Informed Therapy: using ethnographic interviews in family therapy

Jeffery Charles Lashley
Iowa State University

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Informed therapy: Using ethnographic interviews in family therapy

Lashley, Jeffery Charles, Ph.D.

Iowa State University, 1993
Informed Therapy: Using ethnographic interviews in family therapy

by

Jeffery Charles Lashley, M.A.

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 Major: Human Development and Family Studies

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In Charge of Major Work
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For the Major Department
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For the Graduate College

Iowa State University
Ames, Iowa

1993

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ACKNOWLEDGMENTS

I want to express my sincere thanks to Dr. Harvey Joanning for his support and guidance during my time at Iowa State University. His unconditional support and perspective through some very unexpected trials during my tenure at ISU made them much more manageable. I also wish to express sincere gratitude to Dr. Charles Cole and to Dr. Linda Enders who played enormous roles in my development. They too made my experiences at ISU worthwhile and purposeful through their guidance, support, and skills in challenging me to grow. In addition, special thanks must go to Dr. Tahira Hira and Dr. John Littrell for serving on my committee and for challenging me with their ideas and supporting my endeavors.

Deepest consideration and thanks goes to the lifelong friends and colleagues that I have made at ISU. First, thank you to Sally Bald, Tim Heinrichs, and Dan Wulff for your friendship and participation in this study. Next, thanks go to David Brown, Pat Keoughan, Lynn Martin, Scott Hensley, Shi-jiuan Wu, Randy Lyle, and Alan Demmit.

I would like to thank Michael T. Schwend and the staff of Preferred Family Healthcare for their support and understanding as I completed this project. Thank you Jamie Gibbons and Jan Davison for completing the work on this paper that I did not have the skill to do.
Finally, to my family Glen, Betty, Jennifer, and Pamela, I thank you for being my family and providing me with unconditional love, support, and acceptance. To them and to Charles Lashley, I dedicate this work.
INTRODUCTION

Through ethnographic interview methodology, researchers have begun to build a client-based description of family therapy. In a pioneering research project, Kuehl (1987) examined the experiences of clients who participated in family therapy by utilizing ethnographic interview methodology. In this project, the researchers conducted ethnographic interviews with families after the families had completed family therapy treatment regarding their experiences of the therapy. This research was useful in that it provided firsthand knowledge regarding differences between families who completed therapy and were satisfied, and families who did not complete therapy and were dissatisfied. Kuehl (1987) suggested that future research should include interviewing families about their experiences of therapy prior to termination so that the information may be fed back into the therapeutic system. Thus, researchers could determine how this information may influence the process of therapy.

Todd (1989) built on this research by examining how information from ethnographic interviews with clients may be fed into the therapeutic system to create a better fit between a family's semantics of therapy and a therapist's politics of therapy. Interviews were no longer conducted post-hoc, but occurred while the clients were still in therapy. Findings suggested that therapists were able to create a
better fit with the clients if they were aware of the clients' experiences.

The present study built on both the work of Kuehl (1987) and the work of Todd (1989) by examining both clients' and therapists' experiences of therapy concurrently. This was achieved by employing ethnographic interview methodology to examine both clients' and therapists' experiences of Informed Therapy. Informed Therapy was defined as therapy that incorporated ethnographic interview data from client interviews back into the therapeutic process. That is, the therapy was considered to be informed if the therapist was receiving information from ethnographic interviews with client families. This differs from traditional models of family therapy in that ethnographic information is not collected much less reported to the therapist. Additionally, the present study focused on building descriptions of how the therapists and clients experienced and used Informed Therapy in the therapeutic process.
REVIEW OF RELATED LITERATURE

Typically what we understand about therapy and the families we work with comes from therapists' observations within the therapeutic context. Further, most of what is written and discussed about therapy is based upon the therapists' rather than the clients' point of view (Fessler, 1983; Garfield, 1978; Gurman, 1977; Kruger, 1985). The use of qualitative methodology to generate more information from different vantage points has rarely been employed. Newfield, Kuehl, Joanning, and Quinn (1991) related that the reciprocal exchange of information between therapists and clients is crucial to systemic therapy, but that generation of feedback from clients using a structured research methodology has largely been ignored. That is, attempts to gather qualitative information, perceptions, and descriptions from clients, therapy teams, or others involved in the therapy process have been largely absent.

Ethnography is that branch of anthropology concerned with describing individual cultures or aspects of cultures in a noninterpretive manner. According to Malinowski, the goal of ethnography is to "grasp the native's point of view, his relationship to life, to realize his visions of the world" (1961, first printing 1922). In the past, ethnographies have attempted to address what it is like to live in a totally institutionalized environment such as an asylum (Goffman, 1961). Other ethnographies have looked at experiences in a psychiatric facility (Caudill, 1958),
with a schizophrenic family (Henery, 1971), and how to make a living being "crazy" as a part of a community treatment program (Estroff, 1981). Despite the fact that psychotherapy, family therapy, and other various forms of therapy and counseling are relatively common in our society, it has only been a recent phenomenon that researchers have begun to conduct research based on the clients' recounting of their experience.

Keeney and Ross (1985) referred to their work *Mind in therapy: Constructing systemic family therapies* as a "cybernetic ethnography;" however, this work was an ethnography about how practitioners experienced therapy rather than how clients experienced therapy. Napier and Whitaker (1978) wrote an ethnography of family therapy in *The Family Crucible*, but again this account was written from the perspective of the therapist and not the client. Tyler and Tyler (1985) have written an ethnographic account of the experiences of being a trainee in a family therapy training program and related that the greatest challenge of the therapist is not in understanding families, but in trying to understand the supervisor's jargon.

Each of these examples demonstrate qualitative investigation into the therapeutic processes; however, they fail to address issues from the client perspective and with few exceptions they fail to fully recognize the recursive nature of the therapeutic relationship. Newfield, Kuehl, Joanning, and Quinn (1991) stated that studies which
document the therapeutic experience as told by the client are essential from a constructivist-based cybernetic orientation. The doctrine of constructivism asserts that we construct or invent reality rather than discover it. Von Forester (1974) related that objectivity or properties of the observer not entering the descriptions of what is observed is impossible. Thus, since the observer is placed in that which is observed, all description becomes self-referential. According to Keeney (1983), the epistemological implication of cybernetics increasingly points to the position that "objectivity" is erroneous since it assumes a separation of the observer and observed. Accepting the premises of second order cybernetics requires a major shift in one's epistemological stance. In practice a therapist must now become aware of feedback loops of mutual influence between self, family, team, supervisor, and any other component that may be a part of the therapeutic system.

This position is in contrast to logical positivist assumptions, such as quantification and objectivity which supports the idea that perceptions can be the accurate templates of reality. Qualitative research methods, as described by Moon, Dillon & Sprenkle (1990) attempt to:

understand the meaning of naturally occurring complex events, actions, and interactions in context, from the point of view of the participants involved (p. 358).

Qualitative research is therefore, subjective, inductive, and constructive in nature.
In contrast, quantitative research seeks to enumerate, verify, and deduce from an objectivist position. This conventional paradigm assumes that the "real" world exists independent of the observer and is stable and predictable. Because of this, quantitative researchers believe that if proper methods are developed, they can accurately describe the world (Atkinson, Heath, & Chenail, 1991). Modern qualitative investigations are not concerned with first constructing hypotheses based on previous research and then testing them on informants, nor are they concerned with studying independent variables holding all things constant (Newfield, Kuehl, Joanning, & Quinn, 1991).

Within a constructivist-based cybernetic orientation clients are conceptualized as autonomous subsystems which are part of a larger therapeutic system consisting of the interacting meaning systems of the client(s), therapist(s), and any other therapeutic component that may be involved in the treatment (Newfield, Kuehl, Joanning, & Quinn, 1991). Thus, qualitative ethnographic investigation into each component of the therapeutic system, client(s), therapist(s), and other treatment components can challenge the way that therapy proceeds or is conducted. Further, this research will need to address the recursive flow of information and mutual influence between these therapeutic components.

Interpersonal process recall (IPR) is a special interview procedure with a long
history as a method to study psychotherapy process (Elliot, 1986). Studies utilizing IPR have provided information regarding the experiences of both clients and counselors involved in the therapeutic process. Researchers using IPR typically videotape therapy sessions that are immediately played back for client informants. The informants are then asked to remember and describe any experiences or perceptions associated with particular events during the therapy.

Kagan, Krathwohl, and Miller (1963) conducted a study utilizing IPR where counselor and client would review a tape of a just completed session to describe and interpret their feelings about what had just occurred. The researchers concluded that IPR would be a helpful technique for validation of theory, education of counselors, and acceleration of therapy.

Kagan (1980) used IPR as a training method for student therapists by providing client feedback to the student therapist and through additional training in clinical interview. Kagan related that students learned they could be both confrontive and supportive with clients. In addition, students learned how their clients reacted to them and which of their behaviors the clients found helpful and those they did not find helpful.

Elliot (1985) used IPR to obtain volunteer student clients' descriptions of helpful and nonhelpful events in brief counseling sessions. Clients in the study were asked
to describe what therapy events helped or hindered the therapy process. Elliot reported two primary clusters of events that the students described as helpful, and two primary clusters of events that were described as nonhelpful.

Helpful events were considered to be the counselor providing the student with some form of new helpful information which increased the student's insight, and events in which the counselor displayed understanding or was sympathetic to the student's situation. Nonhelpful events were considered to be misperception of events where the student felt inaccurately perceived and events in which the counselor was perceived as uninvolved or critical.

Rennie (1992) conducted a study where clients were asked to review a tape of therapy and recall anything of significance or interest they recalled. Findings suggested that clients were reluctant to voice discontent about their therapy to their therapist. Even when the therapist invited clients to report discomfort with the therapeutic relationship, they would defer to the therapist.

Through ethnographic interview methodology researchers have begun to build a client-based description of family therapy to examine the perceptions of clients in family therapy (Joanning, 1989; Joanning, Newfield, & Quinn, 1987; Kuehl, 1987; Kuehl, Newfield, & Joanning, 1990; Newfield, Kuehl, Joanning, & Quinn, 1991; Todd, 1989; Todd, Joanning, Enders, Mutchler, & Thomas, 1990).
In a pioneering research project, Kuehl (1987) examined the experiences of clients who participated in family therapy. Through the use of ethnographic interviews, he examined what families liked and disliked about the therapy process. Interviews were conducted with clients after they had completed family therapy treatment thereby providing valuable firsthand information about what the families' experiences had been.

Kuehl (1987) found that families were frustrated with what they thought were large abuses of time, such as telling them things they were not ready to do and going over the same issues week after week. This research was particularly important because it addressed the therapeutic process from the client's perspective and not from the therapist's perspective as is typically done (Kruger, 1985). Kuehl (1987) suggested that future research might involve obtaining information about clients' experiences of therapy and introducing this information into the therapeutic context during the course of therapy.

A series of related studies and analysis were subsequently conducted building on the research of Kuehl (1987). Kuehl, Newfield, and Joanning (1990) examined the perceptions of clients following participation in family therapy. An ethnographic interview methodology was employed to generate information regarding the clients' perceptions of the therapeutic process. The authors stated, "The goal of this study
was to initiate the construction of a client-based description of family therapy" (Kuehl, Newfield, & Joanning, 1990, p.1). This study suggested that therapists can benefit from hearing what clients have to say about their experiences of therapy, particularly what they find to be useful and not useful. Again, these interviews were conducted after completion of treatment services.

The researchers identified two important areas from the results of this study. First, the results indicated what clients liked and disliked about therapy. Of significance, the researchers found that clients who viewed their therapist as personable, caring, and competent were more likely to be satisfied with their therapeutic experience (Kuehl, Newfield, & Joanning, 1990). Therapy was viewed more positively when therapists were able to generate what the clients considered to be relevant suggestions. The clients' descriptions also suggested that successes in the later stages of therapy often depended on successes in the early stages of therapy.

Families who did not have a satisfying experience in therapy doubted the therapist's understanding of them or their problem and questioned the therapist's ability to generate helpful suggestions about the problem (Kuehl, Newfield, & Joanning, 1990). The researchers also suggested that therapists may be resistant themselves to the therapy process if they are not flexible in their use of theory. That
is, it seems a therapist may become resistant when they continue to propose a particular model of therapy that the client will not accept.

Secondly, the authors identified the methodology employed in the study as not meeting the usual expectations of objectivity or quantification (Kuehl, Newfield, & Joanning, 1990). That is, the study did not conform to the parameters of logical-positivistic science and the results were not statistically generalizable. The researchers indicated that the ethnographic interview methodology employed in this study yielded results more descriptive of process and connectedness than a less fluid research design would have allowed. The methodology and constructivist perspective utilized by the researchers was a very conscious effort to begin building a description from the client's perception of reality. This study was of particular importance in that it provided important information about how families experience family therapy grounded in the families' perceptions. This provided therapists with firsthand knowledge regarding the families' experiences, thus providing therapists with information that could help them to deliver a higher quality service.

In related work Newfield, Kuehl, Joanning, and Quinn (1991) conducted a mini-ethnography describing clients' perceptions of family therapy from interviews conducted and analyzed using an ethnographic interview methodology. Again, these interviews were conducted with clients after the completion of family therapy.
The authors reported seven primary domains of meaning: 1) expectations of "counseling," 2) types of "psychos" and "shrinks," 3) the setting, 4) individual versus family therapy, 5) characteristics of the counselor, 6) adolescent bullshitting, and 7) how counseling progresses (Newfield, Kuehl, Joanning, and Quinn, 1991). These domains were seen to highlight areas of interaction between therapists and clients where the potential for unvoiced misunderstanding appears to be high. The researchers reported that successful family therapy requires at least a minimal amount of sustained social coherence and shared substantive meaning over many contacts. The results from this study suggested that at times therapy was an ambiguous experience with little consistency in how therapists and clients conceptualize therapy. Often when these experiences were not consistent, the clients seldom brought this to the attention of the therapist. These differences were seen to distinguish between successful and unsuccessful therapy.

Todd (1989) took this process a step further by examining how information from ethnographic interviews with clients may be fed back into therapeutic system to create a better fit between a family's semantics of therapy and a therapist's politics of therapy. This research built upon the work of previous client-based research by incorporating the information from ethnographic interviews directly back into the therapeutic process. Interviews were no longer conducted post-hoc but occurred
while the clients were still in therapy. The information from these interviews was
then fed back to the therapist so the therapist was able to discover if the therapy
was fitting with the family or not.

Findings suggested that clients have certain expectations of therapy, and if these
expectations are not met, the clients become dissatisfied or frustrated with the
therapy (Todd, 1989). Todd's research found that the therapist is better able to fit
with the clients if they are aware of the clients' expectations. Most importantly,
therapists were able to produce a more positive therapy experience for the clients
when they became aware of the clients' negative perceptions by altering the therapy
to address these issues.

Varela (1979) stated that if the context of a situation is changed, then the
meaning is changed. Todd (1989) found that introducing an ethnographic interview
into the therapy process changed the context for the family, thus changing the
meaning for the family. As a result, the ethnographic interviews generated new and
different information from the clients that could be introduced into the therapy
process. This new information allowed the therapist to become more isomorphic
with their client families. This study was unique in that a non-therapy interviewer
was used to gain information about the therapy process, not a cotherapist. The
results of the study indicated that the ethnographer gained information that the
therapist was not generating during the therapy sessions.

The present qualitative study was designed to build on this research by employing ethnographic interview methodology to examine both clients' and therapists' phenomenological experience of therapy concurrently. Ethnographic interviews were conducted with both therapists and families to build descriptions of how they experience the therapy process. The information from these interviews was then fed back into the therapeutic system. The focus of the present study was to evaluate how useful information obtained through the ethnographic interviews was to the therapeutic process. The study was an attempt to generate new information about how clients and therapist experience Informed Therapy and about how this information can be used to guide therapy.

Purpose of the Study

The present study was designed to develop an initial ethnographic description of how therapists and clients experience family therapy treatment, and how therapists' experience information gathered from interviews as a part of family therapy. Thus, this study was a mini-ethnography not concerned with documenting and analyzing a broad range of data or conducting quantitative analysis. Rather, this study was limited to a discussion of the clients' and therapists' construction of the therapy experience around focused domains of inquiry. The primary focus of the study was
to investigate the therapists' perception of the usefulness of Informed Therapy. The information from this study should provide insight into how therapists' perceive the use of ethnographic interviews as a part of the therapy process. Ethnographic interviews are a pragmatic tool that therapists may employ to guide and improve the services that they provide. The procedure that was utilized in this study will be relatively easy for therapists to employ in their practice regardless of the approach to working with families.

Limitations of the Study

The limitations of this study follow:

1. All client families interviewed in the study were Caucasian, thus their experiences may not be generalizable to other client populations.

2. The study will be limited to therapist and client experiences in the early stages of therapy. Therefore, findings may not be generalizable to other stages of therapy.

Delimitations of the Study

The following variables were controlled for the purposes of the study:

1. Both female and male therapists participated in the study.

2. Each therapist in the study possessed a different level of professional experience in conducting family therapy. Therapist (A) had a high degree of
experience, therapist (B) had a moderate degree of experience, and therapist (C) had a low degree of experience.

3. All ethnographic interviews were conducted by the author.

4. The study focused only on client and therapist descriptions of early family therapy sessions.

5. All ethnographic interviews were conducted immediately after the therapy sessions.

6. Only qualitative data was considered due to the preliminary and generative nature of the study.

Assumptions of the Study

The methodology and design of this study carry the following assumptions:

1. The design of the study was deliberately qualitative and subjective in nature.

2. The nature of the study was preliminary and generative, rather than to confirm objective hypotheses.

Questions Posed by the Study

The present study was designed to generate new information about the following questions:

1. What were the therapists' perceptions and experiences of the Informed
Therapy process?

2. What were the clients' perceptions and experiences of the Informed Therapy process?

3. What could have been done differently to make the Informed Therapy process more useful?

Summary

An introduction, brief review of related literature, and the purpose of this study for the field of family therapy have been presented in this chapter. The following chapters will provide a presentation of the methodology employed in the study, the results of the study, and finally the conclusions of the study.
METHODS

This chapter presents a description of the informants, the interviewer, the procedure, and the method of data analysis.

Informants and Interviewer

The informants for the study were client families and therapists participating in family therapy at the Iowa State Family Therapy Clinic in Ames, Iowa. The Iowa State University Family Therapy Doctoral Program has been accredited by the Commission on Accreditation for Marriage and Family Therapy Education, a division of the American Association for Marriage and Family Therapy. The study was conducted with the approval of the Human Subjects Review Committee of Iowa State University.

The sample consisted of nine client families and three therapists who were selected opportunistically. In opportunistic sampling, the ethnographer selects whatever informants are available and might reward them with information relevant to the topic of inquiry (Honigam, 1970). Opportunistic sampling was considered appropriate for the study since it was preliminary in nature, and not an attempt to generate a representative description. Each client family was required to participate in at least three therapy sessions for inclusion in the study. This sample of nine families appeared to reach a saturation point, that is, a point where the informants
were providing little or no new information with the content of the interviews becoming redundant.

The therapist informants involved in the study were one female and two male students in the Doctoral Specialization in Marriage and Family Therapy at Iowa State University. One male therapist (A) had a high degree of experience in working with families, the female therapist (B) had a moderate degree of experience in working with families, while the other male therapist (C) had a low degree of experience in working with families. As with subject families, the interviews with the therapists appeared to reach a saturation point when the information had become redundant with little or no new information.

The ethnographic interviews were conducted by the primary investigator who is a doctoral candidate in marriage and family therapy at Iowa State University. The primary investigator did not participate as a therapist or a therapy team member for any of the client families participating in this study.

Procedure

Two separate formats were employed in the present study. The following is a brief review of each Format. The term "debriefed" signified instances when therapists and clients were interviewed about their experiences of the therapy process. Families were debriefed immediately after sessions one, two, and three.
Therapists were debriefed after sessions two and three. The term "informed" indicated instances when the information from the family's debriefing was reported to the therapist. The term "not informed" indicated instances when the information from the family's debriefing was not reported to the therapist.

In Format I, the client families were debriefed after treatment session one and the therapists were then informed of the families' perceptions of therapy (Informed Therapy). The therapists were not debriefed after session one. After treatment session two, the families were again debriefed; however, the therapists were not informed of the families' perceptions. At this point, the therapists were debriefed regarding their perceptions of the therapy process. After treatment session three, the families were again debriefed regarding their perceptions of the therapy process and the therapists were informed of the families' perceptions. The therapists were again debriefed regarding their perceptions of the therapy process.

In Format II, the families were debriefed immediately after session one. The therapists were not informed of the families' perceptions nor were the therapists debriefed. After treatment session two, the families were debriefed and the therapists were then informed of the families' perceptions of the therapy process. The therapists were then debriefed regarding their perceptions of the therapy process. After treatment session three, the families were again debriefed, the
Therapists were informed of the families' perceptions, and the therapists were again debriefed regarding their perceptions of the therapy process. (See Figure 1.)

Therapist (A) had one client family experience Format I and two client families experience Format II. Therapist (B) had two client families experience Format I and one client family experience Format II. Therapist (C) had one client family experience Format I and two client families experience Format II.

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<td>Treatment Session I</td>
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<td>-Family Debriefed</td>
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<td>-Therapist Informed</td>
<td>-Therapist not Informed</td>
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<tr>
<td>Treatment Session II</td>
<td>Treatment Session II</td>
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<tr>
<td>-Family Debriefed</td>
<td>-Family Debriefed</td>
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<td>-Therapist not Informed</td>
<td>-Therapist Informed</td>
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<td>-Therapist Debriefed</td>
<td>-Therapist Debriefed</td>
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<tr>
<td>Treatment Session III</td>
<td>Treatment Session III</td>
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<tr>
<td>-Family Debriefed</td>
<td>-Family Debriefed</td>
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<tr>
<td>-Therapist Informed</td>
<td>-Therapist Informed</td>
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<td>-Therapist Debriefed</td>
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Figure 1. A diagram of Formats I and II.
This design allowed each family and therapist to experience therapy when the information from the debriefing interviews was shared with the therapist and when the information from the interviews was not shared with the therapist. Further, it allowed each therapist to experience the informed process at different points in the therapy process. Four of the client families received Format I while five of the client families received Format II.

Client families were recruited for inclusion in the study by the primary investigator prior to their first session. Families were given the following explanation in order to solicit their participation in the study:

In order to improve services for the clients who visit our clinic, we are interested in your experiences at the Family Therapy Clinic. Therefore, we are requesting your permission to ask you questions regarding your experiences immediately following your first three sessions of therapy. These interviews should last approximately 15 to 30 minutes. Further, at times I will need your permission to share the information you give me with your therapist. Prior to sharing any information from our interviews with your therapist, I will inform you of what I plan to report to obtain your consent.

Families were informed of the additional time requirements that participation in the study would require. Families were not considered to be incurring any greater risks by participation in the study than they already incurred by being clients at the marriage and family therapy clinic. They were informed of the benefits of participation and any questions they had regarding participation were answered. All clients who agreed to participate in the study had service fees waived. All
participants then signed a written consent regarding participation in the study (see Appendix A). Families also completed the usual client agreement forms that are a part of the normal operation of the Iowa State Family Therapy Clinic (see Appendix B). All consent forms were approved by the Iowa State Human Subjects Review Committee. Families were also informed that a written summary of the study would be made available to them if they so desired.

Of the ten families recruited for the study, nine agreed to participate. One family declined to participate in the study; however, this family did receive services at the Iowa State Family Therapy Clinic. Therapist informants in the study were provided with an overview of the study and informed of potential risks and benefits. Each therapist signed an informed consent form prior to participation in the study (See Appendix C).

Debriefing interviews were conducted with client families immediately after sessions one, two, and three. This allowed the primary investigator access to the families' immediate experiences of therapy. The interviews lasted approximately 20 to 40 minutes. Once each family member had given verbal consent to begin the interview, the debriefing began with the following introduction and question:

As I discussed with you earlier, to improve the services that we provide to clients I am interested in asking you some questions about what you have just experienced. I would like you to think of me as a friend or family member who you are talking with about your visit here. You have just spent the previous hour
talking about issues in your family; would you please describe for me what this experience was like for you?

This question was purposefully general in an effort not to influence family members’ thoughts or opinions. In this manner the interviewer focused on what had been meaningful to the family. The interviewer concentrated on picking out important words and themes from the family and expanding the interview based on this information.

The interviews were conducted using open-ended or moderately structured questions to elicit as much information as possible from informants. The interviewer incorporated three types of ethnographic questions: descriptive, structural, and contrast (Spradley, 1979).

The first question asked of the family is an example of a descriptive or grand tour question. Spradley (1979) related that descriptive questions are grand or mini-tour questions. That is, questions which ask for a tour of the subject of interest. The response to a grand tour question can vary greatly among families; thus, mini-tour questions were based upon what the family had offered.

Structural questions are to be asked concurrently with descriptive questions (Spradley, 1979). These questions were used to gather specific information about the topic being discussed. For example, several of the client families in the present study related that prior to coming to the Iowa State Family Therapy Clinic they had
seen other professionals about their family issues. In response to this information, the interviewer asked the following structural question, "You have stated that previously your family worked with a counselor, could you list all the different people you have seen about family issues?"

Contrast questions were used in conjunction with the descriptive and the structural questions. These questions allowed the ethnographer to ask about differences between perceptions. From the previous example, the interviewer asked the following contrast question to elicit more information, "What, if any, are the differences in your experiences with your therapist at this clinic as compared to your experiences with the other therapists you have worked with?"

The specific descriptive, structural, and contrast questions posed in this study were determined by what the family had experienced as meaningful; thus, they varied from case to case. However, the following questions emerged during the study and were asked of all client families who participated in the study:

1. What, if any, of your experiences from the previous hour did you find particularly helpful or positive?

2. What, if any, of your experiences from the previous hour did you find not to be particularly helpful or that you did not like?

3. What have been your perceptions and experiences of your therapist?
4. What has the experience of these debriefing interviews been like for your family?

The client family interviews conducted after treatment sessions two and three followed the same procedure with only slight variation. Interviews two and three were used to build on the information gathered from previous interviews. Each of these interviews began with a reminder to the family of the purpose of the study, a summary of the previous interviews from the interviewer's field notes, and by addressing any questions the family had. The focus of these subsequent interviews was guided by what the family perceived as meaningful.

After each interview was completed, the interviewer presented the family with a verbal summary of his field notes from the interview to check for accuracy. This was based upon notes taken throughout the interview by the interviewer. Families were then asked for their permission to share the summary information with their therapist. In all cases throughout the study, the family gave unconditional consent for the information from the interviews to be shared with their therapist; however, family members were not informed as to whether the information would or would not be provided to the therapists. All client family interviews in the study were audiotaped which allowed the interviewer to check the accuracy of field notes. These audiotapes were not transcribed verbatim for the purposes of this study;
however, the primary investigator made extensive hand written notes from these
tapes which included verbatim quotes.

Depending upon the format, the therapist may or may not have been informed of
the families' comments. When the design of the study called for the therapist to be
informed, the interviewer would share the information with the therapist verbally
from the field notes. This would occur shortly after the family had left the therapy
clinic, and then the information would again be offered just prior to the next session.
However, therapists sometimes declined having the information again reported prior
to the next session. The decision to inform the therapist through a verbal summary
was chosen for pragmatic reasons. It was assumed that this was the most viable
manner to incorporate Informed Therapy in a clinical setting, since it was unlikely
that many settings would have access to a one-way mirror or taping equipment.
Further, it is likely the most efficient method in terms of time. This is in contrast to
Todd's (1989) procedure where he had a therapist view videotapes of the client
interviews.

Following session two, the first interviews with the therapists were conducted.
The therapists were interviewed regarding each family they worked with in the
study. At this point, each therapist had conducted one Informed Therapy session
and one Uninformed Therapy session with the family. The therapists in the study
were asked the following question:

1. Would you please describe for me your perceptions of the sessions you have had with the _______ family.

Further descriptive, structural, and contrast questions were generated based upon the information related by the therapist. The final interviews with the therapists were conducted after treatment session three, and each therapist was asked the following questions which emerged throughout the course of the study:

1. Would you please describe for me your perceptions of your sessions with the _______ family.

2. Would you describe for me, how, if at all, this informed process has influenced the therapy process?

3. What, if anything, could be done differently with the informed process?

4. What did you find most useful and least useful about the informed process?

Each therapist in the study repeated this process with each of the three families with which they conducted therapy. Each therapist was asked follow-up questions based upon information from their prior interviews. The length of the interviews with the therapists ranged from 15 to 45 minutes with the length of the interviews increasing in the later stages of the study. This related to the fact that the therapists had more comments to make regarding the process since they had received more
exposure to it. In addition, the level of information from the families had increased in
the later sessions which provided the therapists with additional information to
discuss.

Data Analysis

The interviews and data in this study were analyzed following the Developmental
Research Sequence (DRS) as described by Spradley (1979). Spradley (1979)
developed this procedure to examine and define cover terms, included terms, and
the semantic relationships within transcribed ethnographic data. Sturtevant (1972)
related that the goal of domain analysis is to understand how individuals classify
their experience through the terminology they use to talk about it. Spradley (1979)
stated that the domains of meaning are the first and most important unit of
ethnographic analysis. Domains were defined as symbolic categories or cover
terms that included other smaller categories and clusters.

Following the suggestions of Guba (1981), the following steps were taken to
ensure that the present study was conducted rigorously. The following indicators of
rigor were incorporated in the study.

Credibility is concerned with the match between the constructed realities of the
respondents and those realities represented by the investigators (Guba, 1981). In
the present study, credibility was established through the use of triangulation and
member checks. Triangulation was incorporated by providing the major professor in charge of this work with copies of the transcripts for the analysis of the data. He was then frequently consulted throughout the analysis of the data to review, confirm, and suggest changes regarding the findings. Consensus was achieved between the author and his major professor on all the results presented in this paper. In general, consensus was achieved without disagreement in regards to the structure and content of the domains. The triangulation served to provide the author with a mechanism to precisely define and revise each domain.

Member checks were incorporated by providing therapist informants with transcripts of the interviews, and then soliciting their comments regarding the findings. Client informants were provided with verbal summaries of preliminary findings from their interviews and given opportunity to make comments. This process ensured that the final ethnography incorporated the phenomenological experiences of multiple observers rather than the interpretations of only the primary investigator. Again, there was little to no disagreement with the member checks. Therapists and clients were unanimous in agreement that the findings were accurate representations of their experiences.

Transferability is concerned with ensuring that a complete data set is documented so that others can make decisions regarding how well the findings will
transfer to other settings or contexts (Guba, 1981). The present study met this criteria by providing a "thick description" of the findings and context of this study. The presentation of the current research should provide sufficient information for those providing similar services so that they may determine how well this information would transfer to their context. To ensure that a sufficient description of the context was provided in the document, the major professor in charge of this work and two colleagues of the author reviewed the document. All reviewers agreed that a sufficient description of the context of the study was provided so that readers could determine the applicability to other settings.

Dependability is concerned with the stability and consistency of the data, while confirmability is concerned with ensuring that the data are firmly rooted in the informants perceptions (Guba, 1981). Again, the triangulation incorporated into the present study served to address these indicators of rigor.

Audiotapes of the therapist interviews were transcribed into text and then examined by the primary investigator in conjunction with the audiotapes to check for accuracy prior to analysis. Each therapist in the study was also provided with a copy of the transcripts for review and comment prior to analysis. These texts were then subjected to domain analysis as specified by the DRS, and the data was broken into four distinct orders.
The first order of analysis was performed on the raw data transcripts from the therapist interviews. The primary investigator reread the transcripts and identified key words and phrases and verbatim quotes from the therapist comments and copied them on index cards. Redundant comments and themes from the transcripts were formed into synthesized statements and also copied on index cards. Examples of data in this order include "knowing I am on track makes therapy more efficient" and "I was made more aware of his need for a faster pace."

The second order of analysis was performed on the synthesized statements, key words and phrases, and verbatim quotes that represented informant responses from the interviews. The researcher identified semantic relationships between these statements to develop related clusters or categories of meaning. These statements were collapsed into categories or clusters of meaning based upon similarities of experience. For example the statements, "the information is consistent from room to room," and "the information mirrored what I sensed in the session," were identified as having a semantic relationship. Both of these statements were eventually placed in the domain of "validation."

The next level of analysis was to further collapse these clusters or categories of meaning into a formal defined domain of meaning. This was accomplished through the identification of cover terms from the informants' experiences that were inclusive
of an entire cluster or category, such as "validation" and "intervention."

The same procedure and analysis was conducted on the field notes from the
client family interviews. The client family interviews were not transcribed; however,
the primary investigator reviewed all field notes in conjunction with the audiotapes to
ensure accuracy. Further, all field notes were verbally reported to client informants
to ensure accuracy prior to reporting or analysis.

Summary

This chapter presented a general overview of the present study including a
description of the informants, the interviewer, the procedure, and the method of data
analysis. The following chapters include the results of this study and a discussion of
these findings.
RESULTS

The present study was designed to develop an initial ethnographic description of Informed Therapy as described by family therapists and clients that participated in family therapy treatment. This study was a mini-ethnography not concerned with documenting or analyzing a broad range of data or conducting quantitative analysis. Rather, this study focused on qualitative data collected from a series of moderately structured ethnographic interviews. These interviews were transcribed and then analyzed as specified by the Developmental Research Sequence (DSR) of Spradley (1979). The primary focus of this study was to examine therapists' perceptions of the usefulness of Informed Therapy.

The interviews for this study targeted specific domains regarding how therapists experienced Informed Therapy. To a lesser extent, the study provided information regarding how clients experienced the informed process. Five separate domains emerged from the therapists' interviews; these include: Intervention/Fine Tuning, Validation, Supervision/Processing, The Role of the Ethnographer, and The Informed Process. In addition, four recurrent themes emerged from the client family interviews. These themes were not evident across all families; thus, they did not appear to constitute formal domains. However, they do appear to warrant reporting.

The analysis of the data is presented in three parts. The first part provides basic
demographic information on the informants who participated in the study. The
second part reports the analysis of the qualitative data from the therapist interviews.
In this section a brief overview is provided for each emergent domain. This is
followed by the characteristic descriptions of the domain and finally by an
elaborative discussion of the domain. The third part reports the analysis of the client
family interviews. This section provides a discussion of the families' perceptions of
the informed process.

Demographic Data

The nine families that participated in the study include three pre-marital couples,
four marital couples, one family of four with two adolescent children, and one female
seeking therapy alone. All participants were Caucasian. A total of 20 informants
were interviewed. The age range for the sample was 12 to 38 years of age with an
average age of 26.70 years of age.

All three therapists interviewed in the study were doctoral students in the
Marriage and Family Therapy Doctoral Program at Iowa State University. One male
therapist (A) had approximately 16 years experience as a therapist, the other male
therapist (C) was working with clients as a therapist for the first time. The female
therapist (B) had approximately five years experience as a therapist. Therapist (A)
was 40 years of age, therapist (B) was 40 years of age, and therapist (C) was 25
years of age.

Analysis of the Qualitative Data

A total of five domains of meaning emerged from the 18 transcripts of audiotaped interviews with the therapists. They are: Intervention/Fine Tuning, Validation, Supervision/Processing, The Role of the Ethnographer, and The Informed Process.

Domain: Intervention/Fine Tuning

This domain includes those characteristic descriptions of what the therapists found to have influence or serve as intervention in the therapy process. A related elaboration is also provided.

Characteristic Descriptors of Intervention/Fine Tuning

Getting that information I found very useful; I was informed by it as far as what I do with them in the future; those thoughts will be included in my thinking; it's definitely a part of the formula now; I'd like to orchestrate this kind of intervention in the future; I got more information and my system thrives on information; I see advantages of this broadening scope adding more information than I am currently getting; I see you as kind of a team member working together for the benefit of the family; those two ideas I got through your comments they are informing me of this family; the comments have taken effect; it helps to clarify issues; being informed probably
speeded up the process double; I went in with the idea in mind based on the
ethnographic interview they were looking for something concrete; it helped me focus
on their wants which I might have skipped over; if I hadn't been informed I wouldn't
have made such a point of it; without the informed process we probably would have
been stalemated; it facilitated the case it assisted me noticing things and acting on
things; it added something that wouldn't have been there; I was made more aware
of his need for a faster pace; I learned about this family's tone and what they think is
important from the feedback; the ethnographic information helps me to zero in on
the information that was most important to the family; I get to things more quickly;
fine tuning points I will pay attention to; I was made aware of things I didn't pick up
on; in light of the information I am going to start off the next session addressing
satisfaction; this gives greater credibility to the need to address that; the information
clarifies and puts a different label on the sullenness; this puts it right on the table so
it doesn't have to be hazy gut stuff; the information about longer sessions and
meeting the team is definitely information I want to honor; people are afraid to say
we're not on track and that is the kind of information you are giving me; I found I did
not know those things and used the information the next time I saw them; if I did not
know I would not have altered it, and it turned out to be important to them; their
perception of the role of the team was off for three sessions and I didn't know until
the information from the interview; one of them said I didn't seemed focused so I intentionally went more focused the next session; it helped me to adjust and I think it worked; if I had never had that information I might not have gone in that direction; being informed and tailoring my format to their needs I think it really saved something; I don't think I would have gotten to that point if I hadn't been informed; I have been hesitating now I know it's a green light; and that is what they want so it's time to do it.

**Elaboration** The above domain was clearly the most pronounced domain in the study and appears to hold the most clinical significance. The information from the families' ethnographic interviews served to influence or intervene in the therapeutic process in every case. The level of influence or intervention the informed process played existed on a continuum ranging from "fine tuning," which was minimal, to "intervention," which was significant.

The therapists defined fine tuning as new or dissonant information that subtlety influenced the therapeutic process. That is, information from the interviews that was not totally consistent with what the therapist believed, or new information the therapist was not aware of that came from the informed process.

A case example of dissonant information occurred with confusion over the concept of feedback. In this instance, the family stated, "we want feedback from
therapy, not just a listener." When informed of the family's experience, the therapist working with the case stated she had been giving the family her feedback, thus they must not be recognizing her information as feedback. She related that in subsequent sessions she labeled her feedback by prefacing the information with the statement, "here is my feedback." This "fine tuning" allowed the family to recognize feedback, thus clarifying their dissonance regarding the concept of feedback.

A case example of new information related to the pace of therapy. After the initial session with a family, the father related that "it was a good start, but I want to hurry and get into the heavy stuff." The therapist stated that this information made her more aware of the father's need for a faster pace, and subsequently influenced how she conducted the case. In the family interview after the second session, the father reported satisfaction stating the session was more intense and that they got into deeper subjects. Clearly, the therapist would have addressed the family's "heavy stuff;" however, the new information gave the therapist permission to proceed at a quicker pace. In each of these case examples the therapy was proceeding very well, but the informed process allowed the therapist to fine tune the therapy.

As previously stated, the therapeutic process was influenced in each case by the informed process. The case examples of "fine tuning" provided evidence of low to
moderate influence of the therapy. The following case examples are presented to demonstrate high levels of influence on the therapeutic process or what the therapists coined "intervention." An example in which the informed process served as an intervention occurred in the following case example. In this case the therapist gave a couple a concrete intervention or homework assignment which they were to perform outside the session. This intervention was assigned by the therapist after the first treatment session. In the debriefing interview that followed with the couple, they related that the most positive thing that had occurred in their session was this assignment, and that past professionals had failed to be direct with suggestions. Since this client family was in Format II, the therapist was not informed of the couple's perceptions of the first session.

In the debriefing with this couple after treatment session two, they related disappointment that their therapist was less directive in this session and that they failed to receive a task assignment for home. Now that the second treatment session had been conducted, Format II allowed the therapist to be informed of the couple's experience.

Subsequently, in treatment session three the therapist took this information and directly discussed with the couple their expectations and what they want out of therapy. In the final debriefing interview with this couple after treatment session
three, they stated that they felt closer to their therapist and that they had again received a specific assignment. Their overall impression of therapy was again positive as it had been after treatment session one. Further, the male stated, "I would have been pissed off and probably quit coming if he hadn't asked us what we wanted." The therapist working with this couple related that the information from the interview gave him a "mandate" to start instructing them on things they need to do. He stated that although this is not his typical manner in working with families, he believed it was necessary based upon the clients' expressed wants. He stated it is unlikely he would have re-assessed the clients' expectations so quickly without the information from the debriefing interview.

This example clearly demonstrates how information from the interview influenced and changed the process of therapy. Based upon the comments from both the client and the therapist, it appeared to do so in a positive manner. The informed process gave the clients a vehicle to express their expectations of therapy, as well as providing the therapist with information about the family's experience.

A second example of intervention revolved around a family's perception of the team and the role that the team played in the therapy process. In this instance, the couple related comments that they believed the team was developing interpretations behind the mirror and instructing the therapist to share these with the couple. They
related that they were unsure if the information and statements were coming from the team or if these comments were coming from the therapist. This contributed to the couple being unclear as to where the direction of the therapy originated.

When this information was related to the therapist, she stated that this was not her intent, and that this couple was not understanding the role of the team. In the subsequent session the therapist directly addressed the role of the team and how she utilized the team. She stated, "I told the family that whatever I came back with, whether it was a statement or a question, was more reflective of me. What the team had done was help me zero in on the way I wanted to proceed." She related that she felt the therapy and her credibility with the couple was in jeopardy, and that she was concerned the couple may be viewing her as a puppet of the team. In this case, the informed process alerted the therapist to the couple's perception allowing her to clearly define for them how she used the team.

Domain: Validation

This domain provides characteristic descriptions of what the therapists found as Validation in the therapy process. A related elaboration is also provided.

Characteristic Descriptors of Validation

What I learned was what I suspected; very congruent with the family; validation it feels good; the information matched what
I thought was going to happen; people feel good about the way you're doing things; positive feedback; informing allows us to look at what kind of fit we have; it is important to know we are not spinning our wheels; knowing I am on-track makes therapy more efficient; the information is consistent from room to room; the information mirrored what I sensed in the session; clients get what they came for and that is helpful; their comments validate decisions I made; the clients are finding this valuable and worthwhile; my impressions about last night and what the clients told you are very congruent; I really knew we were on track with each other; and we are in step with one another and we can continue.

**Elaboration** The therapists in the study placed significant importance in discovering that their experiences of therapy and the experiences of family were congruent. They discussed that it "feels good" to know that they were on track with the family, thus increasing their confidence in the therapy process. They related that validation allows therapy to be more efficient since they do not have to speculate about how the family is experiencing therapy.

They remarked that throughout the therapeutic process therapists and families are continuously having to assess the therapeutic shape or fit. When the families and the therapist report congruent experiences about this process, it indicates consensus about the realities being constructed in the therapy room. Often when
these realities were not consensual, the therapists and families were not aware of this dissonance. The informed process aided the therapists in assessing the degree of "fit" between their experience and the families' experience. Therefore, changes in the therapeutic process were not indicated when the therapists' perceptions were being validated.

The transcripts suggest numerous instances where validating statements about the therapy process had positive influence, such as validating therapeutic decisions or judgments made by the therapists. The following anecdotes from transcripts are presented to demonstrate how validation or fit between client and therapist perceptions were viewed as valuable.

In case one, the family was participating in family therapy as a condition of the male adolescent's probation. The therapist suspected that the adolescent had significant anxiety at the prospect of being observed via a one-way mirror. Further, the therapist chose not to read a volume of reports sent by the court regarding the juvenile's delinquent behavior, thus allowing his impressions of the family to be based on dialogue with the family. He related that both of these decisions were based on past experiences in working with delinquent adolescents. In the interviews conducted with the family, they stated that the two most positive experiences of the therapy process for them had been: 1) that the therapist had not
read the reports from the juvenile office, thus pre-judging them, and 2) that they were not observed during the therapy sessions. The adolescent stated, "I think it is better this way. Most people look at my record and say he is bad, and then blame everything on me." The therapist related this information had validated his decisions with this case, and corroborated his past experiences in working with similar situations.

A second instance demonstrating the positive influence of validation occurred with a therapist who was conducting family therapy for the first time. The therapist related that the presenting issues in the case closely paralleled his own personal experience. He stated that he was "torn" by the decision to determine at what level, if any, he should self-disclose his own experiences. He related that through consultation with his therapy team he decided to self-disclose his own experiences to the client.

In the ethnographic interview, the client related, "people don't understand what I have been through. I don't talk to people because they can't relate." She expanded that she viewed the therapist's self-disclosure as positive and now felt more confident that therapy was going to be effective, and that she "felt understood" for a change. In this instance, the informed process gave the therapist immediate validation that his self-disclosure had been a positive experience for the client. This
validation was positive when considering the therapist's statement that he was "torn" about self-disclosure. The therapist related that this information indicated that he and the client were really on track, and it served as a confidence builder.

**Domain: Supervision/Processing**

This domain includes those characteristic descriptions that the therapists found to serve as supervision or processing of the therapy process. A related elaboration follows.

**Characteristic Descriptors of Supervision/Processing**

This could be part of the supervision process; I would trust their feedback (the family) more than I would a team behind a mirror; it just occurred to me this is a supervision modality; you can just ask the family; this is a very useful training model; this is extremely high quality supervision; this is the perfect opportunity for a supervisor to hear about a case; maybe this is a good way to go through supervision; the feedback makes me stretch as a therapist; I think it is more honest supervision; it's totally different from the supervision we normally get; I think getting feedback from the family is really beneficial; this kind of learning is probably better than just having a team and supervisor; it's feedback coming from the people I am dealing with; the feedback from the family is more honest because the team will put a nice frame on the
information; this format of interviewing clients and getting feedback would be a way to supervise; this is high quality information from the way you greet them at the door to the stuff that goes on in the room; this would be a perfect feedback mechanism for supervision; it helps me collect my thoughts and rethink the case; thinking about the cases between sessions is helpful; a chance to think about it helps to integrate the case; this information plugs me back into the family; a reiteration of previous cases; debriefing helps me; very valuable so I can run through things again; this information gives me multiple slices of reality; it shows what the family retains as important and critical; the debriefing is a way to get back in sync with the family; processing things is informative for me; and it helps me sort out the garbage in my head.

**Elaboration** The therapist in the study appeared to perceive the informed process, that is, the information from the interviews, as a form of supervision coming directly from the family. Further, they related that the debriefing process facilitated a context for rethinking or hypothesizing about the case which was a form of supervision through the opportunity to process the case. It should be noted that the term supervision as used in this domain has special meaning innate to this study as defined by the therapists in this study.

The debriefing interviews between the therapist and the interviewer appeared to
introduce dynamics that mirrored traditional supervision or that of collegial supervision which often comes from a therapy team. The characteristic comments for this domain were similar across therapists; however, therapist (C) had experiences that were unique to him. First, the elaboration will present the perceptions that existed across all therapists, followed by an elaboration of the experiences unique to therapist (C).

The therapists described the supervision/process experience in two separate ways. First, they related that the informed process, specifically the therapist debriefings, facilitated useful thinking and rethinking about the cases between sessions. They reported that typically they do not give significant attention to their cases between sessions, and that the debriefing process helped them to do this. They related that they were receiving and processing information very similar to what they typically receive from a supervisor or team, but that the information came directly from the family. This information from the interviews provided the therapists with a different slice of reality that they do not typically have in the therapy or supervision process. They related that this information directly informed them of how the family was experiencing therapy. They pointed to the contrast between this format as opposed to a supervisor or teams' perception of how the therapy was proceeding from their observations of a case. Obviously, a supervisor or team is no
more capable than a therapist of knowing what a family is experiencing purely from
observation. It was suggested that the information from the debriefing interviews
could ideally be used in conjunction with traditional supervision.

The therapists stated that the informed process facilitated a focus on the process
or structure of therapy instead of focusing on the content of therapy. They stated
that often when they received supervision or consulted with a therapy team, the
focus tended to be solely on content without significant regard for the structure or
process of therapy. They reported that the informed process allowed them to focus
not only on content, but also on the process, context, and structure of therapy.

The therapists identified a distinct difference in the ethnographer role from the
traditional role of supervisor or team. In this study the interviewer simply reported
the information from the client interviews with as little interpretation or bias as
possible. They related that this clearly differed from traditional supervision where
they typically get value judgments or interpretations regarding what the supervisor
or team has observed. Thus, they stated that they were experiencing two new or
different experiences: 1) a different slice of reality, i.e., the clients' perceptions of
the therapy process and 2) as much as possible, the information was delivered in an
unbiased, non-interpretive fashion. This difference clearly contributed to their
different experiences.
Therapist (C) experienced a unique process not common to the other therapists in the study related to supervision/processing domain. Initially, therapist (C) experienced frustration related to the fact that the interviewer was not providing interpretation or giving evaluative judgments regarding the clients' reports. The therapist stated that the information from the interviews was informative, but that he wanted additional interpretive information from the ethnographer. This experience appeared to relate to the fact that these were the first client families with which the therapist had worked. However, at the end of data collection, therapist (C) stated that he placed more value on this process because it allowed him to struggle with decisions more on his own. When posed with the opportunity to change the format to allow the interviewer to provide interpretive comments, he said he would not favor a change in the format. He stated that even though getting information directly from the family could be intimidating, it was very helpful to his growth as a therapist.

Three additional comments are warranted regarding this domain. First, supervision was present for each therapist for each case in the study; thus, therapist (C) was able to utilize avenues of supervision available to him outside the ethnographer. Second, each therapist viewed this process as being complementary to traditional forms of supervision, not a replacement. The information from the client interviews was experienced as an additional and different slice of reality which
often mirrored the role of supervision. Finally, both therapist (A) and (B) viewed this process as a beneficial learning experience, regardless of their level of expertise in working with families. They related that they would welcome this form of supervision as a continuing improvement to their skills.

**Domain: The Role of the Ethnographer**

This domain includes those characteristic descriptions of the how the therapists experienced the role of the ethnographer. A related elaboration follows.

**Characteristic Descriptors of the Role of the Ethnographer** They tell you things they won't tell me because our relationship is of a different nature; when I ask them a question they have to weigh both the value and effect of the question; there is not the same relationship management with you as an outside party; you maintain a kind of objectivity more a matter of factness; the information is given in a very neutral fashion; I think the family is more honest about therapy with a neutral party; the information is delivered without interpretation; you are more of a non-participant third party; I liked having important parts pointed out in a neutral way; it was just reported, no interpreting; you were like a team member, but a different kind of team member; to have interpretations from the ethnographer would create a film and make things less clear; it was intimidating at first, later I got comfortable; its less
personal, more of a factual thing; in that climate maybe they tell you things that wouldn't come up with me; the ethnographer has a mind of his/her own and will ask questions I might not think of; it is information I would not have had without a third person; I would see you as a kind of team member working together with the family; you are outside, detached, less knowledgeable so you can ask naive questions kind of like Columbo; functionally you were a part of the therapeutic process; and it's like having a second therapist with a circumscribed role to assist, check, and modify the therapy.

**Elaboration** The therapists in the study identified differences in how they perceived the role of the ethnographer in contrast to their role as therapists. They related that the ethnographer maintained a more detached third party role with the families throughout the course of the study. It was believed that this detached role allowed the ethnographer to solicit information from the families that the therapists were not able to gather themselves. The therapists stated that they routinely attempted to gather ethnographic information similar to that given to them by the ethnographer, but that they were not able to gather as high a quality information.

It was suggested that since the ethnographic interviews focused on process rather than content, the interviewer was able to take a more naive position that the therapist could not assume because they had too much information. Further, the
ethnographer was not attempting to intervene in the families' issues like the therapist; thus, the family was less concerned about how their responses may influence the relationship with the interviewer. In contrast, they would have to weigh the impact that their responses may have on the relationship with the therapist. In summary, the interviewer worked from a different position or context with the family, and this context allowed for the different kinds of information gathered by the ethnographer.

The therapists described the ethnographer as a sort of team member or secondary therapist. This role was viewed as different from a traditional team member; however, the therapists all viewed the ethnographer as a part of the therapy process. The ethnographer was described as being akin to a reporter who informed the therapist of the information in very neutral non-interpretive manner. They stated this allowed them to think aloud about their cases with a team member who did not attempt to influence their thinking, and they viewed this as a valuable process. The interviewer's role was described as secondary therapist with a circumscribed role who helped to check, assist, and modify the process through the delivery of special information.

The key factors identified by the therapists was the ethnographer's special context or position with family that allowed for a different slice of information, and the
neutral position the ethnographer maintained while still seeming to serve as a team member or secondary therapist.

**Domain: The Informed Process**

This domain includes those characteristic descriptions of how therapists perceived the informing process. A related elaboration follows.

**Characteristic Descriptors of the Informing Process**

I like the kinds of questions that were asked, about the structure of therapy, the things I do or don't talk about; I like being informed within a few days of the therapy session; the process is very comfortable; I got the information then just kind of brought it up in the session; I just let the information inform me, I did not discuss it with them I just brought it up, kind of built it in; I just act with the awareness of the information; the information after the second session is more pointed and useful; I mentioned to them that you had given me their feedback and that I wanted to discuss it; the ethnographic information they give you is far more articulate; in general the information given after the second session is more valuable content-wise; I am the ultimate screen of what is important; I think the change of context for the debriefing allows the family to give evaluative information; going through a middle person is not as frightening for the family; getting the information just again before the session is like warming up before
exercise; I use the bits of information that fit into the current flow; if it doesn't fit the current flow I put it on the back burner; later information was more valuable; I liked having the information two times, once just after the session and once just before the session; metaphorically I put it in this library and reference it; I incorporate it almost directly; I go in and try to act differently to what they informed you, but try without them knowing; I normally don't go in and say well Jeff told me; I always thought I asked a lot of ethnographic questions, but some things I am not going to get unless they are asked by a third person; having the ethnographer created a little anxiety, kind of exposing yourself to critical review; I work the information into the conversation by forming a question with it; I just re-open the whole thing; I think if you waited beyond two sessions it would be too late for the informing to begin; I used it more clandestine and that worked fine; and interviewing after the first and second session is fine, but they speak with more clarity after the second session.

**Elaboration** The therapists related that initially the informing process created a degree of anxiety ranging from slightly uncomfortable to intimidating.

These feelings apparently stemmed from opening the therapy process up to review by a third party. However, by the conclusion of the study, all three therapists related that they felt very comfortable with the informing process and expressed disappointment at the prospect of not having it continue to be a part of the therapy
The therapists reported that they saw value in being informed after both the first and the second treatment session, but given a choice, they believed the information after later sessions two and three to be more valuable. The debriefing information obtained after treatment session one tended to be more preliminary and mostly validating in nature. Debriefing information from later sessions was more likely to contain new or dissonant information which served to influence or alter the therapy process.

A case example in the study occurred with a family in Format II. In this Format, the therapist was informed of the session one debriefing, but not of the session two debriefing. In this instance, the information from the first debriefing was mainly validating; however, during the debriefing after treatment session two, the couple related that they were confused and concerned regarding the consultation break that the therapist took each session. Since this family was in Format II, the therapist was not immediately informed of this information. In the final debriefing with the therapist, he related this was important information that he would liked to have had immediately.

The therapists incorporated the information from the client debriefings in two ways. Typically, the therapists would introduce the information from the client
interviews into the normal flow of the therapy. They related that they would take the information and form questions that would generate discussion about the information. This allowed them to introduce the information in a covert fashion, and not directly comment that the information had come from the ethnographer.

In contrast, there were a few instances when the therapists directly stated to the family that they wanted to discuss information they had received from the ethnographer. In each of these examples there was a piece of information the therapist believed to be very significant to therapy process. For example, in the case discussed previously where the therapist believed the family was misinterpreting her use of the team she overtly announced she wanted to discuss information she had received from the ethnographer.

In summary, the therapists were very comfortable with the informing process, they viewed the information from the second and third sessions to be most useful, and they incorporated the debriefing information into the therapy in a low-key fashion.

Client Experiences

The following section provides findings based on the families reported experiences of the informed process. These findings are not presented as formal domains since the experiences were not common across all families. However,
some recurrent themes did occur with the client families that warrant reporting. Four separate thematic experiences are presented in a format similar to the elaborative discussion presented in the previous section.

Client Elaboration One

Client informants in the study related that they valued the debriefing process because it provided an opportunity to discuss the process of therapy instead of the content of therapy. They stated talking about what had occurred in the session in general terms without having to discuss the "problems" helped them to understand more about the session. One client stated, "I like the debriefing, talking about the session gives me a chance to talk about and understand our needs."

Families also reported they liked the opportunity to give feedback to their therapist through a third party. One female client stated, "the problem is facing the person, I don't want to hurt someone, so I will probably tell them what they want to hear. If I said I don't like the way you are doing this, he might side with ______ or have hurt feelings." This would indicate at least for some clients it would be very difficult to express concerns or negative comments about the therapy process directly to the therapist. This information indicates that the debriefing interviews gave the clients an opportunity to identify more about their needs and a method of communicating in a comfortable way with the therapist.
Client Elaboration Two  Families reported that the debriefing interview served as "cool down" period after the treatment session. Three different client families stated they often left the therapy session with very negative feelings about what they had just experienced. They reported that the debriefing interviews allowed them to process feelings about what had just transpired, and while it did not serve to solve problems, they would leave the clinic feeling better. One male client stated, "the charge is so negative when we leave the room; it is good to talk about it and wind down. At least we will talk about things now instead of fight."

While the debriefing did not necessarily change the issues the clients were attempting to address, the fact that they felt better after the debriefing seems important. The debriefing appeared to help the clients structure a frame for the therapy session and process among themselves the meanings about their experiences.

In relation to the "cool down," the informants related that having the debriefing in a different room than where the session was held was beneficial. One client stated, "when we come to this room, it's like we have switched worlds, and I am ready to talk again." The change of context appeared to be crucial to the process of the debriefing interview.

Client Elaboration Three  Three client families related they could see the
information from the debriefing interviews influencing how the therapist proceeded with therapy. They reported they believed that the therapist was responding to their needs.

One client stated, "I can see him (therapist) responding to these (debriefing) sessions; he was much more focused tonight." A second client reported that he could tell that the debriefings helped the therapist to focus on what they wanted and in setting ground rules.

The families that reported direct influence from the debriefings were case examples where the information from the interviews was providing new or dissonant information to the therapist. In each of these three cases a form of "intervention" occurred as a result of the information from the interviews. This would indicate the families were more aware of the informing process exerting influence when the therapists were altering their approach in a significant way.

**Client Elaboration Four** Some families showed a tendency to self-correct their own process issues as a result of discussing them in the debriefing sessions. That is, as families identified some change they wanted in the therapy process, they would correct it without therapist intervention.

In one case example, a female client related frustration at the behavior of her boyfriend's tendency to talk at great length about irrelevant information. He
concorded with this appraisal, and both clients related that in future sessions they hoped to be more focused. In the subsequent session, the family and therapist stated things were much more on track. Further, both the clients and the therapist felt the family had in large part corrected the issue themselves with only minimal assistance from the therapist. The therapist stated that he thought the most significant factor in the more focused interview was the client's own observations and judgments and not his help.

The debriefing interview provided a context for the clients to identify any changes they may want in the therapy process. This awareness appeared to influence subsequent behavior.

Summary

This chapter presented demographic data and the qualitative results of the study. The following chapter discusses the tentative conclusions drawn from these findings and presents implications for further research.
DISCUSSION

The goal of the present study was to evaluate how useful information obtained through ethnographic interviews was to the therapeutic process. Ethnographic interviews were conducted with both therapists and client families to build descriptions about how they experience the therapy process. It was anticipated that this information would influence how the therapy process proceeds. The primary focus of this study was to investigate the therapists' perception of the usefulness of ethnographic interviews as a part of family therapy. This study was unique in two ways. First, information from the interviews was utilized during the clients' therapy experience and not used post hoc; second, the therapists were interviewed about their experiences of having the ethnographic interviews be a part of the therapy process. This study provides an initial ethnographic account of how therapists and clients experience family therapy treatment and how therapists' experience information gathered from interviews as a part of family therapy.

The preceding chapters have outlined related literature, the methodology employed in the study, and the results. The present chapter includes a summary of the results and a discussion relating the present results to other research. Recommendations for future research and the implications for the field of family therapy are also discussed.
Summary of Results

A brief summary of the qualitative results outlined in the Results chapter is provided below. This includes five separate domains from the therapist interviews and recurrent themes from the client family interviews.

1. The domain Intervention/Fine Tuning was the most pronounced domain in the study and appears to hold the most clinical significance. Descriptions from this domain demonstrated how the information from the clients' interviews served to influence or alter the therapy process. The level of influence existed on a continuum ranging from "fine tuning" which was minimal to "intervention" which was significant.

2. The domain Validation focused on the fact that the therapists in the study placed significant importance in discovering that their experiences of therapy and the experiences of the families were congruent. Therapists reported knowing they were on track with the family increased their confidence in the process and made therapy more efficient.

3. The domain Supervision/Processing indicated the therapists viewed the informing process as a form of supervision coming directly from the family, further they related that the debriefing interviews facilitated hypothesizing about their cases. The informing process gave them a different slice of the clients' reality that they did not typically receive in traditional supervision.
4. The domain The Role of the Ethnographer described how the therapists' experienced the ethnographer. The ethnographer was described as being a detached third party or a secondary therapist who interacted with and gathered information from the family. This detached role was viewed as providing the ethnographer with a special context that allowed for the gathering of different information than what the therapists gathered. The ethnographer was viewed as being non-interpretive and neutral to the therapy process.

5. The domain The Informed Process outlined how the therapists experienced the informing process. The therapists related they felt comfortable with the informing process and that the information from later session was viewed as more valuable. Information from the client interviews was typically introduced in a covert fashion.

6. Client elaboration one indicated the clients valued the debriefing process, and that they liked having a third party provide feedback to their therapist.

7. Client elaboration two indicated that the clients experienced the debriefings as a "cool down" period. They stated the debriefings allowed them to process feelings, and noted that the change of context to a different room for the interview was important.

8. Client elaboration three indicated that the clients were able to see the
therapist responding to the information from the debriefing interviews. This was most apparent when a high level of dissonance was present.

9. Client elaboration four indicated that clients had a tendency to self-correct their own process issues as a result of discussing them in the debriefing sessions without therapist intervention.

Elaboration of the Results

The present qualitative study examined therapist-based and client-based descriptions of ethnographic interviews as a part of family therapy. Specifically, moderately structured interviews were used to gather information regarding:

1. what were the therapists' perceptions and experiences of the informed therapy process;

2. what were the clients' perceptions and experiences of the informed therapy process; and

3. what could have been done differently to make the informed process more useful?

The primary purpose of the study was to discover how therapists experienced ethnographic interviews as a part of family therapy. Kuehl, Newfield, and Joanning (1990) stated that they believe that therapists can benefit from hearing what their clients have to say about their experiences of therapy. The results indicate that the
therapists found the addition of ethnographic interviews, or hearing about the clients' experiences, to be a significant positive contribution to therapy process. Hoffman (1990) discussed the consequences of using a postmodern anthropological metaphor in family therapy. She related that with this metaphor therapists became "accidental ethnographers" where sessions become more of ethnographic interview rather than a monolithic dialogue to find hidden pathology. Results from the present study indicate that having a designated or purposeful ethnographer as a part of the therapeutic process has benefits.

The most striking finding of the present study was the manner in which the ethnographic interviews served to influence or alter the therapeutic process. It seems intuitively correct if clients are not receiving services that they believe to be beneficial or worthwhile, they will be dissatisfied with their experience of therapy. Todd (1989) reported families became disappointed with therapy when they were not given specific options to try at home or if they were not informed of a rationale of intervention. Kuehl (1987) found that families were frustrated with abuses of time and going over the same issues week after week. Elliot (1985) described nonhelpful events as described by volunteer student clients.

Each therapist in the present study related that the information from the interviews served to influence how they proceeded with therapy as they became
informed of the families' experiences. In every case example in the present study, clients reported at varied levels some form of concern or dissatisfaction with the therapeutic process. The therapists in the study reported that they used this information to alter the therapeutic process in an attempt to correct client dissatisfaction. Findings from the present study indicate routinely conducting ethnographic interviews would serve to increase the clients' satisfaction level with the therapeutic process by allowing therapists to alter the therapy process based upon this information.

Kuehl, Newfield, and Joanning (1990) suggested successes in the later stages of therapy often depend upon successes in the earlier phases. Models of family therapy have also given attention to the importance of the early stages of therapy, e.g., Minuchin's (1974) "joining" and Haley's (1976) "social stage." Findings from the present study suggest that assessment of the early stages of therapy can be conducted through the use of ethnographic interviews. The therapist informants related a high level of importance in knowing they were "on track" with their client families and indicated this allowed therapy to become more efficient. In instances where the families' experiences were not positive, the information from the interviews allowed for a change in the process. The findings from the study provided numerous instances where therapists took corrective action by
the second or third treatment session. In instances where the therapy appeared to be "on track," the therapists proceeded with therapy without major changes building upon what the family reported as positive experiences. If we assume the early stages of therapy are indeed indicative of later stages, present findings indicate that ethnographic interviews can serve to facilitate positive beginnings in therapy.

Newfield, Kuehl, Joanning, and Quinn (1991) stated successful family therapy requires at least a minimal amount of sustained social coherence and shared substantive meaning over many contacts. Findings from this study indicate that ethnographic interviews can help determine if therapists and clients are creating shared meanings. Further, it provides a mechanism for correction when the meanings are not coherent.

The training and supervision of family therapists holds an important position in the field of family therapy. A significant result of the present study was the therapists' perception that the information from the interviews served as a form of supervision coming directly from the family. Traditionally, supervision of family therapists has been hierarchical with the belief there is a wise supervisor and a naive supervisee (Heath & Atkinson, 1990). Heath and Atkinson suggested that when one accepts the paradigm of second-order cybernetics, supervisors can no longer assume the role of expert teacher, but must instead recognize the mutual
influence that occurs in supervision and become an opinionated co-learner. Kagan (1980) in a similar fashion used Interpersonal Process Recall as a training method for student therapists so they may learn how their clients reacted to them and which of their behaviors the clients found to be helpful and not helpful.

The findings from the present study seem to parallel the philosophy of Heath and Atkinson (1990) and replicate in part the work of Kagan (1980). Results suggest that the use of ethnographic interviews as a part of the therapeutic process can be an effective and powerful addition to the supervision process. Therapists are provided with an additional slice of reality about how they are perceived as therapists directly from the individuals they serve. Thus, the family can become the opinionated co-learner providing insight to the therapist. The results indicated this is a useful addition regardless of the therapist's level of expertise. Even therapist (A) with 16 years experience in working with clients found the information from the ethnographic interviews to be "high quality supervision."

The most important task in training and supervision would appear to be developing effective ways to assist clients in changing unwanted behaviors. Direct feedback from the clients regarding their perceptions of what the therapist is doing will provide important insight into the effectiveness of therapy. This form of supervision from the family seems to be a complementary component to traditional
forms of supervision and training.

The therapist informants related the ethnographic interviews provided information different from what they gathered from families even when they attempted to ask ethnographic-type questions. This difference was attributed to the different position or context that the interviewer shared with the family. Varela (1979) stated if the context of a situation is changed then the meaning is changed. Hoffman (1990) stated that an ethnographer is not looking for pathology, nor do they need to provide the client with a final prescription or message. This provides some insight into the different position or context that ethnographic interviews are able to provide.

The information from the interviews tended to focus on the process of therapy and not the content of the problems that had prompted the clients to seek help. Interviews with both clients and therapists were not serving as problem solving sessions nor was the ethnographer providing interpretations or feedback. This change of context appeared to contribute to both the clients' and the therapists' ability to talk aloud without concern for how these comments may affect the relationship with the interviewer. The therapists related they viewed the ethnographer as a secondary therapist who helped to check, modify, and assist the process of therapy through the delivery of special information. They placed value on the fact that the therapist was not attempting to influence their thinking about the
The clients related they valued the opportunity to talk about the process of therapy instead of the content of therapy. They reported they liked giving feedback to the therapist through a third party and expressed concern at providing this information directly to the therapist in fear it may "hurt feelings" or cause the therapist to take sides. This is similar to Rennie's (1992) finding that clients were reluctant to voice discontent about their therapy to their therapist. Newfield, Kuehl, Joanning, and Quinn (1991) also reported when clients had negative experiences they seldom brought it to the attention of their therapist. This indicates the ethnographic interviews provided the clients a vehicle to communicate with their therapist that they do not normally have. Finally, the actual physical change in rooms appeared, in part, to facilitate the special context of the ethnographic interview. One client reported that the change to a different room was like switching worlds and that he was ready to talk again.

Therapists reported they incorporated the information from the interviews into the normal flow of the therapy in a covert fashion. Exceptions to this occurred when they were provided with information that significantly pointed to client dissatisfaction or confusion. In these instances, the therapists were more overt in incorporating the ethnographic information into the session. They reported the information from the
interviews after sessions two and three tended to be more helpful. Information from these sessions was more likely to contain information that influenced the therapy process.

Client informants reported seeing the therapists influenced by information from the ethnographic interviews. Examples where the families noticed therapists responding to information occurred when there was a high level of dissonance or concern about the therapy process. This indicates the families were more aware of the informing process when they had concerns about the therapy process and when the therapist altered their approach in a significant fashion.

Finally, some families showed a tendency to self-correct their own process issues. As families identified concerns or a change they wanted in the therapy process, they would alter their behaviors without intervention by the therapist. This finding indicates the interviews helped families to gain insight into their behaviors and in some cases alter those behaviors. The interviews provided a context for the clients to examine therapy in a way that may not have been available otherwise.

Conclusions

The primary purpose of the study was to investigate therapists' perceptions of the usefulness of ethnographic interviews as a part of family therapy. The findings suggest that introducing information from ethnographic interviews provides a useful
addition to the overall therapeutic process. The findings also provide some limited information regarding clients' perceptions of ethnographic interviews as a part of the therapeutic process.

The work of Todd (1989) indicated that ethnographic interviews could facilitate a more isomorphic relationship between therapists and clients. The present study provides support for Todd's research and additional insight into how that isomorphic relationship is facilitated through the elaboration of the experiences of the therapists in this study.

The data suggested that therapists were directly influenced by the new information and that they altered how they conducted therapy based upon information from the interviews. The therapists related the addition of the ethnographic interviews was helpful to the therapy process and they provided insight into how ethnographic interviews may best be incorporated into therapy. Information from sessions two and three was viewed as more important, and the therapists routinely incorporated the information in a covert fashion.

Because the therapists experienced this process as a form of supervision suggests that information from ethnographic interviews with clients could become a part of the supervision and training of therapists. This would be a relatively easy procedure to include in both training and professional settings.
The findings suggested the information should be gathered and reported in an unbiased and non-interpretive fashion. The different position or context that the ethnographer is able to occupy seems to be related to focusing on process issues rather than content. Conducting the ethnographic interviews in a different room from where the therapy occurred was also important to the contextual change. The results also indicated that including this procedure as a part of therapy influences how clients experience the overall therapy process.

Overall, the results indicated ethnographic interviews can be a positive addition to the therapeutic process. This procedure would appear to be applicable to all kinds of therapy and certainly not limited to family therapy. Creating new and different information for therapists and clients will serve to improve the effectiveness of therapy.

Recommendations

The present study focused on obtaining information only during the early stages of therapy. Future research should focus on acquiring information from all stages of therapy including middle and late stages. Further investigation should also include a more varied sample of both clients and therapists.

Future designs should focus on additional models of therapy as opposed to just family therapy and focus on additional settings. The method employed in this study
could readily be used in other mental health settings, especially a residential or hospital setting.

The relationship between the informing process and the supervision process must be examined at a more intentional level. Specific studies incorporating ethnographic interviews into the supervision process would be important to evaluate how useful it may be as a training mechanism. This research should allow for more flexibility in the role of the ethnographer which would allow one to provide interpretation as in traditional supervision. It would be interesting to contrast the use of interviews as they were utilized in this study with a format that allowed the ethnographer to also serve as a supervisor.

Strategies should be employed which will vary the presentation and method of conducting ethnographic interviews. Studies will need to determine if therapists can effectively conduct ethnographic interviews with their own clients, or if it is necessary to have a third party conduct the interviews. A format utilizing different ethnographers with the same families may be employed to discover if this alters the informing process.

In the present study, the information from the interviews was verbally reported to the therapist by the ethnographer. Future formats could allow the therapist to observe the ethnographic interview as it was being conducted, or the therapists
could view or listen to tapes of the interviews. In this fashion, the therapist would directly hear the families comments.

Finally, future research must sharpen focus on how ethnographic interviews influence clients. The present study was only able to make tentative remarks about how this process affected clients since it was not the primary focus of the study.
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APPENDIX A. INFORMED CONSENT STATEMENT: FAMILY

The Department of Human Development and Family Studies and the Iowa State Family Therapy Clinic 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.

Purpose of the Study: In order to improve services at our clinic for yourselves and other families we are interested in learning about your perceptions of what it is like to receive services from our clinic. We therefore request your permission to ask you a number of questions regarding your experiences at the ISU Family Therapy Clinic immediately following your first 3 sessions. These interviews should last approximately 15 to 30 minutes and will be audiotaped. Further, at times we will request permission to share the information from these interviews with your therapist. Before any information is shared with your therapist you will be provided with a chance to review and approve the information to be given to the therapist. No information from the interviews will be provided to your therapist without prior consent. After completion of sessions 2 and 3 interviews will be conducted with your therapist regarding their perceptions from working with your family.

Participation in the study will entail no greater risks than already incurred as voluntarily choosing to be clients at the ISU Family Therapy Clinic.

Participation in the study may provide you the opportunity to have greater input into the service that you receive. Clients who agree to participate in the study will have all service fees waived.

In the case where individuals under the age of 18 are participating in services the minor's legal guardian, as well as the minor, will have to sign the consent form prior to the minor participating in services.

Every effort will be made to ensure the confidentiality of participants. Information gathered from families will be coded and kept in a locked file cabinet. Client names will not be used to label information or associated in any way with the research findings. The audiotapes will be erased upon completion of the study.

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 in the study please call Dr. Harvey Joanning at 294-5215 or Jeffery Lashley at 294-8885.
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 & Witness


Date:______________________________
APPENDIX B: PERMISSION TO AUDIOTAPE/VIDEOTAPE FORM

Iowa State University Family Therapy Clinic
Permission to Audiotape/Videotape Form

In order to better serve those who come to the ISU Family Therapy Clinic for assistance, 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. The team members are bound to the same rule of confidentiality as the therapist.

I (we) give permission to the Iowa State University Family Therapy Clinic to use audio and/or video recordings of my (our) treatment sessions for supervision purposes. I (we) understand that a condition of this consent is respect of my (our) privacy and the confidential nature of our professional relationship.

In situations involving two or more persons, such as marital or family consultation, each person must give individual permission:

SIGNATURE(S):

DATE:

WITNESS:
APPENDIX C. INFORMED CONSENT STATEMENT: THERAPIST

The Department of Human Development and Family Studies and the Iowa State Family Therapy Clinic 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) client families will be interviewed after sessions 1, 2, & 3 regarding their perceptions of the services they receive at the ISU Family Therapy Clinic while under my care; 2) I will be interviewed after session 2 & 3 regarding my perceptions of sessions with client families I work with while an informant in this study; and 3) that these interviews will be approximately 15 to 30 minutes in length and will be audiotaped.

Participation in the study will likely entail no greater risks than already incurred as a therapist at the ISU Family Therapy Clinic. 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 therapists 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. Neither therapist or client names will not be associated with the study without their prior permission. Audiotapes of the interviews will be erased upon completion of the study.

Any questions concerning the study may be directed to Jeffery Lashley at 294-8885 or Dr. Harvey Joanning at 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 & Witness:

Date: ________________________________