored the study process.

**Confirmability**

Confirmability in naturalistic inquiry refers to the “degree to which its findings are the product of the focus of its inquiry and not of the biases of the researcher” (Lincoln & Guba, 1985, p. 290). The audit trail as described within the previous section provided an external auditor with the ability to “determine if the conclusions, interpretations, and recommendations can be traced to their sources and if they are supported by the inquiry” (Erlandson et al., 1993, p. 35).
CHAPTER IV
RESULTS

However earnest the attempt to tell what is the case, one can only write what one has the wit to see and say of it.

--Robert Kelly, *New York Times*

The formal analysis of the data began subsequent to the collection of the data, but ideas regarding how the data were meaningful began to develop while the study was in progress. The sessions with the families were exciting and there was a feeling of anticipation that the families, the therapists, and the researcher were doing something significant and special. There was an expectation that what we were doing was going to make a difference.

The debriefings of the researcher after each session provided opportunities to reflect upon the sessions in impressionistic and intuitive ways, which helped the researcher form ideas concerning the study’s progress and implications. Commenting on the salient occurrences from the previous session while the study was still progressing sparked ideas/insights that (a) assisted in modifying the study to describe the responses of the participants more accurately and with greater detail, and (b) helped in the subsequent analyses.
and interpretations of the data. Patterns of interaction were
discerned in these debriefings that were corroborated by the
data and formal analysis.

The data analysis system used was adapted from Tesch’s
"Organizing System for Unstructured Qualitative Data" (1990)
in order to create a categorization system that described the
data in a meaningful way. Four sets of data were
systematically analyzed using this categorization system. The
data consisted of (a) audiotapes of the conversations between
the observer families and the researcher, (b) audiotapes of
debriefings of all participants held at the end of each
session, (c) videotapes of the therapy sessions, and (d)
audiotapes of the follow-up interviews with each family. The
videotapes of the researcher debriefings were not formally
analyzed because the families were not present in these
interviews. The data were analyzed sequentially, beginning
with the recordings of the observer families’ conversations
with the researcher. The videotapes of the family therapy
interviews revealed the influence of the feedback from the
observer families on the therapy conversation and process.

Development of Topics and Categories

The first set of data processed was the behind-the-mirror
conversations. The transcriptions of the audiotapes were
read; the main ideas or “topics” of those interactions were
noted. Sometimes a single transcript entry received its own topic designation. On other occasions, an entire page would be grouped under one topic because that section of conversation could be considered as a meaningful whole. That interaction sequence could be described aptly under a single heading. These topics were noted adjacent to the entry or entries. The following excerpt from the transcription of a debriefing interview of *Family Pair B* illustrates this process.

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>CONVERSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moms see</td>
<td><em>Mother in Family 2:</em> I feel that even after this is over with, we could</td>
</tr>
<tr>
<td>themselves as</td>
<td>still be friends and get together.</td>
</tr>
<tr>
<td>on-going friends</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Mother in Family 1:</em> Even though it is confidential at the beginning, it can</td>
</tr>
<tr>
<td></td>
<td>still be confidential, but, as confidential as--like as two friends talking.</td>
</tr>
</tbody>
</table>

*Researcher:* The reason to have this be confidential is for the purposes of this study. You guys are not supposed
to talk about the other family outside of here. In three weeks time when we are finished with these meetings, then you are free to do whatever you want. If you maintain your contact, it is completely up to you. But for the purposes of this study, I just had to do that [take care of confidentiality] to make sure that you felt safe.

Mother in Family 2: Yeah, I feel safe. I feel like there's nothing in my, I mean, there's nothing in my life that I'm hiding--I don't have nothing to hide. My life is not an open book to everybody but with certain people I feel that, hey, I ain't got nothing to hide. I felt behind the thing [one-way mirror] that I felt like it was kind of spying. But I felt like it was okay to spy. And that it wasn't like we were ashamed to be seen through the mirror. Being on both
sides of the mirror, it felt like, um . . . On the other side of the mirror, where I was being talked to and being interviewed [by the therapist] was like, um, a better situation--I don't have the frustration like when I'm at home. It gave me a time away from home. I'm home 24 hours a day--till [therapist] takes me out.

Researcher: So maybe it's nice to get out of the house to talk sometimes.

Mother in Family 2: And that means the experiences that we've shared is like--I'm glad to see someone, I mean this is not really a way--I'm not glad to see somebody going through the stuff they are going through. That's not what I'm trying--I'm glad there is . . .
Mother in Family 1: . . . somebody out there . . .

Mother in Family 2: That someone else knows what I’m going through. I’m home constantly and I got to do a lot of things by myself with these kids and its like--someone else is going through this? I can’t picture the people going through the same things I go through.

Researcher: Do you think you are the only two families going through this?

Joking about how many other families go through this [Much laughter]

Son in Family 2: No, thousands of families.

After the behind-the-mirror conversations were examined and given topic names or phrases, the other data sets were processed in a similar manner. The researcher examined all
transcriptions in this manner, developing a list of topics for each conversation. These topics were listed separately for each conversation behind the mirror (see Appendix C), each session debriefing (see Appendix D), and each follow-up interview (see Appendix E). Notes were made from each therapy interview videotape and these were also examined and given topics (See Appendix F).

These lists of topics were examined for similarities between/among topics. For example, a topic entitled Researcher Gives Instructions resembled another topic listed as Researcher Asks for Feedback. These topics were similar in that both related to the study protocol and thus were grouped or clustered together to form a larger category of relatedness, Research Format and Procedures. Another example of this clustering of topics concerned the topics of Couples are Comparable, Comparison Between Sons, and Identification with Other Couple/Family. These three topics were joined into a category entitled Similarities Between Families. This procedure of finding clusters of related topics continued for all the data. Some topics fit equally well under several categories and were placed in each. There was no effort to restrict the topics to one category and therefore the categories were not mutually exclusive.
The following twelve clusters of topics were formed from the first review of the lists of topics.

1. Research Format and Procedure
2. Differences Between Families
3. Similarities Between Families
4. Focus on Own Family
5. Focus on Other Family
6. Therapeutic Comments by Researcher
7. Researcher Gives Information About Other Family
8. Advice/Interpretations Given by Observing Family
9. Focus on Therapist
10. Discussion of Problems in General Terms
11. Praise of Family in Therapy by Observing Family
12. Distracting/Fidgeting Behaviors

Further analysis refined these categories by joining categories that were closely related and by establishing the categories as either Major or Minor, relative to their significance in the conversations and applicability across the data sets. This process maintained all the data within the refined categories, acknowledging a greater or lesser influence of the categories without excluding any data.
The following six refined categories emerged as the most significant or influential and were considered Major Categories.

1. Research Format and Procedure
2. Therapeutic Interaction
3. Similarities Between Families
4. Differences Between Families
5. Focus on Own Family
6. Focus on Other Family

Three other categories were considered Minor Categories due to their more isolated or limited influence in the recorded conversations.

1. Focus on Therapist
2. Discussion of Problems in General Terms
3. Distracting Behaviors

Each of these Major and Minor Categories will be described in detail. Some categories applied to certain data sets more than to others and those distinctions will be noted in the descriptions of each category. Each category and its component topics are listed in Appendix G.

Major Categories

Major Categories represent significant interactions or behaviors that were predominant in the study. Excerpts from
the transcripts are used to elucidate the descriptions of the categories (both Major and Minor). Many excerpts could have been selected to illustrate these categories equally well, but a few were chosen that were particularly clear.

**Research Format and Procedure**

This category included instructions and information given by the researcher to the families, discussions about the research format or rationale, and questions from the families about the procedures of the study. The characteristic common to the topics in this category was the focus on study design and implementation.

Included in this category were those occasions when the researcher provided information about the circumstances of the family in therapy to help the observer family understand what was transpiring. Occasionally, when they had difficulty understanding the nature of the therapy conversation, the observer families would request information. Providing information about the family being observed occurred primarily in the early sessions, when the families were not well acquainted.

The researcher periodically made comments to orient (or reorient) the observing family to their task or role. The
following is an example of this type of comment from the behind-the-mirror conversation with Family 1 of Family Pair A:

    Researcher: So when you make your comments, or whatever you think to say--it'll be short--just think a little bit about what you would like to hear someone say [to you] rather than “you should have done this." What kinds of comments do you think would be helpful?

Most of these instructive comments were made in the early sessions when the families were somewhat unsure of precisely what was expected. In Session 1 with Family Pair B the feedback given sounded somewhat condescending. The mothers seemed to think they were required to offer advice and it came across in a judgmental manner--as if the person giving the advice was more knowledgeable than the receiver. The researcher reiterated that it was not necessary to produce a solution for the other family’s problems. Both families adjusted their feedback accordingly. As the participants developed an understanding of their roles they became more comfortable with their involvement in the study and consequently needed less direction from the researcher.

    The participants were encouraged to make observations regarding how the study was being conducted and to offer their
suggestions pertaining to any modifications in the procedures. Some of the suggestions made by the families included: (a) involve the problem sons in the sessions (Family Pair A), (b) pair the two husbands with the therapist while the two wives observe, and vice versa (Family Pair A), (c) have the children in both families talk together while the mothers watch from behind the mirror, and vice versa (Family Pair B), (d) eliminate the one-way mirror altogether and have both families meet conjointly (both Family Pairs), (e) do not destroy the videotapes following the termination of the study so the families could review them in the future (Family Pair A), and (f) vary the feedback procedures for the observer families (both Family Pairs). These suggestions were welcomed as valuable ideas but not all were utilized in this study because of time limitations. If the design had included more than three sessions, the suggestions for different pairings would have been implemented.

Suggestions to modify the ways in which the observer families gave their feedback were incorporated into this study. Initially, the families were instructed to give their feedback to the other family by switching positions—the observer family sitting in front of the mirror to present their feedback while the family who had been observed in
therapy (together with their therapist) watched and listened from behind the mirror. Both Family Pairs expressed their opinions that separating the two families in each pair with the one-way mirror was unnecessary. They preferred speaking and interacting directly. One family member said in a session debriefing, "I think we got out, you know, the same thing with all four of us together." They preferred to give their feedback to one another directly. In addition, the families wanted to have a discussion among themselves about that feedback.

The researcher and the therapists believed this modification in the method of giving feedback would stimulate the feedback process and demonstrate the researcher's willingness to incorporate suggestions of the participants. Using these suggestions to modify the study offered the possibility of opening domains unanticipated by the researcher's original design. The reflecting team format (Andersen, 1987) did not appeal to the families in this study. It was too indirect and seemed unrelated to the process of therapy. This opinion is often expressed by therapists who subscribe to problem-focused approaches.

The therapists were participants as well and were invited to modify the study format in ways they believed would enhance the therapy. During Session 2 with Family Pair B, the
therapist asked the researcher to follow a specific line of questioning with Family 2 behind the mirror that she had been developing in the immediately preceding therapy interview. The researcher accommodated the therapist's request and engaged the family in a further discussion of the issue while behind the mirror. This adaptation of the researcher's role will be the subject of the next category, Therapeutic Interaction.

Therapeutic Interaction

This category was one of the most unexpected and intriguing of all the categories. The researcher did not plan to engage any of the families in therapeutic interaction directly; a more neutral role was anticipated in which the researcher would simply answer questions to clarify the procedures of the study was anticipated. The researcher was to serve principally as an observer and recorder of what transpired.

The development of therapeutic interaction with the observer families developed progressively over the course of the sessions. During the first sessions with both Family Pairs, the focus behind the mirror was on observing and listening to the therapy interview in the next room. By the second sessions, the focus behind the mirror had shifted
significantly to center on the interaction between the researcher and the observer family. The conversation in the therapy room seemed secondary. The therapy room conversation stimulated the observer family to make connections with their personal situation, which then led to a discussion with the researcher regarding their situation. This conversation seemed natural and appropriate. The researcher's background as a therapist undoubtedly contributed to the development of this dialogue. He was comfortable engaging families in discussions of their issues or problems.

This therapeutic dialogue between the observing family and the researcher was very noticeable when the sequence or flow of the topics in some of the behind-the-mirror conversations were examined. The following excerpt from the conversation of Family 1 of Family Pair A shows the qualities of this type of therapeutic conversation:

Researcher: Do you think you've moderated yourself at all? Or are you still as you were at the beginning regarding [problem son]?

Stepfather: I still have a pretty hard stand against him. And like I said, I've always given him a chance, you know, to come back . . .
Mother: Yeah, it's not like you'll never give him a chance again. You know [son]--he's 14 and he'll always be welcome here but . . .

Stepfather: I'm always gonna be on guard--I'm always gonna make sure he ain't gonna steal from us anymore. I'm gonna make sure he ain't gonna hurt his mom and lie to her like he did before. So I guess I'll always be on guard, unless he does for a period of time change enough that I can start to respect him for somebody who does tell the truth and comes into my house and doesn't steal from me and . . .

Researcher: [to mother] So does this thing bother you--that he [stepfather] is kind of negative toward your son?

Mother: Sometimes.

Stepfather: I think in some instances it has helped her get over it quicker.

Researcher: Get over . . .

Stepfather: For me to say my point-of-view and straight up tell her "[son] has done this to us and he's done this to us and he's done this to us."
Mother: But most of the time I agree with him
[stepfather]. But it's the fact that I am [son's]
mom and he's so hard on him that . . .
Researcher: Sometimes . . .
Mother: I think that makes me want to be a little more
lenient with [son] because he [stepfather] is so
hard.
Researcher: So if he gets too hard, you feel kind of
compelled to . . .
Mother: Get soft.
Researcher: To be soft. So . . .
Mother: But I do most of the time agree with him, you
know, so it is tense when [son] is in the house.
I'm not sure I want [son] to come back and live in
the house.
Stepfather: I don't want him ever there alone because .
. .
Mother: Until we can trust him again.
Researcher: [to stepfather] Have you ever noticed that
sometimes the harder you get with [son]--the more of
a hard line you take--your wife gets soft?
Stepfather: Oh yeah, I always end up being the bad guy.
At the beginning of something, [son] can steal
something in the house and by the end of the
evening, I’m the bad ass—these two are ganging up on me.

Researcher: Now if you went softer instead of harder—like you usually do—if you went softer . . .

Mother: I think I could be . . .

Researcher: What would happen? What would happen to her, do you think, if you took a softer position rather than the hard one?

Stepfather: I think [son] would walk all over us.

Researcher: So you don’t think she would become any harder—she would just stay soft?

Mother: I’ve become harder.

Stepfather: Yeah, she has become harder, and I think that’s due to—because of me saying . . .

Mother: I think a lot of it . . .

Stepfather: Saying this and this and this . . .

Mother: That might be some of it but I think a lot of it is because I’m just tired of [son] doing what he’s doing.

This conversation is indistinguishable from a dialogue between a therapist and a client. In this conversation, the researcher became a therapist and the family related to the researcher as clients. The researcher asked questions of the family that led them to reconsider their parenting decisions
and the ways they coordinated themselves as a parental unit. The result of these questions was a discussion between the couple regarding their perceptions of their role and their partner's role. This excerpt is a section of a larger conversation in which they discussed other couple issues beyond parenting.

The awareness that therapeutic interactions were developing behind the mirror became apparent in the researcher's debriefings following the first sessions. The researcher viewed this development as an outgrowth of the study design and did nothing to discourage it. Because this type of interaction developed so smoothly and naturally, the researcher decided to let it proceed to see its effects.

The development of therapeutic interaction depends upon a mutual process among the participants involved. In Family Pair A, Family 1 was particularly receptive to such interaction. Consequently, more of the conversation with that family behind the mirror was therapeutic than was the case with the other families.

As mentioned in the Research Format and Procedure section, during Session 2 with Family Pair B, the therapist asked the researcher to continue the therapy conversation that she had been developing. The researcher followed this
recommendation, becoming a "co-therapist" in a sense, by pursuing a specific, coordinated therapy agenda with the family behind the mirror. The following section of dialogue between a mother in Family Pair B and the therapist relates to the researcher's therapeutic (or co-therapeutic) role:

Therapist: So that was real helpful. And then, you know the other family, [mother in Family 1] had comments about it too. And so while you heard some things that [researcher] had to say, you heard some things I had to say, and heard some things that [mother in Family 1] had to say--they may or may not have been similar.

Mother [Family 2]: But they were all just about the same.

Therapist: And yet I thought, is it over-doing it--is it too much? You know, so that was one of my worries--was it overload? I thought it was kind of important... that I wasn't the only one making suggestions or wasn't the only one bringing up those questions. Because I do get worried that sometimes I may be too forward or too pushy.

Mother: But sometimes you gotta be, with some people.
Therapeutic interaction behind the mirror increased the intensity of the therapy experience. Therapist B explains:

There was almost double and triple the talk time than there would have been if we had just met on our daily basis. And it was also more packed, more concentrated.

Although the primary focus behind the mirror was on the observer family, the influence of the family in the therapy room was still present. Periodically, the conversation behind the mirror would diminish and the observer family would refocus their attention onto the therapy in the next room. An ebb-and-flow process of listening to the therapy, then ignoring it in favor of focusing on behind-the-mirror conversation, then back again, and so on was a characteristic of the behind-the-mirror behavior for both Family Pairs. The conversations on both sides of the mirror were related—they both were dealing with issues of common concern to each family. The parallel conversations occurring simultaneously in front of the mirror and behind the mirror will be detailed in the section on Focus on Own Family.

**Similarities Between Families**

Similarities noted by the families in their comments from behind the mirror and in the debriefings included the relatedness of their (a) current situations, (b) histories,
(c) types of problems, (d) significant life events, (e) experiences with their children, and (f) outlooks on life generally. Coupled with the recognition of similarities were feelings of surprise and amazement that, in the words of one of the fathers, "there's other people out there that really have the same problems."

For Family Pair A, the main area of similarity noted was the circumstances surrounding their problem sons. They saw their sons as on very similar paths, with the only difference being that one son was "a little further down the road" (in terms of misbehaviors) than the other. The similar experiences that each couple had in relation to their problem son linked the two sets of parents. They often made comments expressing their surprise regarding how many common experiences they shared. For all practical purposes, they saw their positions vis-à-vis their sons as virtually identical and they therefore could compare their experiences as parents. The parents of the son who was a little further down the road explained how they handled their son and how it worked (or didn't work) with the hope that the other parents could profit from their experience (use what worked, avoid what failed). The mother in Family 2 explained this process.
[In reference to Family 1]

Mother: They had already been through what we were going through. So their input—her [mother in Family 1] input mostly—helped me to be strong and not give in . . . . I could see where she came from—the mistakes she made and what she learned from it. And that taught me how to be strong.

The similarities created a context in which the experiences of each family became credible stories for them, and the information gleaned from those experiences could be readily used.

In Family Pair B, the mothers identified the similarities between them to be primarily in regard to their overall plights as single parent mothers. Comparisons were drawn as well between their problem sons, but the mothers focused more on their mutual stresses as heads-of-households. These concerns went beyond their sons' misbehaviors to include isolation, financial worries, and personal fear. The mother in Family 2 explained.

Mother: Seeing that somebody else is going through stuff similar to what we're going through—that we're not the only ones out there that's got bad kids. . . . I been where she's talking about with her lights and
gas turned off--I been there a couple of times.
Almost being homeless--I was there six times . . .

Another similarity between the parents in Family Pair A was mentioned by their therapist in the debriefings and in the follow-up interviews. He pointed out the tendencies for marital discord to develop as a result of divided efforts to handle the misbehaviors of children. Both sets of parents in Family Pair A were exhibiting this marital "splitting" as they attempted, rather unsuccessfully, to reform their son's behavior (Joanning, Quinn, Thomas, & Mullen, 1992; Kuehl, Newfield, & Joanning, 1990; Newfield, Kuehl, Joanning, & Quinn, 1990). When each family occupied the observer family position, they were able to see this splitting process as exhibited by the other couple. This experience of seeing a behavior or interaction in another person or family that resembles a behavior or interaction pattern that also occurs in the observer's life can facilitate the observer's understanding of that behavior. Because of the close identification between the couples, their ability to see themselves in the other couple allowed them to understand the splitting process more profoundly. Family 2 discussed their splitting process in this way.
Mother: Well he [son] knows his dad will not take his bullshit. . . . he’ll just tell him straight out “you’re not gonna do this.” But me, I’m more like, well . . .

Researcher: You’re a softy.

Mother: Yeah.

Father: It’s just that he thinks that he can just push you because you’re not in the physical mold that I’m in--if I have to take action, I will.

Mother: Yeah, I can say I generally do fear him.

Family 1 also experienced parental splitting along similar lines as the father advocated a more confrontive (physical, if necessary) posture while the mother advocated maintaining a more compassionate position.

Father: But I tell you what--if “mommy’s always there,” he [son] can go “But . . . mom,” and mommy goes, “It’s all right” and on he goes.

Mother: I think its hard to do [say “no”].

Difficulties with children are exacerbated when the parents are in conflict over how to respond. Both sets of parents in Family Pair A split along the lines of fathers’ tendencies to be more physical and immovable contrasted with mothers’ tendencies to avoid conflict and seek harmony. Either parenting position may work satisfactorily, but when
they contradict or countermand each other, stress and conflict occur.

**Differences Between Families**

Although the families were matched by the researcher on the basis of selected outward similarities, some differences between the families—their current situation, their children, their pasts, or their outlooks regarding their problems—were also present. These differences became evident in the data collected from the conversations behind the mirror. Family 1 in *Family Pair A* noticed differences between the misbehaviors of their problem son and the misbehaviors of the problem son in Family 2:

[In reference to the son in Family 2]

Stepfather [Family 1]: See, we never had to deal with anger like that.
Mother: Yeah.
Stepfather: Yeah, [Family 1 son] was always mellow.
Mother: He did a lot of yelling and screaming, but . . .
Stepfather: He yelled and screamed, but that's all we heard.

Despite these particular differences, the similarities of their problem sons in terms of the disruptive effects on their respective families were more noteworthy.
As mentioned in the section on Similarities Between Families, the families in Family Pair A saw their sons as similar, each going down the same path (of misbehavior). But the sons were also viewed as different; each was at a different point on that path. Family 1 saw their son as further along on this path than the son in Family 2. When asked if the parents would like to switch problem sons with the other family, they both replied that they would not, indicating that there were substantive differences between the situations. Family Pair B rarely mentioned the differences between themselves, choosing instead to focus on the similarities.

For both Family Pairs, when differences were noted by the families, they were expressed in nonjudgmental ways. The differences were expressed as factual differences, such as the different ways in which the sons misbehaved or the different choices made by the parents regarding how to respond to the misbehaviors. There was no expression of superiority when these differences were noted.

Focus on Own Family

A fourth clustering occurred around topics in the conversation the focus of which was the personal situation of the observer family. The comments made centered directly on
themselves rather than on their counterpart in the study. Often these remarks were elicited by comments made by the family in the therapy interview, but the conversation behind the mirror specifically related to the observer family's own circumstances.

During the sessions, the researcher developed an interest in the relationships between the simultaneous conversations in front of the mirror and behind the mirror. Due to the similarities in the two families' life situations, the topics discussed in the therapy interview were familiar to the observer family. Even though there was a mirror separating the two families' conversations, the conversations were related in many ways. The therapy room talk often motivated and maintained the conversation behind the mirror.

One excerpt from these simultaneous conversations was selected for closer examination to illustrate the degree of interrelatedness. The excerpt chosen was taken from the early stages of Session 2 with Family Pair A. Family 1 was in the therapy room with their therapist while Family 2 was behind the mirror with the researcher. Family 1 was discussing the current situation with their son. Their son was not staying at home, not going to school, and reportedly living with some adults who the parents believed were bad influences. Although he was not in any pressing legal trouble, the possibility of
placement in a residential treatment facility seemed more and more likely. The parents were trying to reconcile themselves to this possibility, but they were not convinced that placement was the answer. They wanted him to get help but were hesitant to become actively involved in locating him and taking him to a treatment center.

The observer family listened carefully to this conversation. The situation with their son was similar, although theirs was perhaps not as urgent as the situation was with Family 1. The researcher asked the family to try to imagine what they would say or do if they were the therapist in this situation. They responded,

Mother: There's probably a lot of things going through his brain--how am I going to do this situation to where they ain't going to hate me or to satisfy the whole family so that the mother isn't going to kill herself over a child--feel guilt, big time guilt.

Father: I'm trying to relate to the--how I would feel if I had to put [referred to his son] away. So I'm trying to figure out what [the therapist is] going to say--how they're feeling.

The family behind the mirror continued to hear details of the other family's situation that furthered their belief that their situations were highly similar. Silent and highly
attentive for a considerable time, the observer family then engaged the researcher in the following manner:

Father: I used to be in trouble all the time.
Researcher: When you were a kid?
Father: I didn’t have both parents in the home, I only had my mom and she was raising eight kids and I used to steal, do this and that. But to me, I think the best place that a kid can go, I mean you have got to get into trouble to get there, is [state institution for delinquent boys]. Because you’re up at 6:30 in the morning and you’re doing...

Researcher: Did you go there?
Father: [indicates “yes”]. You’re up doing your chores, you’re at school at a certain time, back in by a certain time, and anything that you do... I used to hop box cars and all that stuff.

Researcher: When were you in [state institution]?
Father: The last time was [gives date]. I was in [state institution] four times.
Researcher: When were you in there the first time?
Father: I can’t even remember. It was just four times... I mean it’s too bad that you have to be a thief and get caught so many times and actually, the first time I ever got busted I got sent away.
Mother: I got in trouble too for running away a lot.

Researcher [referring to mother]: Did you ever get sent away?

Mother: Yeah, [two different residential treatment centers].

Researcher: When you were sent away did your parents get upset? Pained by your having to go? Or did they think it was the best thing for you?

Mother: That was the best thing for us ... for me.

Father: My mom didn’t have no say-so in it. The judge said “you’re a threat to the community.”

Researcher: Was she okay with that or did she feel bad?

Father: Oh, I think that she felt bad. But there just was nothing she could do and there was nothing I could do. And my probation officer, he didn’t try anything to stop it.

Researcher: But at the time when you guys were sent away, were you upset by being sent away or were you okay with going?

Father: I don’t think I cared.

Researcher: So it didn’t matter to you.

Father: I knew it was coming so I didn’t care.

The theme of Session 2 with Family Pair A was placement of the problem son in a residential treatment facility. Both
families were faced with that prospect and they talked about it with their therapist, the researcher behind the mirror, during their feedback exchange with one another, and in the debriefing at the end of the session. They examined the issue of placement of their sons from many points-of-view—pragmatically, emotionally, intellectually, optimistically, and pessimistically.

The transcripts of the simultaneous conversations were examined side-by-side in order to identify their connectedness. The conversation behind the mirror bore a remarkable resemblance to the conversation in the therapy room. The connectedness was at a conceptual or thematic level rather than at the verbatim level. These patterns of connectedness tended to ebb and flow like waves that periodically intersected and then deviated, only to return to intersect, and then again to deviate, and so on. The intersection points occurred when the behind-the-mirror conversation would slow or stop. At those moments, the observer family's attention swung back to the therapy room. The coordination of conversation reappeared when the behind-the-mirror interaction resumed its focus on the observer family. This back-and-forth process occurred from two to six times in any given interview. These periods of observation of the therapy family provided the observer family with insights
into their situation which in turn launched the observer family back into the discussion about their situation. Comments made by one family stimulated the other family’s ideas and comments regarding their common issues.

These connected conversations were numerous. In *Family Pair B*, a conversation in the therapy room about a son helping his brother who is confined to a wheelchair launched a discussion behind the mirror with the observer family about their own disabled son and the stress involved. This developed into a discussion of the pain of being unappreciated when you try to help someone else.

Another example of discussion connectedness from *Family Pair B* was when the therapy room conversation revolved around differential parenting--maintaining different expectations and rules for different children in the same family. The observer family reacted to this by stating their differing position in this matter. They believed that children (of approximately the same age) should not be subject to different expectations or rules. The discussion with the researcher developed into a conversation regarding the importance of fairness in raising children. These examples are only a small sample of a large number of connected discussions.
Even though the families watching from behind the mirror were structurally in positions conducive to listening to the other family's situation, the conversation typically revolved around their own circumstances. The researcher did not discourage their desire to discuss their circumstances. The conversation behind the mirror about the observer family's own situation led the researcher to conclude that the family behind the mirror was, in effect, developing with the researcher a parallel therapy experience to the family in the therapy room (see Therapeutic Interaction Category).

**Focus on Other Family**

Another category included those occasions when the family behind the mirror focused on the family in therapy and their situation. These were occasions when the observer family was listening and concentrating on the other family's predicament. As discussed in the preceding section, listening to the other family's therapy often led the observer family to focus on their own situation, but this category of topics refers specifically to comments made behind the mirror that centered on the other family. In the earlier sessions, the focus on the other family was mostly of an informational nature. They were observing the other family to try to understand what was happening in their lives and in their therapy. As mentioned
in the Research Format and Procedure section, the observer family asked questions of the researcher about the other family. As the sessions progressed, however, the observer family began making interpretations, giving advice, and complimenting the other family.

The observer family occasionally interpreted what they thought was happening with the other family. The following are interpretive excerpts:

**Family Pair A**

[In response to hearing about the problem son in Family 2]

Stepfather [Family 1]: Maybe he [son] has "seasonal distress syndrome" or something like that where the changes of seasons affects people differently--depresses them and brings them down. I know that in springtime and summertime I'm always more willing to get out.

Researcher: Nice weather and you want to get out.

Stepfather: So I don't know why it couldn't affect a kid.

**Family Pair B**

[Mother in Family 2 comments regarding the problem son in Family 1]
Mother [Family 2]: I can imagine how he feels. I can feel for both of them [problem son and brother]. He feels that he is losing things that he and his brother can do together. And then if he helps him, he feels like maybe he’s not helping enough. It could be . . . I don’t know, it’s a bad feeling.

In addition to interpreting the other family, advice was sometimes given:

Family Pair B

[The mother in Family 1 comments on Family 2]

Mother: She [daughter in Family 2] should be punished and if he [son in Family 2] went out and he wasn’t supposed to, he should be punished too.

Both mothers in Family Pair B attempted to convince the problem son in the other family to improve his behavior. The mother of the son being “talked to” allowed the other mother to make her points. Although not mean-spirited, these comments were critical of the son’s behavior.

Focusing on the other family also led to complimentary commentary. Families praised one another for their concern/compassion for their children, diligence in working on becoming good parents, demonstration of patience, or
possession of good ideas on how to handle parenting situations.

Minor Categories

Focus on Therapist

The families made comments about their therapist from behind the mirror. The researcher invited these comments, asking the families to discern whether or not their therapist acted differently with the other family than when he/she met with them. The families were in a position to observe their therapist in a new way, that is, from a position outside of the therapy room. The general consensus was that the therapists were very consistent in how they related to each family in terms of their style, degree of respect, and general demeanor. The observer families reported no substantial differences in how the therapist behaved with both families.

During the session debriefings and the follow-up interviews, the therapist and his/her ways of relating to clients were discussed more than during the conversations behind the mirror. The session debriefings and the follow-up interviews included the therapists, whereas the behind-the-mirror conversations did not. Consequently, the debriefings and follow-up interviews provided opportunities for the therapists to comment on how the sessions were impacting the
therapy process. *Focus on Therapist* included the therapist’s comments about their therapy practice, of which the research sessions were only a part.

It was common in the debriefings for the therapist to receive feedback from his/her client families regarding some aspect of his/her work. The comments about the therapist were very complimentary, as evidenced by the following remark by one of the mothers in *Family Pair A*:

Mother: Yeah, but see the way you’re acting is how you’re reaching us--and you’re reaching the kids around you. My fifth grade teacher was open-minded like you are; he always stuck in my mind because he cared . . . he cared enough for his pupils. In other words, see, you’re our teacher and we are your pupils.

In a session debriefing of *Family Pair B*, one of the mothers spoke in glowing terms of their therapist:

Mother [Family 2]: Can we comment about [therapist]?
[to other mother] Can I get your input on her [therapist]? I love her. I think she’s a godsend.
Mother [Family 1]: Yeah.
Mother [Family 2]: I mean, like I said to her . . . I’ll be done in June [with the therapy] and when June
comes I know I have a friend. I can tell [therapist]. . .

Son [Family 2]: Anything.

Mother [Family 2]: How I feel.

In addition to the compliments, the families and therapists would often discuss their progress to date and plan the next step(s). The session debriefings resembled supervision meetings, with each family in a position to offer high quality feedback regarding how the therapy was impacting them. The following quote from the debriefing of Session 3 with Family Pair A captured the quality of the conversation between the therapist and the two families:

Therapist: I felt comfortable saying what I did and if it bothered you, I thought, well--these guys can deal with it . . . I feel like we’re all just human beings--just trying to figure this thing out.

That’s my philosophy on therapy. There’s no great sages or masters out there, it’s just people relating to people . . .

Thus, therapy was examined and evaluated by the participants of that therapy.

Discussion of Problems in General Terms

Another category of comments represented those discussions about the specific problems or issues in broad
generalities. Comments were made about parents, “kids today,” or husbands/wives that were far-removed from the specifics of their case. Discussions of personal situations that were not improving would occasionally lead to commentary about how “the system” didn’t work. The following is an example of such commentary:

Stepfather [Family 1]: You can’t discipline a child severe enough nowadays without them saying “I’ll call the law on you.” They’re out there pulling all this bullshit and when we come down on them with discipline, we’re the ones that’s gonna get in trouble and go to jail.

Researcher: So is it really hopeless or are we just painting a picture that looks hopeless?

Stepfather: I think people need to take a hard line with that shit and realize that if we don’t do something with kids today they’re gonna walk all over us.

Mother [Family 1]: We need to change the laws for 12 to 16-year-olds, you know.

Researcher: To make them tougher.

Mother: Yeah.

Researcher: But at present, that doesn’t look like we got that--it may be a while.
Stepfather: It's gotten more lenient if anything--no money.
Mother: No money for that age bracket.
Stepfather: That's what we always got. The legal system wants us to take care of our kids and make sure they don't go out there but yet don't give us the means, or the way to do it. You know, don't beat them--don't do this, don't do that--but make them mind.

These generalizations were characteristic of the conversations of Family Pair A but not of the conversations of Family Pair B.

**Distracting Behaviors**

This cluster of topics referred to distracting behaviors that occurred behind the mirror. These behaviors belonged solely to the children involved in the study (in Family Pair B). After the novelty of the study diminished, the children engaged in idle chatter and became restless and fidgety. This caused the mothers to intervene to try to keep the children focused and interested. Although the children often behaved in distracting ways, they still were attentive at times. One mother commented on her son:

...he might have acted like he wasn't [listening] but there would be times we'd have meetings like a day or two
later, and he could tell me everything we discussed at
the meeting [preceding study session].

This is an issue for all therapies that include children
in the process. When the activity of the therapy is
predominantly talking on an adult level, the attention spans
of children wane. Despite their restlessness, the children
handled the situation quite well.
CHAPTER V

DISCUSSION

There is always something more to be uncovered.

--Susan Sontag, The Volcano Lover

The analysis of the data produced Major and Minor Categories that corresponded to the reactions and descriptions of the participants in the study. The purpose of this study was to generate descriptions of the experiences of families observing other families in therapy. Four families and two therapists participated in three therapy sessions and a follow-up interview to study a variation of multiple family therapy (Laqueur, 1968, 1973). The study enlivened the influence of the therapeutic team by including persons who do not typically occupy such roles--family members.

In this discussion, significant findings will be examined in detail, replete with interpretative comments and implications for further research. The most interesting or influential findings were (a) the development of therapeutic interactions behind the mirror between the observer families and the researcher, and (b) the correlation between the simultaneous conversations on either side of the one-way mirror.
The data were organized into six Major Categories and three Minor Categories. These categories encompassed all the data, with some data fitting into more than one category. The Major Categories were: *Research Format and Procedure*, *Therapeutic Interaction*, *Similarities Between Families*, *Differences Between Families*, *Focus on Own Family*, and *Focus on Other Family*. The three Minor Categories were: *Focus on Therapist*, *Discussion of Problems in General Terms*, and *Distracting Behaviors*. The categories were developed from the conversations of the observer family and the researcher, the therapy interviews, the session debriefings, and the follow-up interviews. These categories represent the types of interactions, conversations, and commentary that occurred among the study’s participants.

**Therapeutic Effects**

**Relationships Between Families**

The findings of this study corroborate other studies that have examined families' interactions with one another in therapeutic contexts (Laqueur, 1973; Leichter & Shulman, 1974). Families support one another when they experience similar stress or share common experiences. This idea is captured in the rather unfortunate sounding aphorism: “Misery loves company.” Knowing that someone else is experiencing the
same (or similar) undesirable event or situation creates a bond between people. The families chosen for this study shared significant commonalities and through these similarities these families developed a comradeship.

Each family expressed concerns before the study that they would be incompatible with the other family. After the study began, their fears were allayed and the families developed a comfortable relationship. Multiple Family Therapy and self-help groups develop strong emotional bonds among the participants. These bonds serve as the basis for the effectiveness of those models (Katz & Bender, 1976; Laqueur, 1973). The bonds between the families in this study developed to such a level that both Family Pairs were planning to continue meeting after the study concluded. Contact with the families in Family Pair A six months after the sessions ended indicated that the families had stayed in contact with each other.

Families were concerned that they would be matched with someone of a significantly different socioeconomic status, different age group, or with someone racially prejudiced. One of the fathers worried that his long hair would be viewed negatively. He was relieved that the other father also had long hair. Interestingly, the families were more concerned
about physical and social appearances than the nature of their problems.

In Family Pair B, the quick establishment of rapport between the two families was exemplified by an incident that happened at the end of Session 1. As the families were leaving, the problem son in Family 2 assisted the disabled son in Family 1 by pushing his wheelchair to the car. The mother in Family 1 was astonished by this and told the boy's mother and the researcher that her son does not let just anybody push his wheelchair (except his mother or brother). A spirit of goodwill and cooperativeness had been quickly cultivated and persisted throughout the sessions.

The literature indicates that people learn from each other, whether in a formal situation of therapy (Laqueur, 1973; Leichter & Schulman, 1974), an informal self-help context (Gartner & Riessman, 1984; Katz & Bender, 1976), or an everyday situation with a friend or acquaintance who is a good listener (Cowen, 1982; Whitaker, 1976). They listen to the experiences of others and apply those stories to their situations. In this study, experiences of success and of failure in dealing with comparable family issues were described and discussed. This learning process occurred within an accepting relationship where all parties were free to express themselves without any accompanying pressure to
change or accept advice. Information came from nonprofessionals, that is, from another family whose credibility stemmed from an inner sense of understanding rather than from a claim of expertise (Gottlieb, 1981). Information learned in this context was easier to accept and assimilate (Cowen, 1982).

This study was designed to link families who were similar in key respects to ensure relevance and cooperativeness between the families. Comments from all participants verified the importance of comparability between families but a comment from the follow-up interviews indicated the possible advantages of less similarity:

[In discussing the suggestion to use four families together instead of the two used in this study]

Stepfather [in Family Pair A]: ... it would open up a few more thoughts. Maybe the families wouldn't be quite so much the same as what we and the [other family] were.

Too much dissimilarity between families was a concern of this study and was avoided. But the degree of similarity between the families in each Family Pair of this study may not have been required. Further research with pairs of families might explore using families with less in common.
When each family was asked if they would like to trade their problems for the problems of the other family, they declined and said they preferred to keep their own. Perhaps seeing someone else's problems made their own problems seem easier to handle. Bringing families together may provide them with an appreciation of their situation that comes from taking stock of one's situation vis-à-vis another's. This appreciation may allow families to view their problems differently and respond to them in new ways. Bringing families together in this way may itself foster behavior change (Leichter & Schulman, 1974).

The compatibility and cooperativeness of the study families should not overshadow the serious personal distress these families were managing in their lives. The families of Family Pair A were facing the real possibility of removal (forced or voluntary) of their problem sons from their homes. Regardless of their levels of frustration, removal of a child is an enormous emotional drain. Family Pair B families faced serious and chronic social and financial deprivation as well as living in constant fear and violence. The stress associated with their problem sons occurred within a larger framework of pervasive hopelessness and despair.
Therapy or counseling is typically touted as a way to alleviate problems. Usually problems are considered to be specific, circumstantial conditions that can be alleviated by interventions in which clients develop new ideas, perspectives, or resolves. The magnitude of the problems of life that the study families faced show the limited nature of therapy as defined above. The kind of support and comradeship felt by the families in this study may have been more valuable and therapeutic than a series of specific, goal-directed interventions that one typically receives in traditional family therapies.

Session Variety and Intensity

The variety of experiences in each two-hour session—therapy room therapy, observation room therapy, discussions with the other family, and debriefings with the researcher and the therapist—provided an intense therapy experience. The shifting formats within each session kept the participants’ interest high and the sessions seemed to go by quickly. The families often reported feeling tired or stressed-out when they arrived for the session, but by the end they were more upbeat and energized. One of the mothers in Family Pair A put it this way:
Mother [Family 2]: I'd go in there burned out, but then I felt relieved that, hey, I'm not the only one that felt this way. I felt a burst of energy.

During every session, each family had a therapy interview with their therapist for 30 minutes, a short discussion with all study participants, an interview with the researcher/therapist for 30 minutes, another conjoint discussion with all participants, and a 30-minute debriefing of the entire session with all participants. In addition, there was casual talk before the sessions, during breaks, and after the sessions. These various formats facilitated different levels of conversation. The families could speak specifically or more generally about their issues. Including the children in the sessions with Family Pair B naturally created some distractions because the adult talk did not interest them. But overall their inclusion added to the sessions' ideas and the children felt good about being included in the study.

The variety of interactions during each session kept the discussions lively and fresh. Each part of the session was kept relatively short. Because the topics discussed were highly interrelated across the various session formats and conversations, switching formats did not lose the continuity; instead, the changes provided many different ways of examining
and talking about the key issues. Therapist B observed that she, at various times, considered the observer family to be her co-therapists, a therapeutic team to help plan strategy, or a client that she needed to address (albeit indirectly through the mirror). Viewing the observer family in these various ways increased the therapist’s options in handling any given interview. If the therapeutic strategy was unproductive, another option could be utilized by using the team in a different way.

The varied formats blurred the boundaries between the families, the therapies, and the problems being discussed. The multifaceted but interrelated nature of the session facilitated evaluating the session as a single entity. The session could be approached as a systemic whole composed of subsystems that included the families, the therapists, the researcher, and the various formats for conversations (Becvar & Becvar, 1993). The sessions became coordinated around certain themes (see subsequent section on Parallel Conversations).

The families said that they would have preferred to meet conjointly without the mirror or the shifting formats. The mirror and the observation room were not impediments for the families. They placed a high value on the direct discussions with everyone present. The therapists stated that they saw a
need for maintaining the therapies with each family separately. They saw the conjoint meetings as valuable, but the therapists wanted to retain the separate therapy interview time for issues that may be excluded in a conjoint format. This perspective, which differed from the families’ view, highlights important distinctions between the views of therapists and their clients, created in large measure by their different roles within the interaction (Elliott & Shapiro, 1992). Investigations of therapeutic relationships need to take account of the multiple voices present in that structure (Wynne, 1988).

**Supervision Aspects of Feedback**

The therapists felt that the sessions had positive effects on the therapy. The therapeutic agenda and movement toward identified goals were successfully addressed throughout the study. The therapy progressed in tandem with the study.

Through the debriefings, the families provided important feedback to their therapist regarding how they perceived the therapy as well as how they perceived the therapist’s role and his/her performance in that role. Most family therapy models acknowledge the value of the client’s feedback but usually receive it in the form of client satisfaction statements or rankings at the end of therapy. Consideration of clients as key players within family therapy supervision is certainly at
present a minority opinion (Liddle, Breunlin, & Schwartz, 1988). Collaborative Language Systems approaches (Anderson & Goolishian, 1991; Anderson & Rambo, 1988; Goolishian & Anderson, 1992) consider clients and therapists to be in nonhierarchical relationships. This allows the clients and the therapists to join in a continuous appraisal and adjustment of the therapy. The research format allowed the families to watch their therapist working with another family and to compare how the therapist behaved with each family. All the families reported that they saw no difference in how their therapist worked with them as compared to how the therapist worked with the other family.

Feedback from the families during the session debriefings revealed how the families saw their therapy progressing, and even more fundamentally, what the families considered to be therapeutic (Kunin, 1985). Discrepancies between the therapist and client regarding what constitutes therapy or how to understand the meanings of interactions can be a serious obstacle to therapy (Caskey et al., 1984). The mothers in Family Pair B discussed their views about the nature of therapy. They explained that therapy was first and foremost a process whereby a therapist carefully listens to a client. Listening was more important than intervening to create new
behaviors. This kind of feedback is crucial for therapists as they attempt to help their clients.

The therapists received regular feedback from their clients regarding their clients' perceptions concerning the therapy's progress. This regular input allowed the therapist to make adjustments as indicated throughout their work. The feedback served as a constant correction mechanism unlike satisfaction-type feedback provided following the termination of therapy. This regular feedback reinforced the relevant, participatory role of the client in his/her own therapy (Roberts, 1990). The collaborative therapy styles used by these therapists (Anderson & Goolishian, 1988) already valued and utilized consistent client feedback; therefore, this study fit effectively with that procedure already in use.

Therapeutic Interaction

The development of therapeutic interaction behind the mirror was neither predicted from the literature review nor anticipated when the study was devised. The role of the observer family was expected to focus on helping the therapy process in the therapy room. Some benefit to the observer family was envisioned but the therapy in the therapy room was considered to be the primary beneficiary.

Instead, the behind-the-mirror conversation took center-stage in the study. The conversation in the therapy room
seemed to act as a special type of team for the "therapy behind the mirror." The therapy room conversation served as a stimulus for the observer family to launch themselves into a discussion with the researcher concerning their personal circumstances. When the dialogue behind the mirror quieted, the observer family returned their attentions to the therapy in the therapy room. Before long, however, the observer family would again initiate a therapeutic conversation with the researcher behind the mirror. These behind-the-mirror therapy interviews lasted 30 minutes at which time the observer family would begin their "real" therapy interview with their therapist.

The families developed an image of the researcher as a therapist. Because the researcher observed the therapy and talked directly with the families, he was aware of most of their problems. His responses encouraged the families to discuss their situations. The researcher was receptive to, and comfortable with, this role, which undoubtedly fostered the development of this type of interaction. The researcher had a therapeutic style similar to the therapists' styles, therefore his comments and interactions with the families fit with the comments and actions of their therapist. Therapist B requested the researcher's direct coordinated involvement. This team approach worked well.
This development of behind-the-mirror therapeutic interactions suggests some possibilities in terms of therapy design. Similar to Multiple Impact Therapy, approaches that organize multiple formats using several clients conjointly and several therapists may address client issues more effectively than traditional one-hour interviews with one therapist. Several therapists working collaboratively with groups of families may have a significantly greater impact than traditional individual family practice, at least with some families or with certain problems. These suggested alternate formats for family therapy are not promoted as superior to other approaches but instead discussed as legitimate configurations of therapy that may, after further study, prove to be particularly advantageous in some situations. Families have preferences for certain therapies and the families in this study responded well to the multiple family structure.

Therapy is designed to bring about desired change in clients. Various conceptualizations of how this change occurs lead therapists in different directions utilizing a variety of different models (Gurman & Kniskern, 1981; Nichols & Schwartz, 1991). Maturana and Varela (1988) explain that when a therapist interacts with a client system, he/she does not make that system behave differently. Instead, the therapist only perturbs that system in ways that invite the system to adjust:
the system may react by making fundamental changes, shifting
decently, or not changing at all. To Maturana and Varela, the
notion of a therapeutic intervention acting like a surgical
knife has been an unfortunate metaphor. Therapists provide
ideas or behaviors that client systems may (or may not) relate
to by adjustments in structure or process. Given this view of
therapy, providing client systems multiple perturbances to
which to respond, as demonstrated in this study, represents an
effective way to engage families in distress. A model that
uses multiple formats, multiple therapists, and multiple
clients can provide a set of perturbances or potential
influences to which a family may respond in a variety of ways
in their efforts to meet their particular needs.

This view relies on an ontology and epistemology that
considers families competent to select and utilize significant
influences effectively. From this perspective, an expert is
not needed to assess and organize therapy for a client. The
client is considered capable and responsible for choices they
make, including their choices within a therapy experience.
This perspective deviates from some popular models of brief
treatment that showcase a focused, guided therapy that is
problem-centered and intervention-driven. The multiple format
multiple therapist multiple client system used in this study
allows families to choose how they are to be helped.
Parallel Conversations

The mirror dividing the therapy room from the observation room sometimes seemed to have little effect in separating the two families or the two conversations. As stated previously the talk on one side of the mirror often mirrored the talk on the other side. The families occasionally even attempted to talk through the mirror to each other. Although the therapy family could not hear the observer family’s discussion with the researcher and the observer family was often oblivious to the therapy room talk because they were immersed in their own discussion, the conversations were very similar in substance and flow. While not matched on an item-by-item examination of the transcripts, they resembled each other in tone and in theme.

The interrelatedness of these simultaneous conversations was a part of even larger patterns of relatedness. The multiple conversations that took place on both sides of the mirror and in the variously configured discussion formats coalesced into distinct themes. This synchronicity of ideas or themes evolved without a deliberate or conscious effort by either the researcher or the therapists. Examination of all the conversations of any given session revealed an interesting and surprising unity.
An over-arching theme emerged for each session with each Family Pair. This theme co-evolved from the conversations of all the participants during that session. Examples of themes include: “Kids Have Bad Attitudes,” “Pros and Cons of Placing Children in Institutions,” “Even Families Under Serious Stress Need to Have Fun,” “Parents Must Be United,” etc. The theme of each session represented a specific issue and mood as collectively constructed by all the participants through the multiple conversations of that session.

Family Pair A’s Session 1 was characterized by descriptions of the difficult and intractable problems they were experiencing with their problem sons. During Session 2, the theme centered on careful consideration of the positive and negative effects of placing children in treatment facilities. Both families were aware that this was a distinct possibility with their problem son and highlighted this issue in this session. The theme of Session 3 revolved around the importance of parents working as a team when dealing with the misbehaviors of their children. Their conflict over how to handle their problem sons was undermining not only their parental effectiveness, but their marital stability as well. Parental solidarity was the central point of this session.
The first session with Family Pair B centered on the struggle these mothers were experiencing with their problem sons. They chronicled their efforts to improve the problem son’s behaviors and described the frustration they felt as a result of their ineffectiveness. Session 2 focused on the overwhelming number of problems (beyond the misbehaviors of their sons) these mothers faced. This session was an emotionally intense account of the overall depth of despair these mothers felt. The theme of Session 3 centered on the importance of finding moments of happiness or pleasure in life. There was a sentiment expressed that despite serious personal problems and stress, they needed to laugh occasionally and take a less serious approach to life.

Each session was characterized by a unified theme. Further examination revealed a logical progression of themes in the three sessions for each Family Pair. This logical progression of session themes was very similar between the Family Pairs. Session 1 was an accounting of the extreme frustration over the problem son’s behaviors. Both Family Pairs spent the entire session explaining how problematic their son had been and how unsuccessful they had been in changing him. Session 2 revealed the depth of the despair and the extreme measures that were being considered as a result of
their frustration. Both Family Pairs grappled with the extreme pain they felt in their lives and the desperation they were experiencing. Session 3 dealt with parental responses, which were focused on practical solutions that emphasized the parents' needs as well as the son's needs. This session was more upbeat and encouraging compared with the previous two sessions.

The comparability of the themes and their progression between the Family Pairs was intriguing. The families were aware that the study involved only three sessions. Therapy groups typically move from giving initial information about themselves to sharing more detailed or emotionally charged information followed by a lighter, less negatively focused presentation (Yalom, 1975). The general group dynamics of the study families followed the patterns in the literature on group behavior (Bion, 1961; Yalom, 1975).

**Methodological Issues**

The families capitalized on the opportunity to learn about another family in similar distress and applied what they learned to their own circumstances. This unique therapy experience involved their collaboration in developing certain elements of the design. They were involved with the ways in which feedback was given and in the activity behind the
mirror. They suggested ways of proceeding, which were adopted.

The emergent design, which allowed the participants to decide how certain protocols would be managed, incorporated their new ideas and also demonstrated to the families that their ideas were worthy of being included in this research project. They felt like true collaborators in the study (Elden, 1981; Maguire, 1987; Mishler, 1986). With their involvement clearly evident, they had a "stake" (Guba, 1989) in the outcomes, which encouraged them to be active participants throughout.

This research design resembled the structure of their therapy. Both therapists utilized models of therapy based on collaboration between therapist and client (Anderson & Goolishian, 1988). This partnership approach worked well. The therapy revolved around the families' expectations of how therapy should work with them rather than working to discover the "psychological truth" of their situation or attaining a priori therapeutic outcomes (Goolishian & Anderson, 1990; MacGregor et al., 1964). The participants' subjective reports were the data. Categories of that data were constructed in ways that kept their meanings intact. Their phenomenological experience was invited by the study design.
The similarities of the study design to therapy likely facilitated the development of the therapeutic interaction behind the mirror. The boundaries between research and therapy blurred so that the sessions were viewed equally as therapy sessions and research sessions. Therefore, the research experience was therapeutic for the families.

The therapists were also participants in the research and their feedback regarding the research design was incorporated into the study. Viewing the research sessions as having therapeutic potential and consequences for their clients encouraged them to actively participate in order to help direct the therapeutic possibilities. Relevant involvement in design decisions enlisted and continuously encouraged the therapists' investment in all facets of the study (Lather, 1991; Maguire, 1987).

Tesch's organizing system for unstructured qualitative data served as an efficient and effective method to categorize the data in meaningful ways. This system of analysis allowed for the development of key themes or categories that resembled other systems of analyses, such as Spradley's "Developmental Research Sequence" (1979). Tesch's system was used in this study because of its clear (nonjargon) language, ease of application, and flexibility to modifications regarding how it is applied. The modifications of Tesch's system used in this
study 1) allowed for data analysis to be developed from videotapes rather than from transcripts of the verbal exchanges, and 2) resulted in the development of categories that were distinguished as either Major or Minor. Deriving the topics from the video record included a great deal of nonverbal and contextual communication that would have been missing from verbal transcripts (Acker et al., 1990; Bottorff, 1994).

Another characteristic of this study was its degree of readability by a nonprofessional audience. Van Maanen (1988) explains "the categories of readers an author recognizes and courts help shape the writing" (p. 25). Addressing a nonprofessional audience requires the removal of jargon and references to specialized procedures. The use of families in this study initiated the process of using everyday language from the beginning of the study. Labeling the categories in the analysis process as Major and Minor fit the style of this study better than Tesch's tripartite system of Major, Unique, and Leftover. Avoiding jargon and technical concepts allowed the study to be understandable to the participants, which was crucial to establishing their full participation. Likewise, the write-up of the research is clear and straightforward so that it can easily be read by a nontechnical audience.
The roles of the researcher extended beyond those typically prescribed for researchers. The researcher's high degree of involvement in many aspects of the study made him as influential as the families and therapists in the development of the findings of the study. He was a participant in the study along with the families and the therapists (Oakley, 1981). The researcher's ability to facilitate an atmosphere in which the participants became active in the study was crucial to the generation of quality data (Lather, 1991). The participants were very active in the study due, in part, to the researcher's active involvement with them.

The researcher's involvement was key to the development of the Major Category Therapeutic Interaction. If the researcher had resisted being drawn into this interaction, this category of interaction would have been missed entirely. The study was designed to develop multiple descriptions of the participants' experiences, and the researcher was willing and able to explore actively the ideas and suggestions of the participants, even to the point of engaging with the families and the therapists in ways that allowed the researcher to also generate ideas in the course of the study.

The intimate connection between therapy and research in this study suggests the importance of research usefulness or utility in regard to the phenomena being studied. The term
"utility" refers to the degree to which the research impacts positively the phenomena under investigation. This idea acknowledges that research invariably has an influence on the participants to some degree. The standard position is that the impact of the research design on the subjects should be minimal. Some action researchers and evaluators maintain that research rigor should include, along with trustworthiness measures, a utility dimension (Patton, 1978; Winter, 1987). If research were viewed as potentially useful in the amelioration of the problematic conditions under investigation, a utility dimension could estimate that ability. This dimension would lend credibility to a research project's abilities to improve the quality of life it ostensibly studies.

Experiences of conjoint therapy with several families together are under-represented in the therapy literature (Becvar & Becvar, 1993; Gurman & Kniskern, 1981; Nichols & Schwartz, 1991). This study attempted to describe with richness and texture the experiences of four families, two therapists, and one researcher in a multiple family therapy situation. The methods chosen and the flexibility in their utilization highlights abilities of research designs to coordinate with practice settings. The therapeutic focus can
work together with research demands to accomplish the goals of each.

Contributions

This project has implications for both the practice of family therapy and research into therapeutic interactions. The distinction between therapy and research is dependent on the specific question posed and the answer expected. In this study, the objective of eliciting reactions to an experience allowed the researcher to create a research context that was resonant with therapy. The research not only allowed the therapy to proceed uninhibited, it actually facilitated the therapy. The research was a part of the therapy. This study had a high utility value because of its ability to be therapeutic and its ease of administration. Conducting research in agency settings requires that the activities of the study be easily and smoothly adapted to the agency's normal functioning. If the research demands too much in terms of time or alteration in normal routine, the agency will not likely respond as fully or effectively as it would to a study that fit better into their normal operations.

Family therapy has developed into an efficient and orderly mode of therapy that typically includes one family (nuclear) and one therapist, meeting once per week (for about one hour) and working with one specific problem. This
procedure fits well with current societal mandates (cost minimization) regarding how family therapy should be conducted. This approach may not suit all families or best address all problems.

In the second session with Family Pair B, the issues in the families moved beyond the specific misbehaviors of the problem sons to include the deep personal stress and despair associated with abuse, financial destitution, and personal fear. These issues were fundamental problems of living for these families that specific interventions directed at the problem sons would not be able to address. The importance of other types of therapy or assistance became obvious. The mothers in Family Pair B articulated their idea of a therapist as a caring listener. Christopher Lasch (1979) explains his view that turmoil in people's lives today that oftentimes lead them to therapists is a response to feeling isolated from one another. People feel alone and long for connectedness. A problem that presents itself to therapy may be viewed as symptomatic of larger issues or problems (Becvar & Becvar, 1993). The relationship dimension of therapy may well be a more salient characteristic of successful treatment than application of technique or intervention (Satir, 1967; Whitaker, 1976).
This study demonstrated a different way in which families could be engaged in therapy. Concerns for privacy and confidentiality have historically been important professional and ethical considerations that have, in large measure, precluded therapists from working conjointly with two or more families. This has had the unfortunate consequence of eliminating the positive effects that could be realized from such connections. This research removed that barrier and examined how families could work together for their mutual benefit.

This study structured an experience where client families were active co-designers with their therapist of their therapy experience. This system did not require an expert therapist to decipher the family's problem and direct the solution. The family was given the opportunity to collaborate with another family, a second therapist, and an adaptable therapy format, which provided the tools with which to create a unique therapy experience. Clients were seen as capable and helpful, which allowed the therapist to see and work with the strengths and potentials of each client.

This study questions our thinking about privacy/confidentiality in therapy, a priori therapy structures, and therapy done by one therapist with one client. The experiences of the families in this study indicate that
there are advantages to altering customary formats in therapy. These alternate formats and processes are not considered superior, nor are they necessarily suited to all families or all situations, but their reported utility for the families in this study is noteworthy and warrants further study.

**Limitations**

A small selected sample does not allow generalization of the results and conclusions to all families in therapy. To generalize was not the intention of this study. This study revealed reactions of the sample families to a variety of experiences associated with seeing another family in therapy. Further investigation of the specific issues that were raised would be an important next step in learning more about the effects of multiple family therapy models.

This study included two therapists and a researcher who worked similarly and compatibly, which greatly facilitated conducting the study as well as the positive results. The two pairs of families were also very cooperative and incredibly well-matched in terms of their problems and family situations. The collaborative spirit of all the participants was an achievement for all involved. The esprit de corps was a combination of the characteristics of the participants, the situation, and the effort given. Such group spirit may not always develop as deeply as it did in this study. Replication
would be characterized by a different group spirit. The specialness felt by the participants likely affected their responses in significant ways. Their high motivation to do well was a major factor influencing the results of the study (Selltiz, Wrightsman, & Cook, 1976).

True triangulation of methods of data collection, which some researchers insist upon to develop a confidence in the accuracy of the data collected, was not used. This study was based upon the views expressed by the participants' self-reports.

**Implications for Further Research**

One of the findings of this research was that the distinctions between practice and research can be reduced successfully. Research can be designed to be a therapeutic experience for the participants while at the same time providing meaningful research data. Research of therapy should be evaluated, in part, on its therapeutic capacities. Along with the criteria of trustworthiness, a dimension for utility is valuable. This would not preclude basic research but would nonetheless establish a means by which a project's utilitarian abilities could be evaluated.

This descriptive study was designed to generate ideas. Many ideas emerged that deserve further description or analysis, qualitatively and quantitatively. One idea worth
developing is the effects of simultaneous therapy interviews occurring on both sides of the one-way mirror. Research into the effects of several therapists working with the same client together or coordinated sequentially may yield interesting findings when compared with the customary one therapist-one client model.

Combining two, three, or four families in therapy has some distinct possibilities. Notwithstanding the potential for improved outcomes, such combining of families may demonstrate a cost-effectiveness that, in the current climate of mental health care service delivery, would make such treatment particularly inviting. Using models that involve several families with several therapists in multiple formats sequentially over a short period of time may be efficiently and effectively administered. With current interest in brief therapy, perhaps this brief intensive model may be a significant addition.

The therapists in this project used collaborative therapy models. Further research into how this experience would be different using therapists who subscribed to less collaborative practice models would reveal the significance of the therapeutic model to the outcomes of this method using multiple families.
The careful matching of families played an important role in this study. Would clients who were significantly different or unmatched in any systematic way be able to derive benefits from participation in a study such as this? Finding families who are very similar may not always be feasible and therefore it would be important to investigate the significance of that variable.

The matched configurations could be drawn along lines other than family membership. As suggested by the families in the study, joining the husbands/fathers and the wives/mothers may provide unique results. Putting the children from two families together and pairing those groups of children with groups composed of their parents may also be valuable. Another suggestion was to have the families observe while the therapists and researcher talk about the therapy and the research, followed by the families' feedback regarding that observed conversation.

What would be the effect of structuring more than three sessions? Some participants said that three was enough; others wanted the sessions to continue. What if the sessions were the only form of therapy used, as opposed to only a part of the therapy (as was the case in this study)? Given the usefulness of this method, what would happen if it was used only on occasion with families? Some of the participants saw
this method as useful periodically as an ongoing adjunct to their regular therapy.

Putting families together in therapy deserves further investigation. Recent trends to structure therapy in narrow, problem-specific terms risk missing other dimensions of families' life situations. Sometimes problem remediation is only one part of a much larger issue that therapy, as currently defined, is ill-suited to address. Therapy, if defined as remediation of a problem, may have limited utility in people's lives or may need to be redefined to deal with a client's life circumstances. Methods that join families in an effort to better respond to the dilemmas faced by families today may increasingly be a more attractive and viable option.
REFERENCES


APPENDIX A: CONSENT FORMS

INFORMED CONSENT STATEMENT (FAMILY)

The Department of Human Development and Family Studies and Family Resources, Inc. recognize the importance of the protection of human subjects participating in research studies. The following information is provided so that you may decide if you are willing to participate in the present study that will be used as part of a doctoral dissertation. You should be informed that even if you agree to participate, you are free to withdraw at any time.

The purpose of this study is to provide new opportunities for families who come to Family Resources, Inc. that may assist them in resolving those issues that are troublesome to them. In this study, one family will be paired with another family and each family will serve as a "therapeutic team" (under the supervision of the investigator) for three of the other family's therapy sessions. Your permission is requested to be introduced to another family who has come to the agency for family therapy and to consent to have this other family serve as your "therapeutic team" behind the one-way mirror. Your family will serve as their "therapeutic team" as well. In this role as the "therapeutic team," the investigator will assist you in making observations and offering ideas very much like "therapeutic teams" of therapists. The investigator is an experienced therapist and supervisor who has worked with "therapeutic teams" for 15 years.

You will meet the family that you are paired with before the therapy begins. Efforts will be made to match families so that they are comfortable with one another. If you have any objections to the pairing, you may choose at that time (or at any subsequent time) to withdraw from the study. Your therapy would continue with no lapse and with no reduction in service quality.

Three sessions will occur in this format. The therapist for both families is a very experienced clinician who is in the doctoral program in Marital and Family Therapy at Iowa State University. The three therapy sessions will each last 90 minutes (two 45 minute therapy interviews, one with each family). Therapy sessions will be followed by a debriefing meeting lasting 30 minutes, involving both families, the therapist, and the investigator to discuss the experience of therapy that has just occurred. Four weeks following the last therapy session, a follow-up meeting (lasting approximately one hour) will be held with all participants in order to discuss anything about the study and their experience as a participant.
The inclusion of another family in your therapy process is a significant difference in this therapy experience as compared to the typical family therapy process at the agency. All participants will be expressly required to maintain confidentiality regarding the therapy of the other family with whom you have been paired. Families in serious crisis or urgent distress will not be included in this study. Families who agree to participate will be given a stipend to compensate them for their time invested.

The perceptions of families are valuable additions to the therapy process. This study asserts that a family's perspective given from the position of being on a "therapeutic team" adds significant insights to therapy that would enhance the therapeutic potential of that therapy.

Every effort will be made to ensure the confidentiality of all participants. Information gathered in this study will be coded and kept in a locked storage room at Family Resources, Inc. Client names will not be used to label information nor will they be associated in any way with the research findings. Tapes, transcripts, and field notes will be destroyed upon completion of the study. The project staff are experienced therapists who adhere to professional ethical guidelines regarding confidentiality.

Your participation in this study is requested, but strictly voluntary. Please do not hesitate to ask any questions about the study or confidentiality. If you ever have questions about your participation, please call Dr. Harvey Joanning at 294-5215 or Daniel Wulff at (319) 323-1852.

I/we understand what participation in this study will involve. It is also understood that participation is voluntary and that I/we may withdraw at any time.

Signatures of Participant(s)/Guardian and Witness.
Witness: ________________________________
Date: ________________________________
INFORMED CONSENT STATEMENT (THERAPIST)

The Department of Human Development and Family Studies and Family Resources, Inc. recognize the importance of the protection of human subjects participating in research studies. The following information is provided so that you may decide if you are willing to participate in the present study that will be used as part of a doctoral dissertation. You should be informed that even if you agree to participate, you are free to withdraw at any time.

I understand that my participation in this study as a therapist will include the following: 1) The families chosen for this study will come from my caseload, 2) When I see each family in therapy, the other family will be serving as the "therapeutic team" behind the mirror along with the investigator who is in the role of supervisor, 3) Each family will have three sessions under the above format, 4) A debriefing interview will occur with myself and both families after each therapy session, 5) After all three therapy sessions are completed, the families and myself will participate in a final meeting to discuss the study. Each session with a family will last approximately 45 minutes, the debriefing session will last 30 minutes, and the final follow-up meeting will last approximately one hour.

Participation in the study will likely entail no greater risks than already incurred as a therapist at Family Resources, Inc. A potential risk is information that client families provide that may reflect negatively upon their experience in working with the therapist. In such cases, clinical supervisors will be made available to the therapist to discuss and address these issues. Participation may give the therapist greater insight into how families perceive them as a therapist.

Every effort will be made to ensure the confidentiality of participants. Information gathered in the study will be coded and kept in a locked file cabinet at the Family Resources, Inc. Neither therapist nor client names will be associated with the study without their prior permission. Audiotapes and videotapes of the interviews will be erased upon completion of the study.

Any questions concerning the study may be directed to Daniel Wulff at (319) 323-1852 or Dr. Harvey Joanning at (515) 294-5215.

I understand what my participation in this study will involve. I understand that participation is voluntary and that I may withdraw at any time.
Signature of Therapist and Witness:

__________________________  Date:____________________

__________________________  Date:____________________
PERMISSION TO AUDIOTAPE/VIDEOTAPE/OBSERVE

Family Resources, Inc.

In order to better serve those who come to Family Resources, Inc., the therapists audiotape/videotape sessions and use therapy team members to observe through a one-way mirror. These recordings are kept strictly confidential and are used only with the client(s)' written permission. Those serving on the team behind the mirror are committed to confidentiality of the therapy proceedings.

We give permission to the Family Resources, Inc. to use audio and/or video recordings, as well as to have our therapy sessions observed, for purposes of supervision and participation in the research being done by Daniel Wulff. We understand that a condition of this consent is respect of our privacy and the confidential nature of our professional relationship.

SIGNATURES: __________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

DATE: __________________________________________

WITNESS: _________________________________________
FAMILIES HELPING FAMILIES
A Doctoral Study by Daniel P. Wulff, M.S.W.

The following information is provided so that you may decide if you are willing to participate in the present study that will be used as part of a doctoral dissertation. You should be informed that even if you agree to participate, you are free to withdraw at any time.

The purpose of this study is to provide new opportunities for families who seek assistance in resolving those issues that are troublesome to them. In this study, one family will be paired with another family and each family will serve as a "therapeutic team" (under the supervision of the investigator) for three of the other family's therapy sessions. Your permission is requested to be introduced to another family who has come for counseling and to consent to have this other family serve as your "therapeutic team" behind a one-way mirror. Your family will serve as their "therapeutic team" as well. In this role as the "therapeutic team," the investigator will assist you in making observations and offering ideas that may be helpful to the other family. The investigator is an experienced therapist and supervisor who has worked with "therapeutic teams" for 15 years.

You will meet the family that you are paired with before the therapy begins. Efforts will be made to match families so that they are comfortable with one another. If you have any objections to the pairing, you may choose at that time (or at any subsequent time) to withdraw from the study. Your therapy would continue with no lapse and with no reduction in service quality.

Three sessions will occur in this format. The therapist for both families is a very experienced clinician who is in the doctoral program in Marital and Family Therapy at Iowa State University. The three therapy sessions will each last 90 minutes (two 45 minute therapy interviews, one with each family). Therapy sessions will be followed by a debriefing meeting lasting 30 minutes, involving both families, the therapist, and the investigator to discuss the experience of therapy that has just occurred. Approximately four weeks following the last therapy session, a follow-up meeting (lasting approximately one hour) will be held with all participants in order to discuss anything about the study and their experience as a participant.
The inclusion of another family in your therapy process is a significant difference in this therapy experience as compared to the typical counseling experience. All participants will be expressly required to maintain confidentiality regarding the therapy of the other family with whom you have been paired. Families in serious crisis or urgent distress will not be included in this study. Families who agree to participate will have all service fees waived.

The perceptions of families are valuable additions to the therapy process. This study is based on a belief that a family's perspective given from the position of being on a "therapeutic team" adds significant insights to counseling that would enhance the therapeutic potential of that therapy.

Every effort will be made to ensure the confidentiality of all participants. Client names will not be used to label information nor will they be associated in any way with the research findings. Tapes, transcripts, and field notes will be destroyed upon completion of the study. The project staff are experienced therapists who adhere to professional ethical guidelines regarding confidentiality.

Your participation in this study is requested, but strictly voluntary. Please do not hesitate to ask any questions about the study or confidentiality. If you ever have questions about your participation, please call Dr. Harvey Joanning at (515) 294-5215 or Daniel Wulff at (319) 323-1852.
## APPENDIX C: LIST OF TOPICS FROM BEHIND THE MIRROR CONVERSATION

### FAMILY PAIR A

<table>
<thead>
<tr>
<th>SESSION 1</th>
<th>SESSION 2</th>
<th>SESSION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family 1</strong></td>
<td><strong>Family 2</strong></td>
<td><strong>Family 2</strong></td>
</tr>
<tr>
<td>• introduction</td>
<td>• &quot;other&quot; focus</td>
<td>• researcher instructions</td>
</tr>
<tr>
<td>• identification with other couple/family</td>
<td>• instructions</td>
<td>• focus on &quot;other&quot; family</td>
</tr>
<tr>
<td>• difference in their child's misbehavior</td>
<td>• comparison: we've switched positions</td>
<td>• therapy comments</td>
</tr>
<tr>
<td>• difference in child's behavior</td>
<td>• instructions</td>
<td>• couple views other couple of &quot;giving in&quot; to their son</td>
</tr>
<tr>
<td>• questions about the other family's situation</td>
<td>• &quot;other&quot; focus</td>
<td>• therapy interpretation</td>
</tr>
<tr>
<td>• difference</td>
<td>• therapeutic comment</td>
<td>• &quot;other&quot; family focus</td>
</tr>
<tr>
<td>• similarity</td>
<td>• researcher makes connecting comments</td>
<td>• concern that other parents' strategy won't work</td>
</tr>
<tr>
<td>• researcher gives instructions</td>
<td>• therapist comment and reactions</td>
<td>• pros and cons of accepting the son's running around</td>
</tr>
<tr>
<td>• reference to their problems</td>
<td>• format rationale</td>
<td>• therapist interpretation</td>
</tr>
<tr>
<td>• therapeutic comment</td>
<td>• connection of sons</td>
<td>• researcher gives information about other family</td>
</tr>
<tr>
<td>• personal commentary about themselves</td>
<td>• son's trouble with the law is compared to son in other family</td>
<td>• compare their son to other couple's problem son</td>
</tr>
</tbody>
</table>
- difference in boys
- asking about the other family
- similarity between boys
- talk about their situation
- their own situation

- researcher instructions to look at the therapist
- explaining the other family's situation
- family giving advice to other family
- researcher instructions
- researcher instructions
- asking about other family
- researcher instructions
- therapy talk

- direction to view from therapist's position
- identification with therapist
- therapist comment
- discussion about parents' teenage years
- parents' teenage years
- their parents' reaction to being sent away
- reaction of parents to being sent away
- comparison to their son
- comparison of their adolescence with their son's
- differences between their adolescence and their son's adolescence
- discussion about the inadequacies of school
- format decisions

- differences between sons
- problem son is "not so bad"
- life would be happier if son behaved properly
- problem son holds family hostage
- couple would not "trade" their problem child for other couple's son
- couples were more relaxed--less focus on problem kid
- "other" focus
- researcher provides information on "other" family
- kids change moods/behavior quickly
- joking about therapist
- couple asks researcher about the research
couple teases each other about their household responsibilities

Family 1

***************

Family 1
- therapy talk
- personal situation
- personal situation
- researcher instructions
- comment on other family
- personal

***************

Family 2

researcher instructions

***************

Family 2

- researcher information about other family
- researcher instructions
- researcher information about other family
- positive talk about other family

- instructions from therapist
- question about other family
- researcher instructions
- couple interprets other couple's stress
- researcher wants stepfather to ease up on son
- stepfather thinks therapist is upset with him
- stepfather says he is just being honest
- wife defends therapist
- therapy question
- stepfather defends his position
- therapy question
- parental split in parenting discussed
- therapy question
- stepfather appears to be bad guy
- therapy question
- mother has become tougher
- stepfather defends his position
- researcher information about other family
- researcher information about other family
- researcher instructions
- joke about other couple
- "other" focus
- therapist question linking two couples
- focus on their family
- therapist questions
- therapist questions
- therapist questions
- therapy question
- discussion about differences in parenting now from the past
- father tells story of his childhood
- difference between how they were parented and how they parent
- kids are spoiled
- fathers are "tougher" than mothers
- mom fears son
- therapist is seen as an enforcer to son
- discussed son's shoplifting
- focus on self
- kids are greedy

***************

Family 1

- focus on their family
- emphasized that parents should have power over their children
- stepfather critical of famous musicians who committed suicide
- focus on self
- therapy question
- therapy question
- therapy question
- kids are greedy
- therapy question
- discuss mother's tougher stand
- stepfather tells about his childhood
- researcher provides information about other family
- son was limiting their family life
- son holding family hostage
- son holding family hostage
- focus on personal
- stepfather critiques therapist
- stepfather critical of stepson
- focus on their situation
  - comparison to when the parents were kids
- "other" focus
  - researcher instructions
- connection to their situation
  - "other" commentary
  - trying to be tough with kids
  - kids manipulating parents
  - researcher gives information about other family's week's events
- therapist comment
  - hard to be tough with kids
  - "other" focus
  - connection with other family's experience
  - difference between the problem boys in each family
- information about other family
  - their son getting too much parental attention
  - all focus on problem kid--"good" kids go unnoticed
- their own situation
  - focus on problem kid reduces couple's fun time together as a couple
- format
  - negative influence of modern rap music on kids
  - danger of ignoring your other kids in order to deal with the problem kid
  - therapy question
• husband critiques wife's anger management process
• parents argue a little
• researcher gives information about other family
• discussion—"bad" kid's behavior
• mom mentions "bad" kid's good points
• rotate kids from family-to-family idea
• "rotate kids" idea
• mom talks about misbehaviors when she was a kid
• "get tough on kids" philosophy
• parents can't get tough with their kids
• the system prevents parents from disciplining their kids
• parents are powerless
• system needs to help kids before they get into serious trouble
• the system has failed their son
• parents have no authority
<table>
<thead>
<tr>
<th>FAMILY PAIR B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SESSION 1</strong></td>
</tr>
<tr>
<td>Family 1</td>
</tr>
<tr>
<td>researcher instruction</td>
</tr>
<tr>
<td>mom telling son to listen</td>
</tr>
<tr>
<td>discussion about having an &quot;attitude&quot;</td>
</tr>
<tr>
<td>mom connects &quot;attitude of boy in room to her son</td>
</tr>
<tr>
<td>discuss &quot;problem&quot; son's brother--mom says he is a good kid</td>
</tr>
<tr>
<td>mom says that she disciplines both boys</td>
</tr>
<tr>
<td>son behind mirror anxious to get done</td>
</tr>
<tr>
<td>researcher tries to get son behind mirror to comment on boy in room</td>
</tr>
<tr>
<td>son behind mirror fidgets</td>
</tr>
<tr>
<td>researcher tries to get boys to talk</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
son behind mirror fidgets
mom asks about the situation of family in room
discuss other family's situation
mom remarks that boy in room acts "too cute"
researcher says that boy's mom and therapist have tried to tell him this
mom says that she would let her son go to jail if he breaks the law
mom threatens her son that the therapist can take him away if he's bad
mom says her son is not too bad

plans for treatment of disabled son
plans for other son while mom and son are away in treatment
discussion of disabled son's recovery
boys rough-housing
physical therapy will be tough
kids distracting
physical therapy location
son objects to plans for him while his mom and brother are in Chicago

other family looks happier than last week
mom explains she is from Boston originally
story about older brother nearly dying
older son upset when mom teases him about becoming independent
discuss the audio- and video recording
mom teases researcher about their not listening to the therapy session
teasing about older sons moving out

researcher informs family about crisis over the weekend with the other family
should get tougher on problem son

Family 1
Family 2
- mom acknowledges the stress of the other mom
- son behind mirror fidgets—mom threatens with punishment
- researcher asks mom to compare therapist with how she is with her family
- family likes therapist
- mom sees herself as a fair parent
- mom sees herself as patient with her kids
- boys distract the conversation
- researcher gives instructions
- format comments
- format comments

***************

Family 2

- kids don't compare themselves to kids in other family
- format decisions
- therapeutic comment
- teasing about mom trading kids in
- sibling jealousy
- anger and jealousy of son toward his sisters and stepfather
- mom and son battle over who's in charge
- researcher asks about therapist's value
- mom and son continue argument
- discussed tyrants
- discuss being silly and non-serious
- discussion of bi-raciality
- moms spend extra money on their kids rather than indulge themselves
- son's grades in school
- son's grades
- mom may spend the money from this study on herself
- kids support her spending money on herself
- discuss getting—specifically to a family reunion in Missouri
- likes to visit her family, but doesn't want to live there
- mom doesn't get out socially very much

Family 2

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- mom may spend the money from this study on herself
- kids support her spending money on herself
- discuss getting—specifically to a family reunion in Missouri
- likes to visit her family, but doesn't want to live there
- mom doesn't get out socially very much
other mom makes connection between kids in both families

***************

**Family 1**

- mom comments on other mom--compares her situation with other mom's
dad

- kids distract

- compares her son with boy in room

- mom chastises son for not listening

***************

**Family 2**

- researcher informs family about family in the room

- family interested in boy in room's disability (brother of problem son)

- questions about how disabled boy gets around

- discuss situation between problem sons in each family

- son uses therapist as threat against mom

- mom's older sons fight with her too

- therapy question

- mom feels unloved

- son complains about being unloved by mom

- therapeutic—redirect question to older boys

- mom portrays sons as good kids

- older sons are involved in illegal activities

- mom pretends not to know about the illegal activity

- discuss plans for a move

- son tries to get mom and researcher to end early so he can go home

- researcher talked about where other family lived

- drug neighborhoods

- plans to move
- mom having hard time hearing the other room
- mom asks kids for their feedback
- format questions
- difficulty in listening and talking at the same time
- mom interpreting disabled kid's thoughts
- researcher provides information about other family
- mom gets sad thinking about the boys in the therapy room
- empathy for disabled son
- researcher provides information
- mom compares to her son who is disfigured
- researcher suggests boys are normal siblings
- loyalty between brothers
- researcher asks for comments on therapist
- mom's affection level
- mom would throw boys out if they had drugs in her house
- son distracts
- discuss son's desire to have a "beeper"
- money troubles
- son's prospects in getting a job/making money
- son tells mom that older brothers have drugs in the house
- mom disturbed by the prospect of drugs being in her house
- brother's drug use
- mom unaware of son's activities
- therapy question
- mom says she won't save her sons from getting into trouble
- researcher compliments mom on older son
- mom complains of older son's laziness
- mom's G.E.D. program
• format talk

• mom went to
  G.E.D. classes
  only a few times

• older sons are
  bad influence on
  "problem" son

• son battles mom

• therapy comment

• race issue
  (black, white,
  biracial)

• white-black
  conflict

• discussion about
  gangs

• mom and son
  argue

• son sees himself
  as black

• unprepared to
  talk to other
  family
## FAMILY PAIR A

<table>
<thead>
<tr>
<th><strong>Session 1</strong></th>
<th><strong>Session 2</strong></th>
<th><strong>Session 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• researcher instructions</td>
<td>• researcher instructions</td>
<td>• researcher instructions</td>
</tr>
<tr>
<td>• felt a little strange</td>
<td>• one father was stressed out</td>
<td>• couples were more relaxed--not solely focused on boys</td>
</tr>
<tr>
<td>• therapist felt awkward too</td>
<td>• stress was reduced with having someone to share it with</td>
<td>• therapist felt open to say what was really on his mind</td>
</tr>
<tr>
<td>• got easier as we went along</td>
<td>• wife was not as stressed as her husband</td>
<td>• couples express interest in maintaining contact after the study is over</td>
</tr>
<tr>
<td>• felt validated by what they heard</td>
<td>• kids in next room were an extra stress</td>
<td>• researcher comments on therapist's openness</td>
</tr>
<tr>
<td>• felt like problems were similar</td>
<td>• compliment to other family</td>
<td>• discussion of honesty of therapist</td>
</tr>
<tr>
<td>• compared their up-bringings</td>
<td>• compliment to other family</td>
<td>• therapist is pressured to be the &quot;expert&quot;</td>
</tr>
<tr>
<td>• researcher questions</td>
<td>• one husband offers advice to other couple</td>
<td>• therapist was a good collaborator with parents</td>
</tr>
<tr>
<td>• comments about therapist</td>
<td>• comparison between sons</td>
<td>• other counselors are bossy</td>
</tr>
<tr>
<td>• researcher questions to therapist</td>
<td>• one couple advises other couple to place their son (something they didn't do)</td>
<td>• therapist's personal involvement is crucial</td>
</tr>
</tbody>
</table>
confused at times about who he (therapist) was addressing
thought about how to address both families simultaneously
group family therapy--good idea
comfort level with other family
worries coming in
worries about coming in therapist's goofing up children's names
teasing therapist about kids' names confusions
format questions
format discussion
save videotapes
save video discussion
instructions about research format
difference between sons
concern for violence erupting in son's behavior
ambivalence about placement or no
advice to other couple to be tough with their son
researcher instructions
joking about the format
researcher comments about interaction between couples
couples are compatible
researcher didn't want couples exactly the same
problem kids are different
husband criticizes his wife's "softness" as a parent
format shift--husbands together, wives together
therapist encourages couples working together
past bad experiences with counselors
therapist encouraging cooperativeness
therapist as compassionate
clients want solutions
therapist tries to provide answers
researcher instruction
parents decide to relax their stance against their son
format discussion
suggestion to have both couples conjoint
researcher describes protocol
therapist reports improvement through the study
mom acknowledges personal change
therapist sees changes as solid
- researcher protocol
discussion
- discussion about why our kids developed misbehavior--our past?
- couples come up with their "own" answers
  - transmission from generation to generation
  - format suggestions: new configurations
- format adjustments
- researcher explains the need for this to be useful to them
- joking about parents selecting mates
- with problem kid gone, family life is happier
- father wishes he could send his son to a good place
- sex differences in parental roles
- discussion about research protocol
- joking about format, therapist, researcher
- research protocol
- therapist praise
- researcher expresses confidence in therapist for this research
- therapist likes his style
- researcher values therapist's openness and clients' receptiveness
- therapist puts down "expert" role
- therapist describes his development
### FAMILY PAIR B

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• researcher asks for feedback</td>
<td>This debriefing is on the video of the therapy interview</td>
<td>• researcher asks for feedback</td>
</tr>
<tr>
<td>• moms liked it</td>
<td></td>
<td>• more enjoyable session</td>
</tr>
<tr>
<td>• moms felt comfortable with each other</td>
<td></td>
<td>• more relaxed, fun</td>
</tr>
<tr>
<td>• one mom likes to be helper</td>
<td></td>
<td>• discuss one mom's nickname</td>
</tr>
<tr>
<td>• racial issue mentioned</td>
<td></td>
<td>• fun to get away from your own problems for a while</td>
</tr>
<tr>
<td>• one mom initially worried that other family would not be accepting</td>
<td></td>
<td>• families tease therapist</td>
</tr>
<tr>
<td>• moms see themselves as ongoing friends</td>
<td></td>
<td>• therapist was tired tonight</td>
</tr>
<tr>
<td>• researcher explains confidentiality</td>
<td></td>
<td>• okay to not always be &quot;serious&quot;</td>
</tr>
<tr>
<td>• mirror was not intrusive</td>
<td></td>
<td>• format without children present</td>
</tr>
<tr>
<td>• similarity of life situations is comforting</td>
<td></td>
<td>• son said he was reason for our coming together</td>
</tr>
<tr>
<td>• joking about how many other families go through this</td>
<td></td>
<td>• mom says kids were important part of the sessions</td>
</tr>
<tr>
<td>• format discussion</td>
<td></td>
<td>• researcher mentions format for next meeting</td>
</tr>
</tbody>
</table>
• mom chastises son for not listening
• therapist is complimented by moms
• positive comments about therapist
• too bad we meet under these conditions
• therapist indicates some nervousness with the mirror
• therapist feels a little funny being watched
• family behind the mirror can help
• mom asks therapist for feedback regarding improvement
• why those families were chosen
• one mom wants to help the other family
• researcher asks for feedback regarding format
• moms talk together
• research information
• other format changes--who watches whom

• moms like being happy--there's been too much sadness lately
• one son who was usually quiet spoke more tonight
• other son distracting
• mom teases sons
<table>
<thead>
<tr>
<th>FAMILY PAIR A</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Family 1</strong></td>
<td><strong>Family 2</strong></td>
</tr>
<tr>
<td>• therapist compliments couples</td>
<td>• research instruction/question</td>
</tr>
<tr>
<td>• mom worried that her advice would be seen as criticism</td>
<td>• received good advice from other couple—back off of son</td>
</tr>
<tr>
<td>• couples were comfortable with each other</td>
<td>• learned from other couple’s mistakes</td>
</tr>
<tr>
<td>• clients don’t have to take therapist’s advice</td>
<td>• surprise to find someone else going through similar struggles</td>
</tr>
<tr>
<td>• therapist receives valuable feedback from clients</td>
<td>• research question</td>
</tr>
<tr>
<td>• couple reports better relationship with each other</td>
<td>• more sessions would have been good</td>
</tr>
<tr>
<td>• personal situation talk</td>
<td>• research questions to therapist</td>
</tr>
<tr>
<td>• couples value other areas, even if problem son is still &quot;bad&quot;</td>
<td>• sessions helped therapy to get unstuck</td>
</tr>
<tr>
<td>• hard for couple to not be so worried when son acts up</td>
<td>• reduced feelings of isolation</td>
</tr>
<tr>
<td>• couple acknowledges improvement in marriage</td>
<td>• helped therapist maintain optimum therapeutic &quot;distance&quot;</td>
</tr>
<tr>
<td>• therapist suggests that son's misbehavior actually brought them together</td>
<td>• &quot;non-expert&quot; stance was reinforced</td>
</tr>
<tr>
<td>• criticizing problem son</td>
<td>• researcher asks for feedback on design of study</td>
</tr>
<tr>
<td>• researcher asks if research interviews helped their situations</td>
<td>• initial concerns did not happen</td>
</tr>
<tr>
<td>• researcher mentions mom's comment that she hears her own advice better when she tells it to the other couple</td>
<td>• does connectedness do anything other than make you feel better?</td>
</tr>
</tbody>
</table>
researcher asks if therapist acts different with each couple
• couple says therapist is the same
• couple sees the sessions as "calming"

researcher reminds the couples that during this time their problems were severe
• therapist and couples were "stuck" in therapy
• therapist has reduced contact with families since the end of the study
• family life is improved

research question
• discussed four couples instead of two
• couples were matched, but not exactly the same
• three sessions was good—not more would have been redundant
• this format was a blend of therapy and support group
• suggestion to have had the boys included
• discussed multiple impact therapy

mom says she will not blow-up (crack-up) now
• father no longer fights (physically) with son
• couple had (prior to the study) entered into a relationship with another couple where they shared parenting ideas
• other family in this kind of arrangement is crucial—it must be a good match

• match of couples is important
• such sessions should be implemented in agencies on a regular basis
• more than two couples would be problematic
• discussion of paring husbands together and wives together
• discussed if we had used their kids in the study
• with kids, it would have been more chaotic
• research question

• couple liked it
• couples and therapist "relaxed" more as a result of these sessions
• emphasis on meeting and talking with others of similar experience
• therapist described the value (professional) of this experience
• this study will be mentioned at a national conference
• researcher describes the data and plans for using it
FAMILY PAIR B

Family 2

- researcher asks for feedback on the three sessions
- daughter acts silly and shy
- mom spent money on herself
- kids being silly
- mom describes how she spent the money from the study
- helpful to know other families have similar troubles
- knowing others have similar problems lets you ease up on yourself
- mom says kids got little out of the session
- mom frustrated with kids' silliness
- mom teases researcher
- researcher asks therapist for feedback
- certain themes in therapy got very concentrated attention here
- mom felt "pushed"
- mom was relaxed with other family
- kids being silly
- format feedback question

FAMILY PAIR B

Family 1

- researcher feedback request
- son wants to see the video of himself
- son said they liked coming, but couldn't say why
- mom teases researcher
- mom received support and ideas on how to deal with son
- mom gave advice too
- therapist saw the other mom as offering things that she, as a therapist, was not able, or less able to provide
- feedback question
- mom didn't like other family's problem son's "attitude"
- that bad attitude did not adversely affect her son
- kids didn't pay attention
- discussed how it would have been different if we had left the kids out
- kids did listen to some things
- impact of these sessions on their overall therapy
- mom said it helped, but not clear how
- therapist said the sessions speeded up the process
• in the therapy room seemed more productive, serious
• families were well-matched
• format was designed to use other family's comments in therapy
• therapist is friend
• mom doesn't feel other mom "judged" her
• mom explains her desire to help her son
• other family was being helpful not judgmental
• other kids were quiet
• kids' behavior here is more playful than at home
• format idea to meet in families' homes
• meeting in homes would be too chaotic, stressful
• mom likes to talk to therapist away from the home
• therapist and mom had emotional experience recently
• content of meeting more important than location
• mom considering moving her family to another town
• son objects to moving
• therapist sees the process as more intense, more impactful
• mom teases researcher

• initial fear of whether or not the other family would be accepting of them
• moms connected with each other well
• mom suggests another meeting in a few months
• using more families would not be as good
• mom preferred both families together in the same room talking
• mom teases researcher
• researcher would have said less without the mirror format
• kids were distracting behind the mirror
• therapist concerned about how to focus on family when both are in together
• therapist concerned about how families would evaluate her
• therapist was seen as even-handed with each family
• mom says she has changed--but not the kids
• format discussion--what if this format was all of your therapy?
• mom would like it
• mom doesn't think that she'd get tired meeting with the other family
• playful session
• recap of sessions

• researcher asks for continued help from moms in write-up--mom agrees
• topics were covered by many voices—researcher, therapist, other mom
• issue of "too intense?"
• researcher recaps the breadth of topics discussed over the three sessions
• joking between researcher and mom
• therapist worked similarly with each family in the sessions
• therapist available to family in crisis
• son being silly
• son expresses concern with the therapist leaving
• daughter sees therapist relating to the other family members in similar ways
• researcher outlines protocol follow-up—calls may be necessary
• mom says she'll continue to help

• mom sees her situation with her boys as improved
### FAMILY PAIR A

#### NOTES OF THERAPIST

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<td>• stepfather still negative toward stepson</td>
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<td>• mom blames herself</td>
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<td>&quot;problem son&quot; less a focus</td>
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<td>• therapy effectiveness</td>
<td>• placement as a viable option</td>
<td>• dads join with each other</td>
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</table>
• mom blaming herself issue

Family 1

• couples shared information about their sons and what to watch for

Family 2

• parents unified

• couples shared stories in common

• focus on non-problematic children

Families Together

Family 1

• couple unity theme

Families Together

• therapist gets validated
• therapist compares families
• "problem kid" focus
• emphasized positives
• compared the two families

Families Together

• both families try to give everything to their kids
• couple unity theme
• moms connected with each other
# NOTES OF RESEARCHER

**Family 2**

- bad behavior of son
- suicide risk of son
- parental unity
- therapist challenges parents on being too lenient with their son
- suicide risk
- mom feels guilty for son's behavior
- therapist notes positives in their parenting
- mom guilty
- parental unity
- mom's fear
- parental unity

**Family 1**

- problem son focus
- therapist switches to other kids
- how problem son got this way
- hopelessness regarding how to deal with son
- focus on "bad" son
- family more relaxed with son gone
- society is now different

**Family 1**

- stepfather's physical problems
- focus on bad son's problematic living arrangements
- focus on problem son
- parental disunity
- parents seem happy
- family more relaxed with son gone
- stepfather sees family mood dependent on mom
- problem son behaving better, but mom feels unsupported
- mom feels guilty and depressed
• parents need help
• parents split on how to parent son
• mom guilty

------------------------
Families Together
------------------------

Family 2

• similar situation between sons in two families
• parents want to handle son differently
• therapist tries to give them some pointers--they are still hopeless

Family 1

• dad gives advice
• mom supports other mom
• similarities and differences between sons
• son has good qualities and bad qualities
• need to support non-problem kids too

------------------------
Families Together
------------------------

• issue of son living with biological dad
• parents are divided
• background information on mom and stepfather
• stepfather pessimistic about son
• parental disunity
• strategies to help sons don't work
• research format comment
• parents divided
• parents feel guilty about son's bad behaviors

• change can occur
• couples see each other differently

• parents divided
• therapist feels inadequate

• therapist compliments mom
• son is hard to parent
• "problem son" talk
• therapist notices that parents are more relaxed regarding son

***************

Families Together

• parents need to be firm
• dads have given a lot to their sons
• sons' behaviors have not improved
• parental unity
• moms share fears
• parental efforts to make life better
• parental disagreements and ineffectiveness
• therapist gets to hear clients' views to check if he is in "sync" with them
FAMILY PAIR B

NOTES OF THERAPIST

SESSION 1

Family 2
- mom and son argue
- therapist tries to divert the argument
- mom seems to see her role in argument maintenance
- use team behind the mirror

SESSION 2

Family 2
- mom mad about son’s recent misbehavior
- therapist tries to get son to elaborate
- mom ill and is frustrated by son’s goofing around
- format switch

SESSION 3

Family 1
- mom optimistic about son
- school problems of son
- kids who “take off” without permission—typical?

Families Together

Family 1
- family behind the mirror was not listening

Family 1
- mom’s sick
- mom comments that all children should receive equal punishment
- researcher tries to focus on parenting issues

Family 1
- therapist gets teased

Families Together
- playfulness
Family 1

- mom struggles some to accept other mom's compliments
- mom sees similarity with other mom
- mom defends unequal treatment of kids
- mom accepts her good work
- talk about kids' activities
- discuss problem kid's behavior
- discuss problem kid's behavior and some possible solutions
- positive side hard to bring up

Family 2

- son's talk to each other
- moms align with the need to be tough with their kids
- one mom heard the other mom's comment about equal treatment of kids
- problem son is discussed in relation to his older brothers
- rough world when moms were younger still exists--mom worries about her sons

Families Together

- discuss namecalling
- moms will spend stipend for/on themselves
- son wants some of the money
- moms say they don't socialize anymore

- mom talks discipline
- problems between mom and her boyfriend are discussed
- problems with housing
- therapist asks to have her role clarified
• format switch

Families Together

Families Together
• drugs

• mom compares herself to other mom
• mom lectures other mom’s kid
• mom praises her kids

• son compares himself to son in other family
• other mom confronted son in other family
• one problem kid is the focus

• crippled son given compliments
• mom compared herself to therapist
• one son scapegoat of session?
• similarities between families noted
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• mom pressures her son to talk—researcher deflects this
• son connects with other family's son
• mom compliments other mom

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Family 2

• mom doesn’t accept compliment given by other mom
• mom connects with other mom
• kids are treated differently
• mom talks hopeful
• mom returns compliment to other mom

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Family 1

• physical activities of her boys
• boys are normal

• sons have good days and bad days
• therapist encourages positive focus

• moms talk about parenting

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Family 2

• mom helps other mom by talking to her son
• older boys issue
• moms join with each other

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Family 2

• too silly can be a problem
• mom will spend stipend on herself

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Families Together

• son’s misbehavior
• cussing
• son diverts

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Families Together

• moms think of doing more for themselves

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Families Together

• physical punishment questioned
• mom upset with boyfriend and landlord

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Families Together

• mom teases researcher
Families Together

- one mom speaks to mom in other family
- comparison between problem sons
- mom lectures son in other family
- son compares himself to other son
- other mom speaks to son in other family
- mom compliments other family
- mom compares her family to other family
- moms both encourage crippled child
- researcher asks for feedback regarding the therapist
- mom's heart goes out to other family
- mom identifies with other mom
- one son was focus—he says he was okay with that

- moms talk about unhappy pasts
- moms have to get real upset before changes occur
- kids joking—moms are getting something out of these sessions
- stress in other areas is huge
APPENDIX G: CATEGORIES AND COMPONENT TOPICS

RESEARCH FORMAT AND PROCEDURES

Researcher instruction

Format comments

Format questions

Difficulty in listening and talking at the same time
Researcher says that mom and therapist have tried to get
problem son to listen
Researcher informs family about family in the room
Mom having difficulty in hearing the interview in other room
Researcher provides information about other family

Format decisions

Unprepared to talk to other family

Discuss the audio and video recordings

Researcher informs observer family about therapy family’s
weekend crisis

Researcher talked about where other family lived

Mom teases researcher about their not listening to the therapy
session

Introduction

Researcher instructs observing family to watch their therapist

Explaining the other family’s situation

Format rationale
Direction to view from therapist’s position

Family asks researcher about the researcher

Researcher asks for comments on therapist
THERAPEUTIC INTERACTION

Researcher tries to get son to comment on boy in the therapy room.

Researcher tries to get boys to talk.

Researcher asks mom to comment on the other mom’s stress level.

Researcher asks mom to compare therapist’s behavior with therapy family and her family.

Researcher suggests boys are normal siblings.

Therapeutic statement.

Therapeutic comment.

Teasing about mom trading kids in.

Therapy question.

Therapeutic--re-direct question to older boys.

Researcher compliments mom on older son.

Teasing about older sons moving out.

Should get tougher on problem son.

Discussed tyrants.

Discuss being silly and non-serious.

Therapy talk.

Therapist question linking two couples.

Rotate kids from family to family idea.

Rotate kids idea.

Therapy interpretation.

Couples were more relaxed--less focus on problem kid.
Researcher makes connecting comments

Therapist comment and reactions
SIMILARITIES BETWEEN FAMILIES

Mom connects “attitude” of boy in room to her son

Mom acknowledges the stress of the other mom

Other mom makes connection between kids in both families

Mom compares her situation with other mom’s

Compares/contrasts her son with boy in room

Discuss situation between “problem son” in each family

Mom compares to her son who is disfigured

Comparison between two sons

Identification with other couple/family

Similarity

Similarity between boys

Link to their situation

Connection to their situation

Connection of sons

“Run-ins” with the law is compared between boys’ parents

Connection with other family’s experience

Compare their son to other couple’s “problem son”
DIFFERENCES BETWEEN FAMILIES

Compares/contrasts her son with boy in room

Kids don't compare themselves to kids in other family

Difference in their child's misbehavior

Difference in child's behavior

Difference

Difference in boys

Comparison: we've switched places

Difference between the problem boys in each family

Problem son is "not so bad" [as problem son in other family]

Couple would not trade their problem child for other couple's son
FOCUS ON OWN FAMILY

Discuss "problem son's" brother--mom says he's a good kid
Mom says that she disciplines both boys
Mom says her son ought go to jail if he breaks the law
Mom threatens her son that the therapist can take him away if he's bad
Mom says her son is not too bad
Tease son about liking daughter in other family
Mom sees herself as a fair parent
Mom sees herself as patient with her kids
Mom's affection level
Mom gets tough when kids misbehave
Disabled son doesn't get preferential treatment
Discuss disabled son's plan for rehabilitation
Plans for other son while mom and son are away in treatment
Discussion of disabled son's recovery
Boys' rough-housing
Physical therapy will be tough
Physical therapy location
Son objects to plans for him while his mom and brother are in treatment
Plans for Chicago trip
Sibling jealousy
Anger and jealousy of son toward his sister and step-father
Mom and son battle over who is in charge
Mom and son continue argument
Son angry with mom
Son uses therapist as threat against mom
Mom’s older sons fight with her too
Mom feels unloved
Son complains about being unloved by mom
Mom portrays sons as good kids
Older sons are involved in illegal activities
Mom pretends not to know about the illegal activity
Mom would throw boys out if they had drugs in her house
Discuss son’s desire to have a beeper
Money troubles
Son’s prospects in getting a job/making money
Son tells mom that older brothers have drugs in the house
Mom disturbed by the prospect of drugs being in her house
Brother’s drug use
Mom unaware of son’s activities
Mom says she won’t save her sons from getting into trouble
Mom complains of older son’s laziness
Mom’s G.E.D. program
Mom went to G.E.D. classes only a few times
Older sons are bad influence on “problem son”
Race issue (black, white, bi-racial)
White-black conflict
Discussion about gangs
Mom and son argue
Son sees himself as black
Mom and kids quarrel about son’s squirt gun
Discuss squirt guns
Mom explains that she is originally from Boston
Story about older son nearly dying
Older son upset when mom teases him about becoming independent
Mom spends extra money on her children rather than herself
Son’s grades
Mom may spend the money from this study on herself
Kids support her spending the money on herself
Discuss going to a family reunion in Missouri
Mom likes to visit her family but doesn’t want to live there
Mom doesn’t get out socially very much
Discuss mom’s musical tastes
Discuss son’s dad
Drug neighborhoods
Discuss plans for a move
Reference to their problems
Personal situation
Focus on their family
Focus on their situation
Discussion about parents’ teenage years
Their parents’ reaction when they were “placed” as teenagers
Comparison of their adolescence with their son’s
Difference between when parents were teens and now
Talk about a previous counselor
Father tells story of his childhood
Difference between how they were parented and how they parent
Mom fears son
Therapist is seen as an enforcer to son
Discussed son’s shoplifting
Son is getting too much parental attention
All focus on problem son—good kids go unnoticed
Focus on problem kid reduced couple’s fun time together
Husband critiques wife’s anger management process
Parents argue a little
Discussion about problem son’s behavior
Mom talks about misbehaviors when she was a kid
Parents feel powerless
The “system” has failed their son
Life would be happier if son behaved properly
Problem son holds family “hostage”
Couple teases each other about their household responsibilities
Stepfather says he is being honest
Stepfather defends his position
Discussed parental split
Stepfather appears to be a "bad" guy
Mother has become tougher
Stepfather tells about his childhood
Son was limiting their family life
Stepfather critical of stepson
FOCUS ON OTHER FAMILY

Discussion about having an “attitude”
Mom asks about the situation of family in room
Discuss other family’s situation
Mom remarks that boy in room acts “too cute”
Family interested in son’s disability
Questions about how disabled boy gets around
Mom interpreting disabled kid’s thoughts
Mom gets sad thinking about the son in the therapy room
Empathy for disabled son
Loyalty between brothers
One mom has tough stance on kids leaving home at age 18
Children should be treated equally
Other family looks happier than last week
Asking about the other family
Family interpreting/giving advice to other family
Comment on other family
Focus on other family
Positive talk about other family
Joke about other couple
Information about other family
“Other” commentary
Couple views other couple as “giving in” to their son
Concern that other parents’ strategy won’t work
Pros and cons of accepting the son’s running around
Couple comments on/interprets other couple’s stress
FOCUS ON THERAPIST

Identification with therapist

Joking about therapist

Stepfather thinks therapist is upset with him

Wife defends therapist

Stepfather critiques therapist

Family focuses on therapist’s posture

Family likes therapist

Comment on therapist
DISCUSSION OF PROBLEMS IN GENERAL TERMS

Discussion about the inadequacies of school

"Kids" change moods/behavior quickly

Discussion about the past--times were tougher

"Kids" are tough to deal with

"Kids" are demanding

"Kids" don't listen to parents

Discussion about differences in parenting now from the past

"Kids" are spoiled

Fathers are tougher than mothers

Emphasized that parents should have power over their children

"Kids" are greedy

Step-father critical of famous musicians who committed suicide

Comparison to when the parents were kids

Trying to be tough with kids

"Kids" manipulating parents

Hard to be tough with kids

"Get tough on kids" philosophy

Parents can't get tough with their kids

"The system" prevents parents from disciplining their kids

Negative influence of modern rap music on kids

"The system" needs to help kids before they get into serious trouble

Parents have no authority
Mom telling son to listen
Son behind mirror anxious to get done
Son behind mirror fidgets
Kids distracting
Son pretends to squirt researcher
Mom tries to get kids to listen
Son behind mirror fidgets--mom threatens with punishment
Boys distract the conversation
Mom chastises son for not listening
Son anxious to go home
Small talk about the weather
Son tries to get mom and researcher to end early so he can go home
Son distracts