1995

Therapist conducted debriefing interviews

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Therapist conducted debriefing interviews

by

Lloy Lane Brigham

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
(Marriage and Family Therapy)

Signature was redacted for privacy.

In Charge of Major Work
Signature was redacted for privacy.
For the Major Department
Signature was redacted for privacy.
For the Graduate College

Iowa State University
Ames, Iowa

1995

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INTRODUCTION

Using ethnographic interviews, family therapists have begun to gather information from clients about their experience of therapy. Ethnographic interviews are descriptive anthropologies of diverse groups of people. Kuehl (1987) first utilized ethnographic interview methodology examining the experiences of clients who participated in family therapy. Interviews were conducted with client families following the completion of therapy during which they were asked questions about their experiences of therapy. His work was beneficial because it furnished information to the therapist regarding the family's experience of therapy. Kuehl recommended that future research encompass family interviews preceding termination so that the information could be fed back into the therapy process. Ethnographic interviews would help the therapist deliver a higher quality service while the family would experience a more fulfilling therapeutic process.

Todd (1989) continued these ideas by examining how information from debriefing (ethnographic) interviews with families could be fed back into the therapeutic process to create a better fit between the family’s understanding of therapy and the therapist’s methodology. His debriefing interviews occurred while clients were still in therapy compared with previous studies that only interviewed families upon termination of therapy. Findings indicated that debriefers were able to assist in accommodating a better fit between the expectations of clients and the methodology of therapists.

Lashley (1993) used ethnographic methodology to determine the usefulness of debriefings to the overall therapeutic process including both therapists and clients. The results of his study suggested that the interviews served to positively modify the therapeutic
process by amending client dissatisfaction and ensuring that therapy was “on track” and providing a supplementary form of supervision to family therapy. This additional form of supervision could be called “client supervision of the therapist.” Families were effectively supervising therapy when asked how the therapy was going and what, if any, changes could be instituted to enhance the process.

Ethnographic debriefing interviews have typically been conducted by someone other than the therapist. Input from families comes from debriefing interviews conducted by an ethnographer or debriefer. The family's description of therapy to this third party, or ethnographer, is then given to the therapist to improve the process. Lashley (1993) called this experience Informed Therapy. Therapy was considered informed if the therapist received information from ethnographic interviews with client families.

But, what about the times when there is no third party or ethnographer available, a situation that most clinicians regularly encounter. The questions may then become: “How can a therapist obtain needed information from clients without the presence of an ethnographer?” “Can the therapist successfully conduct debriefing interviews and, if so, how can they best be conducted?”

The present study builds upon the work of Kuehl (1987), Todd (1989), and Lashley (1993) by examining whether or not therapists can successfully conduct their own debriefing interviews. The two methods in question are ethnographer-conducted debriefings compared with therapist-conducted debriefings.
REVIEW OF RELATED LITERATURE

Most of what is written about therapy is based upon the therapists' rather than the clients' point of view (Garfield, 1978; Gurman, 1977; Kruger 1985). Efforts at gathering qualitative information concerning clients' perceptions about the process of therapy have been largely absent. Ethnography and its usefulness in qualitative research methodology in the fields of sociology and anthropology have been long established. Ethnography is a term which may describe the operation where an investigator attempts to capture the point of view of people going through therapy by describing the individuals and interviewing them about their experiences.

Social psychologist Kurt Lewin (1946) used ethnographic methods in his “action research” in community studies examining attitudes among people. His work influenced researchers (Corey, 1953; Marrow, 1956) in education who were interested in teacher-managed research projects. Action research became the method of choice whenever teachers were continually monitoring and reporting the results of their work to administrators. The value of action research was determined by its ability to improve practice in given situations (Odell, 1976; Oja & Smulyan, 1989; Cunningham, 1993) rather than a predictive value typically associated with conventional studies. Action research has surfaced in social administration and management studies with the goal of pursuing professional innovation by initiating and conducting research from the “inside” (Winter, 1987). In the educational setting action research assumed that practitioners were autonomous, committed, discriminating thinkers who were capable of making important decisions following the interviews which provided them a reciprocal exchange of information (Rapoport, 1985).
The need for ethnographies and the reciprocal exchange of information between families and their therapists is critical to family therapy (Newfield, Kuehl, Joanning, and Quinn, 1991). Ethnography, or client debriefing, is an effective method of gaining information about how family therapy is progressing (Kuehl, 1987). Ethnographies have been used in collecting accounts of experiences of the mentally ill (Caudill, 1958; Goffman, 1961; Henery, 1971), but has only recently begun to be used in family research (Brown, 1992; Brotherson & Goldstein, 1992; Lashley, 1993: Moon, Dillon, & Sprenkle, 1990).

Over the past few years ethnographies describing therapists and their experiences of therapy have been written (Keeney & Ross, 1985; Napier & Whitaker, 1978). Tyler and Tyler (1985) described the various experiences of being supervised in a family therapy program and the tasks often encountered by student therapists.

These examples of qualitative investigation into therapeutic processes fail to address issues from the client’s perspective. A recent trend in marriage and family therapy has been the development of collaborative approaches which include the family’s point of view. Collaborative therapeutic approaches tend to highlight the narrative aspect of treatment (Anderson & Goolishian, 1988; de Shazer, 1994; Hoffman, 1990; White & Epstein, 1990) or identify themselves as feminist family therapists (e.g., Bograd, 1992; McGoldrick, Anderson, & Walsh, 1989). Although using different theories of treatment, clinicians advocating both the feminist and narrative approaches express concern that traditional hierarchical approaches can disempower clients, fail to capitalize on client strengths, ignore client’s experience, and perpetuate dependence on the therapist rather than promote self-reliance.
Collaborative therapies are client-driven (Anderson & Goolishian, 1988). The client's goals and strengths become the impetus that guide the therapy. Families are given the opportunity to explicitly accept, reject, or revise the course of treatment to best fit their situation. Rather than the conventional hierarchical relationship, collaborative therapy may be conceptualized as the co-participation of family and therapist.

Co-participation in the therapy process recognizes the recursive nature of the relationship between family and therapist. Newfield, Kuehl, Joanning, and Quinn (1991) found that studies which document therapeutic experiences as told by the family are indispensable from a constructivist-based cybernetic orientation. Constructivism proposes that we invent or construct realities rather than discover them. 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 descriptions become self-referential. Objectivity, according to Keeney (1983), is inaccurate since it presumes a separation of the observer and the observed. This assumption of second order cybernetics insists that the therapist must now become attentive to feedback loops of interdependent influence between therapist, supervisor, reflecting team, family or any other factor that may be an element of the therapeutic milieu.

The call for a new research methodology that is consistent with the cybernetic underpinnings of family therapy has begun to emerge (Atkinson, Heath, & Chenail, 1991; Keeney & Morris, 1985; Newfield, Kuehl, Joanning & Quinn, 1991). Drawing on traditions rooted in anthropology and sociology, the qualitative research paradigm provides an
alternative to the quantitative research paradigm for exploring social science phenomena (Cook & Reichardt, 1979; Hoshmand, 1989; Lincoln & Guba, 1985).

During the past ten to fifteen years, researchers and theorists in the field of education have refined and expanded the qualitative paradigm (Goetz & LeCompte, 1984; Merriam, 1988). Much of the expansion involved the primary data gathering technique of ethnography (Erickson, 1986). Ethnographic interviews were Dillon's (1989) primary tool for generating theory about what made classroom teachers effective. In spite of the many differences in education and family therapy, the two fields have one important thing in common—they tend to be interventionist. Dillon's (1989) work was a model for family therapy researchers using qualitative methodology. She clearly delineated consequential aspects of her own background that informed her viewpoints and influenced her research. The qualitative research movement in education (Smith & Heshusius, 1986; Smith & Shepard, 1988) appears to be more applicable to cybernetic thought, that is so prevalent in family therapy, than earlier developments in sociology and anthropology.

Qualitative ethnographic investigations into various components of the therapeutic system can question the manner in which therapy is conducted. Research has demonstrated that addressing the recursive flow of information and mutual influence among therapeutic components can be a valuable practice (Kuehl, 1987; Newfield, Kuehl, Joanning, & Quinn, 1991). Through Interpersonal Process Recall (IPR) clinicians have employed videotapes of sessions (Kagan, 1980; Kagan, Krathwohl, & Miller, 1963) to learn client reactions to therapy and to identify therapist behaviors that clients found beneficial and those they did not find
beneficial. Studies utilizing IPR have provided information regarding both client and therapist experiences (Elliot, 1985; Elliot, 1986).

Rennie (1992) managed a research project which asked clients to analyze a tape of their therapy session and recollect anything of importance or interest. Conclusions from the study indicated that clients were reluctant to voice dissatisfaction about the therapy process to their therapist. Even when the therapist invited clients to relate any dissatisfaction with their therapy experience, they would not share those experiences with the therapist.

Through the use of ethnographic interviews clinical researchers have proposed the construction of client-based portrayals of therapy to explore the experiences of families, couples, or individuals who receive treatment (Brown, 1992; Joanning, 1989; Joanning, Newfield, & Quinn, 1987; Keoughan, 1993; Kuehl, 1987; Kuehl, Newfield, & Joanning, 1990; Lashley, 1993; Newfield, Kuehl, Joanning, & Quinn, 1991; Todd, 1989; Todd, Joanning, Enders, Mutchler, & Thomas, 1990; Ulberg, 1994; Wu, 1993). Kuehl’s landmark undertaking investigated the experiences of clients who participated in marriage and family therapy. Using ethnographic interview methodology, he looked at the experiences of families who had just completed family treatment. He found that families were often disconcerted with what they thought were liberal violations of time, such as going over the same topics session after session.

Kuehl’s (1987) efforts were especially significant because they addressed therapeutic processes from the client’s view instead of the therapist’s. He recommended that future studies include obtaining information from client families about their therapeutic experience and feeding that information back into the therapy process.
Several projects were subsequently performed following Kuehl’s (1987) original inquiry. A study by Kuehl, Newfield, and Joanning (1990) investigated the observations of families following participation in therapy. Their research suggested that therapists can profit from knowing what clients have to say regarding therapy. Not unlike Kuehl’s (1987) original study, these ethnographies took place following the completion of treatment with the goal of finding what the family found to be effective and not effective.

This study seemed significant because it focused upon what families found to be helpful or not helpful in the course of their treatment. Researchers found that families who viewed their therapist as friendly, empathetic, and capable were more inclined to be pleased with the entire therapy experience (Kuehl, Newfield, & Joanning, 1990). When clinicians were able to create what families believed were appropriate recommendations the therapy was viewed as helpful and positive.

The study also indicated that therapists may be contentious themselves to therapy proceedings if they are not adaptable in the overall presentation of themselves and their interventions. Contention may be defined as a therapist who continues to present an exclusive pattern of therapy that the family cannot receive or understand. Clients who did not have a satisfying experience tended to doubt their therapist’s understanding of them or their difficulties and even disputed the therapist’s overall competence to produce remedial recommendations for the family in regard to their specific difficulty (Kuehl, Newfield, & Joanning, 1990). Ethnographies from the study also indicated that success in the latter stages of treatment correlated with success in the earlier stages of treatment.
In another related study, Newfield, Kuehl, Joanning, and Quinn (1991) interviewed families concerning their experiences of therapy upon completion of treatment. The findings suggested that families often experienced their therapy as an uncertain, uncontrollable weekly event with little correspondence between how the therapists viewed the therapy and how the families viewed the therapy. This lack of correspondence between family and therapist eventually translated into the difference between favorable and unfavorable therapy. Favorable therapy was identified when families and therapists had compatible or corresponding views of what transpired during therapy, while unfavorable therapy was identified when families and therapists views were incompatible. Often when therapist/family views were inconsistent or incompatible families refused to bring this to the attention of their therapist. This study also found that favorable therapy required a period of sustained compatibility and shared purposes across several sessions.

Todd (1989) built upon previous work of client-based research by feeding information gathered during ethnographic interviews back into the therapeutic process. The importance of his interviews was that based on the information gained the therapist could make stylistic changes if expectations of the family were not being met or if the therapist had inadvertently created a negative relationship with the family. This maneuver was an effort to create a better fit between the families’ perceptions of therapy and the therapists’ style of doing therapy. Debriefing interviews were no longer structured after the family had completed therapy but conducted during the course of family therapy treatment. Data from these debriefings was then presented to the therapist so that harmony could be reached between therapist offerings and family expectations.
Todd's (1989) study found that therapists were better able to be in harmony with families if they were aware of the families' expectations (Todd, 1989). Families often anticipate certain outcomes as a result of therapy and if these outcomes are not met, they become disconcerted or unhappy with the process. Results indicated that when therapists became aware of client expectations and negative perceptions they were better able to produce a positive therapeutic outcome for families. This study was also unusual in that a non-therapist interviewer was used to gain information about the process. Findings implied that the ethnographer gleaned information that the therapist was not creating during the therapy sessions.

Lashley (1993) built on this research by employing ethnographic interview methodology examining both clients' and therapists' experiences of therapy. Debriefing interviews were conducted with both therapists and families to organize descriptions of how they experienced the course of therapy. Ethnographers in his study routinely reported family accounts back to the therapist. Results of his study suggested that introducing information from debriefing interviews into family therapy provided a useful addition to the overall process. Interviews were said to positively influence therapy by rectifying client dissatisfaction or dissonance and ensuring that therapy was more efficiently conducted. Lashley depicted these debriefings as an additional mode of supervision to the therapy.

Information obtained from ethnographic interviews has been found to be helpful to the therapeutic process from both therapist and client points of view (Lashley, 1993), but what about obtaining this valued information when an ethnographer is not accessible? Most practitioners do not have the availability of a third person to conduct debriefings following
sessions. Since clients have been found to resist voicing discontent about their therapy to their therapist (Rennie, 1992), the question then becomes, "Can therapists successfully conduct their own debriefing interviews and, if so, how can they best be conducted?"

The present study builds upon the work of Kuehl (1987), Todd (1989), and Lashley (1993) by examining whether or not therapists can successfully conduct their own debriefing interviews. The two methods in question are ethnographer-conducted debriefings compared with therapist-conducted debriefings.

Purpose of the Study

The present study was designed to determine how ethnographer-conducted debriefing interviews compared with therapist-conducted debriefing interviews of families following therapy. The study was confined to a discussion of the clients' account of their debriefing experiences with both types of interviews. The concentration of the study was the investigation of client experiences and the comparisons and contrasts of the two types of debriefings.

Information from the present study provided understanding into how ethnographer and therapist debriefing interviews compare. Since the availability of ethnographers is rare in most clinical situations, the concern becomes whether or not the therapist can successfully conduct his or her own interviews. Ethnographic or debriefing interviews are a valuable device which therapists may use to refine the overall therapeutic process. The comparison of the two methods is an intermediate step, or process, to go through in informing which of the methods might best be indicated in a given therapeutic situation. The debriefing approach
employed in this study was simple and straightforward. Most therapists could easily insert the debriefing questions in order to generate new information to the therapy process.

Questions Posed by the study

The study was designed to produce additional data relative to the following discussion:

1. How do debriefing interviews with an ethnographer compare with debriefing interviews conducted by the therapist?

2. What were the families' impressions of ethnographer-conducted debriefing interviews compared with therapist-conducted debriefing interviews?

3. Can therapists successfully conduct debriefing interviews with their own clients?

4. What could have been done differently by the therapist or ethnographer so that she/he may approximate the effectiveness of the better interview?

Summary

An introduction, review of related literature, and purpose of the study have been presented in this chapter. The following chapters will include methodological procedures used in the study, data analysis results, and conclusions.
METHODS

Informants

The informants who participated in the study were recruited from client families being seen at the Iowa State University Family Therapy Clinic in Ames, Iowa. The informants were selected purposively, a method of sampling done with some purpose in mind. Specifically, informants were selected with the purpose of obtaining information from as broad a range as possible among the families chosen to participate. By purposively sampling a range of families the study addressed the transferability issue of qualitative research design and methodology. The goal of transferability for this study is that findings will be applicable to a wide range of families, thus the range of families used in this sample.

Six families were recruited with the intent of completing a sample of no fewer than four families. The sample size of four to six families has been suggested as a typical point of saturation (McCracken, 1988). Saturation is said to be reached when little or no new information is being provided by the informants. Informant families were from the area of central Iowa surrounding Ames. To be included in this study each client family was asked to participate in at least four therapy sessions and a final follow up debriefing. Families for this study were defined as families, individuals, or couples.

Therapists who were involved in this study were also selected purposively. Therapists were students in the Doctoral Specialization in Marriage and Family Therapy at Iowa State University. One therapist had a high degree of experience in family therapy, five had a moderate degree of experience in family therapy, and two therapists had a low degree of experience in family therapy. Gender was another factor considered in therapist informant
sampling. Attempts were made to balance male and female among the therapists utilized in the study. Eight therapists were involved in the study.

Two types of ethnographers were utilized in this study. The first was doctoral students in the marriage and family therapy program who debriefed families about their therapy sessions. The second ethnographer “debriefed the debriefings” at the conclusion of the study. This second ethnographer was 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 team member for families participating in this study. Consulting team members were student observers behind a one-way mirror who were supervised by a member of the clinical faculty. Utilization of a consulting team and clinical faculty person is in keeping with the general operations normally conducted within the clinic. The clinical faculty members were Approved Supervisors of the American Association for Marriage and Family Therapy (AAMFT).

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 AAMFT. This study was conducted with the permission of the Human Subjects Review Committee of the Graduate School at Iowa State University.

Procedure

The plan of this study (see Figure 1) followed the sequence of screening and recruitment of informants, procedural meetings with therapists and ethnographers, weekly
Therapy sessions and debriefings, debriefing of debriefing by the author, member checks by the author, and the analysis of data from the debriefing of debriefings.

Therapists were contacted and invited to participate in the study based upon gender and the amount of experience each had in family therapy. When therapists agreed to participate they were asked to choose a family, couple, or individual they were currently seeing or would begin seeing who might be included in the study. Therapists were advised of the range of families sought for inclusion in the study.

Therapists and ethnographers met with the author for a brief preliminary meeting with the purpose of examining details and expectations of all who were involved in the study. In addition, families, therapists, and ethnographers were each provided a packet of printed materials which specified the plan and expectations of the study.

Therapy was conducted as usual with participating families experiencing alternating versions of debriefing. When four sessions had been completed the author audiotaped a final
debriefing which asked questions about the family’s experience of the two types of debriefing.

Upon completion of the final debriefing of debriefing the author later contacted families to test the factual and interpretive accuracy of findings. Family members were in agreement with the author’s interpretations and there was no need for revisions or corrections. Interpretations were also presented to the auditor during the dependability audit for further consideration of either inclusion or exclusion. The auditor was in agreement with conclusions reached by the author.

Two separate formats were used in this study. Format One involved the therapist debriefing the family after session one. Following the second therapy session the ethnographer debriefed the family. Session three featured the therapist debriefing the family, while session four again featured the ethnographer debriefing the family. At the conclusion of Format One, the second ethnographer conducted a final follow-up debriefing regarding their perceptions and comparisons of the two types of debriefing. All but one family experienced four therapy sessions where half the sessions were debriefed by the therapist and half debriefed by the ethnographer.

Format Two involved the ethnographer debriefing the family after session one. Following the second therapy session the therapist debriefed the family. Session three featured the ethnographer debriefing the family, while session four again featured the therapist debriefing the family. At the conclusion of Format Two, the second ethnographer conducted a final follow-up debriefing regarding client perceptions and comparisons of the two types of debriefing. The only difference between these two formats was which type of
<table>
<thead>
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<th>Format One</th>
<th>Format Two</th>
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<td>Therapy session one</td>
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<td>-Therapist debriefs family</td>
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<td>-Ethnographer debriefs family</td>
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<td>Follow-up debriefing</td>
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<td>-2nd ethnographer debriefs</td>
<td>-2nd ethnographer debriefs</td>
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</table>

Figure 2. A diagram of Formats One and Two

debriefing experience would be first in the rotation. Client families experienced either Format One or Format Two. This design allowed families to encounter debriefing interviews conducted by their therapist and an ethnographer in order to make comparisons and contrasts concerning the two types (See Figure 2).

The rationale for employing two formats grew out of a concern for balance in the study’s design. Consideration was given to furnishing three consecutive debriefings by the therapist followed by three consecutive debriefings by an ethnographer. However, the present design was adopted based upon previous studies which similarly counterbalanced the treatments in alternating weeks without difficulty for families (Brown, 1992; Lashley, 1993; Todd, 1989; Wu, 1993).
Families recruited for inclusion in this study were either new client families or client families already experiencing therapy at the clinic. Families were recruited by the primary therapist and were given the following explanation of solicitation:

In an effort to improve services for families who visit our clinic, we are interested in your experiences during therapy. We are requesting your permission to ask questions about the therapy process immediately following four of your sessions. These conversations should last approximately 15 to 30 minutes. They will be conducted alternately by your therapist and another interviewer. Each week, either your therapist or an interviewer will talk with you about the experiences of that session. The interviewer will ask your permission to share the information you gave with your therapist. Finally, at the end of four sessions a second interviewer will talk with you about the entire experience.

An explanation was provided each client concerning the demographic descriptions of their family which would eventually be written up and included in the final dissertation. Families were informed of the additional time requirement that participation in this study would require, were given a copy of the write-up, and informed of their opportunity to provide feedback to the primary investigator concerning the description. Families who decided to participate were not considered at any greater risk than families not participating in the study. They were informed of the benefits of participating and asked whether or not they had questions. Each participant was asked to sign a written consent form regarding inclusion in the study, as well as the usual client agreement forms that are part of normal operation of the Family Therapy Clinic. Consent forms were approved by the Iowa State Human Subjects Review Committee. Families were also offered a written overview of the study.

Family members above age 18 were asked to fill out the Family Adaptability and Cohesion Evaluation Scale III (FACES III) (Olson, Portner, & Lavee, 1985). Information
from FACES III was used to help describe informant families. Individuals, couples, and families are typically asked to fill out the questionnaire as a part of clinic protocol.

FACES III is one of the recent self-report scales developed by Olson and his colleagues to assess family cohesion and ability to change (adaptability). This measurement device tests the Circumplex Model of Family Functioning (Olson, Portner, & Lavee, 1985). FACES III consists of 20 items which are responded to twice by each family member, first indicating how the person sees the family now and second, how the person would like the family to be. The internal consistency reliability was .77 for the 10-item Cohesion scale, .62 for the 10-item Adaptability scale, and .68 for the total FACES III (Olson, Portner, & Lavee, 1985).

Therapists were supplied with a packet which furnished details of the study and they were informed of potential risks and benefits. Each therapist participated in an individual preliminary procedural meeting conducted by the primary investigator.

Debriefings following therapy sessions were typically begun by asking families to describe the therapy experience. The lead question was: "Please tell me what it has been like for you to be here today as if I were a friend who has asked you about the experience."

General questions about their experience informed the interviewer, whether therapist or ethnographer, about important themes or words which needed to be expanded. Successive questions facilitated the enlargement of key statements or abstractions. Interview questions were open-ended or moderately structured to obtain as much information as possible from client families.
Spradley suggests three types of questions: descriptive, structural, and contrast (Spradley, 1979). Descriptive questions ask informants to describe their experience more fully. For example: “Could you tell me what you mean by you ‘talk more openly now’?” Structural questions are asked concurrently with descriptive questions. They are used to gather information about the topic being discussed. For example: “You’ve talked about having different kinds of fights with your son. Could you tell me more about these different kinds of fights?” Contrast questions are designed to further define the meaning implicit in symbolic language used by informants by finding out how one symbol is different from other symbols. For example: “What are the differences in your therapy experience at this clinic compared with your experiences with the in-home therapist you worked with last year?”

Although these three types of questions are not totally discrete, they tend to capture the various dimensions of meaning and allow the interviewer to more fully understand how informants may view their therapeutic experience. The debriefing interviews ended when families seemed to have shared all relevant information, that is, until families began to repeat themes.

Following Lashley’s (1993) example the following questions were asked by the first ethnographers and therapists of all families who participated in the study:

1. What, if any, of your experiences from the therapy session did you find helpful or positive?
2. What, if any, of your experiences from the therapy session did you not find to be helpful or that you didn’t like?
3. What have been your perceptions and experiences of me/your therapist?
4. What has the experience of these debriefing interviews been like for your family?

Interviews began with a reminder about the purpose of the study, a summary of previous interviews from the interviewer’s field notes, addressed any questions the family had, and asked the lead question “Please tell me what it has been like for you to be here today as if I were a friend who has asked you about the experience.” Family interviews were audiotaped or videotaped allowing the interviewer to check the accuracy of field notes. After each interview was completed, interviewers furnished families with a spoken synopsis of debriefing notes from the interview as a review for correctness. This was based upon notes taken throughout the debriefing by the interviewer. Families who were debriefed by the ethnographer were asked for their permission to share the summary with the therapist. Information was censored to remove comments the family did not want shared. In order to maintain consistency in the therapeutic relationship, each family had the same therapist and ethnographer for the required four sessions.

The final follow-up debriefing interviews were audiotaped and transcribed for the purpose of analyzing the hard copy. During these interviews clients were asked to offer suggestions or ideas about how the types of debriefing compare and how one type of debriefing may begin to approximate or equal the other. The following lead question was used to begin the final interview: “Please describe your overall experience of debriefing interviews by your therapist and the interviewer as if I were a friend who has asked you about the experience.” The final debriefing of debriefings included the following questions when clients did not spontaneously supply this information in response to the lead question:

1. How would you describe the experience of being interviewed by your therapist?
2. How would you describe the experience of being interviewed by the ethnographer?
3. What did you like about the approach of being interviewed by your therapist?
4. What did you like about the approach of being interviewed by the ethnographer?
5. What did you not like about the approach of being interviewed by your therapist?
6. What did you not like about the approach of being interviewed by an ethnographer?
7. If you could change how the therapist interview was conducted, how would you do so?
8. If you could change how the ethnographer interview was conducted, how would you do so?
9. Which of the debriefing formats did you prefer, and why?
10. How do the two methods of debriefing compare?
11. How do the two methods of debriefing differ?
12. How can the therapist more successfully conduct debriefing interviews in order to best elicit how you experienced therapy?
13. How can the ethnographer more successfully conduct debriefing interviews in order to best elicit how you experienced therapy?
14. How much, if any, information did you withhold and for what reason?

If the families indicated that either therapist-conducted or interviewer-conducted debriefings were inferior, the following question was asked: "What changes need to be made
by the therapist or interviewer so that she/he may approximate the effectiveness of the better interview?" This question facilitated the goal of suggesting formats for therapists who want to do their own debriefing.

After all four sessions had taken place, families could continue with their therapist under typical therapy conditions of the clinic.

Data Analysis

The debriefing of debriefing interviews conducted by the second ethnographer was recorded and transcribed. The transcribed data was then analyzed by Spradley's (1979) Developmental Research Sequence (DRS). This procedure was developed to examine and define cover terms, included terms, and the semantic relationships within transcribed data. The goal of domain analysis is to discern how people classify or categorize their experiences through the terminology they use to talk about those experiences (Sturtevant, 1972). To do this, Spradley (1979) developed the analytic procedure (DRS) that examined and defined terms within transcribed ethnographic data.

The first level of analysis involved reviewing the audiotapes of interviews to clarify and validate the transcript data. The researcher then examined the basic transcribed text with no attempt being made at analysis. During the second level of analysis, the researcher reread the transcripts and highlighted characteristic comments or phrases. Key words and phrases were noted. The third level of analysis included a clustering of key words and phrases together into related clusters across families to form cover terms that defined domains of meaning common to all informant families.
Following the recommendations of Guba (1981), several steps were taken to warrant that the study was managed rigorously. The following standards for rigor were incorporated in the study.

Credibility was established when correspondence between the realities of the informants and the realities of the investigator was reached (Guba, 1981). In this study, credibility was verified through the practice of member checks and triangulation. Triangulation was introduced by asking an informed but uninvolved person to review the analysis and suggest modifications. Similarly, member checks were arranged by asking participant families to review and comment upon the initial findings of the qualitative analysis. Further triangulation in this study was provided through the complementary use of descriptive data generated by the FACES III, the debriefings, and videotapes/audiotapes of the therapy sessions. Triangulation served the author with a system to carefully define and revise the various domains of meaning. Consensus was achieved between the author and the uninvolved person, as well as between the author and the families. This consensus ensured agreement over interpretations of the author and that his findings were accurate representations of the families' experiences.

Transferability was established by ensuring that the context of the study was documented so that others can make decisions regarding how well the findings will transfer to other clinical situations (Guba, 1981). Two methods were used to establish transferability. The first was purposive sampling. Attempts were made to sample the range of families likely to participate in family therapy under most circumstances. For example, a younger newly formed family, a middle-aged or established family, and an older family were recruited to
ensure diversity across the family life cycle. Transferability was subsequently established by writing a contextual description of the people, the findings, and context of the study. This description included sufficient demographic information and examples to allow readers to determine the applicability of the study to other settings.

Dependability is concerned with the stability and agreement of the data (Guba, 1981). Dependability was established by overlapping methods of data interpretation such as triangulation and member checks mentioned above. The author organized and managed data collection and analysis so that an uninvolved party was readily able to understand what, how, and why the study was conducted. The researcher’s careful organization and documentation of the process of the study provided an audit trail. Adequate records rendered an audit trail that informed the reader precisely how the analysis was done and how the methodology evolved during the course of the study (Lincoln & Guba, 1985). Sources of data providing the audit trail in this study were:

1. Raw data (audio/video recordings and transcripts)
2. Data reduction and analysis (transcript summaries, domains of meaning, and clusters and collapsed categories of meaning)
3. Research proposal
4. Assessment instrument (FACES III and results)
5. Reflexive journal (daily record of methods, decisions, thoughts & feelings, schedule, & overall notes).

Using the above mentioned items as an audit trail a dependability audit was conducted by Dr. Patricia Keoughan, an informed and experienced person in both qualitative
methodology and family therapy. Dr. Keoughan is a graduate of Iowa State University with a Ph.D. in Human Development and Family Studies with a Specialization in Marriage and Family Therapy. She has been a professional Quality Manager with experience conducting similar research. The dependability audit was conducted in order to ensure a logical progression throughout the course of the study. Dr. Keoughan concluded that the study was clearly conceived and coherent, and also agreed with interpretations made by the author.

Confirmability was established by ensuring that the data was firmly rooted in the informants perceptions (Guba, 1981) and was accomplished by attempting to introduce neutrality into the efforts of the investigator. The researcher attempted to remain neutral by using triangulation and an audit trail to warrant that the procedure followed during the study was not an arbitrary application of only the researcher’s interpretation of the data.

Rigor was ensured in this study by using a variety of methods, which at times overlapped, to increase the probability that credibility, transferability, dependability, and confirmability were established.

**Summary**

This chapter furnished a general outline of the study including portrayals of families and therapists, and formulas for analysis of data. The following chapters include the outcomes of this study and a discussion of those conclusions.
RESULTS

This study was devised to expand the information base regarding client descriptions of ethnographic interviewing methodologies as described by families who participated in treatment at the Family Therapy Clinic. Family interviews were transcribed and analyzed according to the Developmental Research Sequence (DRS) of Spradley (1979). The primary concentration of the study was to investigate families' perceptions of similarities and differences between therapist conducted debriefing interviews and debriefer conducted interviews.

The debriefing of debriefings had as its purpose the analysis of how families experienced the two methods of debriefing. The study also produced information about how families generally experienced therapy and debriefing at the ISU clinic.

Therapist and Family Descriptors

A range of families and therapists were included in the study. Families were current residents of central Iowa yet several were originally from various sections of the United States with one international couple. Four of the six families received all four debriefings according to the prearranged format, while one family experienced three debriefings, and a final family decided to conclude therapy after two debriefings. All of the families experienced both methods and made comparisons of the two upon the final debriefing of debriefings.
Therapist combinations included three co-therapy teams, and three therapists who conducted their sessions individually. Therapists varied in ranges of age, cultural background, and experience levels.

**Therapist descriptors**

Eight therapists were involved in the study. All were doctoral students in the Marriage and Family Therapy Doctoral Program at Iowa State University. Five therapists were married while three were single. Amount of therapy/counseling experience ranged from one to fifteen years. All of the therapists listed themselves as Caucasian, with one distinguishing himself as Greek American. When asked about preferred therapy style, four identified themselves as brief solution-focused therapists, and four thought of themselves as collaborative language systems types of therapists. Interestingly, both these types of therapy begin with the assumption that families are the authorities or experts on their own lives.

Ages of therapists ranged between 25 and 44 with a mean of 31.9 years of age. Four therapists said they preferred working with couples, while three preferred working with families, and one therapist preferred working with couples or families. None of the therapists identified preferring to work with individuals.

When asked about experience in debriefing clients, four had never formally debriefed families prior to the study, two listed considerable experience in debriefing, while two identified limited experience in debriefing. Following the final session, therapists were asked about their perceptions of the present study and debriefing in general. All but one listed the experience as helpful, positive. The therapist who did not list the experience as helpful said
that he was neutral in regard to the debriefings. Each therapist said that they were beginning
to more frequently incorporate debriefing into their therapy sessions.

Therapy combinations included three male/female co-therapy teams, one individual female therapist, and two individual male therapists. Half of the therapists debriefed their families in a room other than where the therapy session took place. The other half debriefed in the same room. All the families were asked about whether or not changing rooms helped or would help. The author collaborated with participating therapists to recruit new families and families already being seen at the clinic. Eleven families were recruited for the study with six agreeing to participate for four sessions. Two families decided to withdraw prior to completing four sessions but did receive debriefings by both therapist and debriefer, plus the final debriefing by the author. One of those two families withdrew following two sessions and debriefings while the other family withdrew following three sessions and debriefings. Both of these families had been served by the clinic for several months and their explanations for withdrawal was that they believed their therapy had been completed.

Family descriptors

The six families involved in the study included a single mother with four children, a blended family with four children, an intact family with two children, and three couples. Ages of the eleven adults who participated ranged from 22 to 47 years with a mean of 29 with children ranging from ages eight months to 14 years with a mean of 8 years. Education among adult informants included one college graduate, two high school graduates, and eight adults reporting one to three years of college.
Religious preferences of adult informants included two who reported themselves as Catholic, five as Protestants, and two as agnostic. Incomes of families ranged from less than $10,000 to over $40,000. Seven adults described their work as technical/service related, one person was a student, one salesperson, one listed himself as a laborer, and one was unemployed.

Individual FACES III measures denoted that four families fit the mid-range category while one family fit the balanced category. One family did not fill out the scale. Of the families who were considered mid-range, five individuals described their family or marital relationship as flexibly disconnected, two as flexibly connected, and one as structurally disconnected. Within the family that was considered balanced, one person described the relationship as structurally separated and the other person described the relationship as flexibly separated. Due to the ages of children in this study, none were asked to complete the FACES III scale. The FACES III inventory was utilized to assist in determining how families in the present study might compare on levels of functioning with other client families at the clinic. Results indicated that families in the present study were comparable to client families normally seen at the ISU clinic.

Olson et al (1985) describes balanced families as maintaining balance between structure and closeness. These families have sufficient flexibility to adapt to either external difficulties or internal developmental transitions. Balanced families tend to be organized in ways that promote stability and continuity which is thought to contribute to cohesiveness as a family unit.
Mid-range families probably have a smaller behavioral repertoire than balanced families. These families are often characterized by their lower adaptability and their fragile level of cohesiveness. They are described by Olson (1985) as neither high nor low functioning and often need professional assistance, such as counseling, in negotiating life cycle transitions or stressful family predicaments.

**Analysis of Qualitative Data**

A total of 11 domains of meaning were determined from field notes and five audiotaped interviews from families who experienced the two debriefing formats. Five imposed domains were determined, while six domains emerged from families' digressions during final debriefing interviews. Imposed domains were elicited by the structured interview questions of the final debriefing. Emergent domains emanated from the digressions in conversation by families during the final debriefing. Characteristics of both imposed and emergent domains are included in Appendix G.

**Imposed domains**

Final debriefing interviews were modestly structured and included several standard questions if families did not spontaneously supply information. Imposed information, which the study was designed to obtain, involved therapist-debriefer comparisons/contrasts, descriptions of the debriefing experience, and how debriefings could be made different or better. Imposed domains included: Therapist and debriefer comparisons, preference for debriefer, preference for therapist, experience of being debriefed, and how debriefing could be made better.
**Domain: Therapist and debriefer comparisons**

This domain comprised the characteristic descriptions of what informant families offered as comparisons between being debriefed by their therapist/s and a debriefer. A narrative elaboration is also included.

**Elaboration**

The preceding domain was imposed by the interview questions which tended to pursue further distinctions and contrasts regarding the two debriefing methods. Nearly a third of the respondents preferred to be debriefed by their therapist, another third by the debriefer, while the remainder seemed comfortable with either method.

Some family members reported little or no differences between the two styles. Typical comments included, “We were comfortable with either one,” “I didn’t see any difference,” “I can’t compare, they are pretty much the same,” “They were very similar,” and “Nothing bad about either one.” Individuals who chose to be debriefed by their therapist made remarks like, “You can be more personal with your therapist,” and “Debriefing is probably more personal for the therapist than hearing a report from the debriefer.” Family members who chose the debriefer made comments such as, “I was more forthcoming with the debriefer,” “He was like a third party observer,” “He became part of our relationship and our extension,” and “Better to be debriefed by a third party.”

Several families reported that they actually enjoyed reflecting upon the process and differences in methods. Family members who voiced preference for one or the other types seemed to feel strongly about their opinion while those who had no preference were less persuaded about which method was more useful.
Domain: Preference for debriefer  This domain includes characteristic descriptions of family members who clearly voiced their preference for a third person or debriefer. A descriptive elaboration follows.

Elaboration  The focus of this domain was that some family members distinctly chose the debriefer over a therapist as the favored method. Most of the respondents who preferred debriefers identified that it would be uncomfortable to verbalize dissatisfaction with therapy to the therapist, “If there was something wrong I would rather talk to a third person.” One individual believed that the debriefer brought a fresh perspective to the process stating that, “He had a different approach, a different view of things.”

Several identified that it was easier to tell anyone other than the therapist their negative opinions of how therapy was proceeding. One person said, “Who wants to stand in front of a person you see weekly and say something negative.” Another respondent remarked, “I think on the average that if a person had something negative to say they would probably be more likely to say that to a third person versus a therapist.” One man stated, “She’s not afraid to say she doesn’t like something, but I just wouldn’t come back if there wasn’t a debriefer to tell.”

One of the couples found it easier to convey their enthusiasm and satisfaction to a debriefer citing that it might seem less than believable if revealed to the therapist. The husband said that, “Telling a debriefer about what we like would carry more authenticity because its coming from a third person.” This couple was observed by the team behind the mirror as they experienced the two methods and it was noted that their ebullience regarding the therapy experience did seem more intense with the debriefer.
A few individuals noted that they might even have difficulty describing some of their unpleasant experiences to a debriefer and suggested alternatives to verbal debriefing.

**Domain: Preference for therapist**

This domain involves the descriptions of family members who stated their preference for the therapist as debriefer. A descriptive elaboration follows.

**Elaboration**

The thrust of this domain was that some family members preferred to be debriefed by their therapist rather than a third party. Typical comments included, “I like the therapist because of what she knows,” “I was more forthcoming with the therapist,” “I'd rather talk to the person I have a problem with,” “Because I liked my therapist it was easy to talk with him,” and “It would give the therapist the opportunity to see how they could change for the next couple.”

Most of the respondents who preferred the therapist debriefing cited the rapport which was already established and the history that family and therapist have together. A mother commented that “If it's someone we totally didn't know it might be upsetting.”

Family members who preferred therapist debriefing often believed that eliminating the possibility for mistaken or misinterpreted communications would be ideal. Thus their preference for debriefing with the therapist.

A few of these respondents said they would choose to air their grievances in the company of the person with whom they are dissatisfied. Only two family members actually chose the one to one method of communicating their dissatisfaction over therapy.
Domain: Experience of being debriefed

This domain developed out of family responses to their overall experiences in debriefing. An elaboration of the characteristics is included.

Elaboration This domain demonstrates the positive nature of debriefing to all of the respondents in the study. Comments ranged from, “There’s nothing but good that’s come out of it” to “I felt pleased you would go to such lengths to see how therapy was going.”

Observations by families appear to suggest that the process allowed them to assume a more active participatory role in the therapy process. A mother felt that “It gave us a chance to say what was working.” Another person believed that “It’s necessary to control what’s going on and to find out if therapy is working.”

Remarks by respondents inferred that debriefing served to foster an atmosphere where family and therapist could generate new information and thereby change the course of therapy. In reference to the feedback generated during debriefings one man said, “You knew your contribution was valuable.” In addition, comments from families implied that debriefing allowed them to think of therapy from another perspective. One person said, “It’s a fresh outlook.” This higher order (Keeney, 1983) of thinking afforded families with a broader scope of their successes and failures during the course of therapy. One respondent felt that “You get more depth with the therapy” as a result of debriefing. Another felt that debriefing was a “Reflection on the process.”

Client experiences of debriefing suggest that another level of collaboration has taken place whereby families directly influence the direction and progress of therapy. This may impact the family’s overall satisfaction with therapy. Finally, families overwhelmingly felt
respected and valued as a direct outcome of their debriefing interviews. Typical comments included, “Showed genuine interest and not phony,” “Very helpful, its a two way street,” “That’s a step more than most places would go,” and “It helped us to do more for ourselves.”

Domain: How debriefing could be made better

This domain reflects respondents’ answers to interview questions concerning how debriefing could be made different or better. A narrative elaboration is included.

Elaboration

The preceding domain reflected the comments by families regarding how debriefing could be made different or better and offered an opportunity for respondents to further elaborate upon what they liked or disliked about debriefing in general. Two family members stated that changing rooms would make a difference in how they experienced debriefing. One commented that changing rooms, “Separates the two.” The remainder of respondents stated that changing rooms made little or no difference. “Changing the room wouldn’t have changed anything at all.”

Most of the families struggled with making suggestions and offered that they were unable to comment on how to improve the debriefing process. “I don’t think there’s anything to change.” A husband remarked that, “I wouldn’t have any idea how to change, it was so well done.”

Several individuals suggested that families could be provided with paper and pencil forms for eliciting their responses to therapy. “Maybe a question and answer page.” Writing would be better.” Two respondents suggested that the form include standard questions as well as a discussion section for individualized comments. One couple believed that a written form and anonymity was very important for families whose responses were negative.
A range of suggestions were made by family members, “I would like a room that was enclosed without cameras and mirrors,” “Wait until we get to know the therapist before debriefing,” “It needs to happen after emotional sessions,” and “They could keep us from wandering off the topic.” Family remarks concerning privacy during debriefing, waiting until rapport is established, debriefing after emotional sessions, and staying focused on the debriefing seem to suggest the need for therapist/debriefer sensitivity. Sensitivity to clients while debriefing may reflect the need for formal training in the debriefing process.

Therapists at the ISU Family Therapy Clinic are routinely trained to conduct debriefings with families. During the course of the study, however, it was suggested by several members of the observation teams and therapists/debriefers alike that some review in debriefing would have been helpful. Although therapists and debriefers followed clinic protocol during debriefing, it may have been useful to incorporate a brief review during the preliminary procedural meeting.

**Emergent domains**

The six domains that emerged from conversational digressions by families during the final debriefing interview included: Frequency of debriefing, influence of debriefing upon families, discomfort with communicating negative experiences, client satisfaction with therapy as a result of debriefing, debriefing as therapeutic, and rapport with therapist.

**Domain: Frequency of debriefing** This domain includes informant descriptions of how often families should be debriefed. A related elaboration is included.
Elaboration  Frequency of debriefing seemed important to many families. Half of the respondents suggested that being debriefed after every session was unnecessary. Typical comments included, “It probably is not necessary after each session but probably each is different,” “Probably not after every session,” “Once every five to eight sessions,” “Every two months,” and “Every week is too often.” One family said they were comfortable with debriefings after each session but suggested that those debriefings be kept brief. Most families indicated that going over the same material week after week would not be productive. “You say the same things every week probably.” This saturation point probably varies from family to family and necessitates special attentiveness on the part of the person who is debriefing.

Domain: Influence of debriefing upon families  This domain includes descriptions of how debriefing impacted or influenced families and their therapy. A descriptive elaboration is also enclosed.

Elaboration  This domain may be the most significant of both emergent and imposed domains. Client families overwhelmingly identified the overall utility of debriefing. “This is really helping and I came into this thinking it would be like the other therapy.” Remarks suggested that debriefing improves collaboration between therapist and client system. “Helps us realize what’s going on.” “Its somewhat necessary that you can control what’s going on and to find out if the therapy is working because who wants to keep doing the same thing over and over again if its not working.” “Gives the power back to us.”

Family members generally believed that debriefing’s effect was an even further reflection upon the process of therapy. “Debriefing would be a reflection on the process.”
Most seemed to think that it kept therapy focused and was a further extension of the helping process (Carkhuff, 1987). Two families utilized their debriefings as generators of additional therapeutic conversation after going home. One spouse remarked that “It gives a conversation piece” after returning to their home.

Families often agreed that debriefing cast the clinic in a more professional light, going beyond what is normally indicated for therapy. Typical remarks included, “Its a fresh outlook to see you’re concerned with helping us,” “It really says something that you care,” “That you change the way things are being done,” “That this whole place was concerned about whether they were doing their job right,” “A step more than most places would go,” and “Pleased that you would go to such lengths to see how therapy was going.”

Family members reported that debriefing adds depth and richness to therapy. “You get more depth with the therapy.” Families felt that they have more control over the process and that debriefing makes therapy less hierarchical than was previously experienced. “Its not clinical.” Debriefing may serve to avoid future pitfalls, according to families, and offers a fresh approach to therapy. Nearly all families reported that debriefing demonstrated care on the part of the therapist and the clinic.

The influence of debriefing upon families was quite positive. “I thought it was really important.” “Positive.” Debriefing interviews appeared to influence client satisfaction with therapy and therapist. Families reported feeling “Cared about” and that the therapist “Cared about the work.”
Domain: Discomfort with communicating negative experiences

This domain reflects client descriptions of discomfort with communicating negative experiences to the therapist. A narrative elaboration is also included.

Elaboration

The majority of respondents claimed that it would be difficult to convey their displeasure to the therapist as debriefer. “I enjoyed the therapists but I didn’t want to say anything negative to them.” A few informants speculated that negative messages delivered to someone who was attempting to help would be especially difficult. “Even if the relationship is not that well it’s still the feeling that they are trying to help and I wouldn’t want to hurt their feelings.” One person preferred to not be asked any questions regarding a therapist’s performance if she was dissatisfied with that person.

The majority of family members ventured that they would not want to be debriefed by the therapist if unhappy with the progress of therapy and preferred to be asked by a third person or debriefer. Since all the family members in this study were pleased with how their therapy was going the ‘negative feedback about therapy’ stories were simply hypothetical scenarios. Typical comments included, “I’m sure that for the typical standard person if there was something that was not quite right, they would probably not say that to the therapist,” “If I wasn’t happy with our therapist and he debriefed us I would be kind of unresponsive,” “I would be angry if I was debriefed by someone who I was forced to say something nice to,” “If somebody had something bad to say, they would be upset about it but we had nothing but good to say,” and “I wouldn’t agree to the debriefing (if unhappy with the therapist).”

During a debriefing of debriefing interview with a couple the author asked, “What if you didn’t like the therapist and the debriefer comes in and talks about how the therapy is
going?" The wife responded, "I might have been a lot less comfortable with the questions."

The husband followed by saying, "If therapy's going up and down and there's a trend, you
might bring the third party in and say 'Hey what's going on? What's the problem? This may
need to go in a different direction. Is there a conflict with the people you are working with?
Is there something you would change?' I can see that the third person would work out. 'Is it
something our people are doing or is it you guys in general? If it is our staff and if they
change, would that help you out?' If the debriefer said things like that." The author then
replied by stating, "I think I hear you saying it might be easier to say to another person that
there are some things that aren't working here and you think it would be easier to tell
someone other than the therapist there was something wrong?" The wife's response to the
author's remark was, "Oh yeah, if there was something wrong we would, but in our situation
things worked out very well."

**Domain: Client satisfaction with therapy as a result of debriefing**  
This domain includes those characteristic descriptions of how family members satisfaction with therapy seemed to rise as a result of being debriefed. A related elaboration is also included.

**Elaboration**  
This domain included those narratives of how families were satisfied or more satisfied with therapy as a result of debriefing. Several family members stated that debriefing helped them know where they were going in therapy and how they would get there. Others viewed the debriefing interviews as helpful in making adjustments to therapy, thus increasing its effectiveness. Typical comments from this domain included, “It was a study about it (therapy) and was kind of like a security blanket,” “It helped me realize what we've been coming here for,” “It makes you stop and think how therapy would work for
you," "It gave us a direction," "During therapy itself we stopped several times and said, 'Is this working?' and we made changes then too," and "He wanted to know personally from us how we felt about the sessions, I was happy about that."

Most family members seemed to sustain an increase in satisfaction with therapy simply because they had been asked about the process. "I like this debriefing, it brings new light to me." Four of the families interviewed seemed to be saying that they could see a difference in how things were going as a consequence of debriefing. Two families believed that debriefing interviews helped them to become more appreciative of therapy and made them realize its overall benefits. "It gave us a direction." "We did see a difference." One couple preferred to think of debriefing as an adjunct to therapy and something they should expect.

**Domain: Debriefing as therapeutic** This domain includes informant descriptions of debriefing and its therapeutic effect upon the family. A narrative elaboration is also enclosed.

**Elaboration** This domain spoke mainly to the therapeutic nature of debriefing. Characteristic comments included, "We noticed how much change really did happen for us," "It lets you know you're doing a lot better than you thought," "Really helped us focus on us," and "Helpful for us, gives us more to talk about." One family reported that change happened for them as a direct result of being debriefed about their experiences. Another family believed that their therapy continued during the debriefing and saw little difference between the two. "In a way therapy's just continuing."

Other families said that debriefing had considerable impact upon how the therapy progressed. "The therapy and this (debriefing) had a lot to do with how we progressed so
far.” One person emphasized the therapeutic importance of debriefing following emotionally laden sessions. “Especially helpful after an emotional session.” General impressions of families seemed to conclude that debriefing should be included as a component of the overall treatment protocol. “Shows sensitivity.”

When a mother was asked by the author, “Is the debriefing anything at all like therapy?” she responded by saying, “It was more directly to the point. The progress we’ve made and what we have and haven’t done. It gave us direction.” To which the author replied “So, was it really therapy rather than an interview .... am I reading too much into that?” The mother remarked, “No. It helps us realize what’s been going on. We’ve been doing it this way. It made me think about it more.” “It made you think of therapy in a different way?,” replied the author. The mother responded, “It made me think about it more, instead of it being a conversation between us and them it became ... it had points to it, and things we need to think about.”

Domain: Compatibility with therapist This domain includes family descriptions regarding how compatibility with the therapist influences therapy and debriefing. A descriptive elaboration is also included.

Elaboration The preceding domain was derived from comments by family members who equated therapist compatibility with debriefing success. Several families elaborated upon their comfort level with the therapist and its correlation with favorable debriefing interviews. Representative comments include, “We were used to talking with them (but) if things were going bad with us, or something upset us, it might be different,” “If I wasn’t happy with our therapist and he debriefed us I would feel kind of unresponsive,”
“Debriefing helps when the person is respectful,” “If I wasn’t happy (with the therapist) I would feel uncomfortable (being debriefed),” and “Not everyone is happy with their therapist, if I wasn’t happy with our therapist and he debriefed us I would feel kind of unresponsive.”

Four families hypothesized that poor rapport with their therapist might impact debriefing interviews. Informants went on to say that therapist/family compatibility was the key to successful therapy and successful debriefing (by the therapist). “Since we were pleased with the therapist it was more personal to be debriefed by the therapist.”

Summary

This chapter presented demographic data plus the qualitative results of the study. The following chapter discusses inferences drawn from these discoveries and condenses their implications for future research and clinical practice.
DISCUSSION

The qualitative study described in this document examined therapist conducted debriefing interviews compared with interviews utilizing an ethnographer. Family narratives with reference to therapist conducted debriefings were acquired through moderately structured interviews. Transcripts of these interviews were analyzed to develop an account of debriefing methodology comparisons as described by family members who participated in family therapy treatment.

The preceding chapters have detailed the foundational clinical and conceptual literature for the study, the methodology employed in the study, and the results. This chapter includes a synopsis of the findings and a discussion relating present results to findings from other studies. Conclusions are drawn with recommendations for further research. Implications for the field of family therapy are also explored.

Summary of Results

Qualitative conclusions were described in the Results chapter. A more concise rendition is outlined below.

1. The domain of therapist and debriefer comparisons reflected the primary objective of the study. Family members were evenly divided along lines of preference. A third of the respondents preferred to be debriefed by their therapist, another third by the debriefer, while the remainder declared comfort with either method. However, all the individuals in this sample were content to be debriefed by their therapist regardless of their preference.
2. Some family members verbalized definite preference for a third person, or debriefer, to talk about their experiences and impressions of therapy. These individuals tended to believe that it would be more comfortable to give both negative and positive feedback to someone other than the therapist.

3. Respondents who verbalized preference for their therapist as debriefer usually cited rapport and an established relationship as the basis for this choice. Respondents also suggested that communication deficiencies might be minimized by dealing directly with their therapist. An equal number of individuals found no difference in either the therapist debriefing or the ethnographer debriefing.

4. Respondents expressed that debriefing seemed to generate new information and create a more collaborative relationship between family and therapists. Families reported debriefing as positive and helpful, allowing them a more active role in their therapy.

5. Several family members had suggestions as to how debriefing could be made different or better. Recommendations included paper and pencil forms for debriefing, debriefing after difficult sessions, and staying focused upon the debriefing. Many of the respondents did not offer advice and seemed unable to respond to how the process could be made better.

6. All but one family believed that the frequency of debriefings was important. Recommendations varied from every other session to once every eight sessions. Most informants seemed to indicate that repetition and saturation should be avoided. The saturation point probably varies across families necessitating a special sensitivity on the part of the person who is debriefing.
7. Perhaps the most significant domain was that of debriefing's influence upon families. Respondents were unified in their remarks concerning the usefulness of debriefing interviews and their feelings of being cared for by the clinic. According to family members, debriefing interviews improve therapist/client collaboration and are a further enlargement of the helping process. They perceived debriefing as giving them more control over the process and reported that debriefing makes therapy less hierarchical.

8. Most family members spoke hypothetically in regard to disapproving comments made to therapists concerning the therapy. Not surprisingly, most respondents claimed that it would be difficult to convey negativity to someone who was seeking to help them. In the event that therapy was not going well several informants verbalized preference for debriefing by a third person.

9. Families seemed to sustain an increase in satisfaction with their therapy because they had been regularly asked about the process. Roughly two thirds of respondents said that they believed therapy was going better as an outgrowth of the debriefing. Others concluded that the debriefing interviews helped therapist and family to make adjustments, thus increasing its effectiveness. Notably, debriefing helped families become more appreciative of therapy and its benefits.

10. Debriefing, by therapist or debriefer, can be therapeutic. Families noted that therapeutic conversation happens during debriefing, change often occurs subsequent to debriefing, debriefing positively influences the progress of therapy, and should be integral to treatment protocol. Families generally found it difficult to distinguish between debriefing and therapy itself.
11. Informant families equated debriefing success with therapist compatibility. Clients want to be comfortable with their therapist before being asked questions about how the therapy is going. Believing that poor rapport with the therapist would negatively impact debriefing, most informants observed that therapist/family compatibility was the key to therapeutic success.

Elaboration of Results

The present study examined family accounts of two debriefing formats during the course of family therapy. Specifically, transcripts of modestly structured ethnographic interviews were explored to collect data concerning:

1. What families experienced during the two debriefing formats;
2. What families liked and disliked about the approach of being interviewed by their therapist and by the debriefer;
3. What could the therapist/debriefer have done differently or changed to become more helpful;
4. Which of the two formats did they prefer and why; and
5. How did the two methods compare or differ?

This study was designed to explore how families experienced two methods of debriefing as a part of their family therapy. Results must be observed as characteristic of six families descriptions of their encounter with eight therapists and four debriefers. Inferences drawn should thus be tentative.
Outcomes indicated that families experienced debriefing in a variety of ways. Clients in this study were satisfied to be debriefed by their therapist but speculated about other forms of debriefing interviews. Family comments about their debriefings were completely positive and supported the belief that therapists can benefit from hearing what clients have to say regarding their experiences of therapy (Kuehl, Newfield, & Joanning, 1990).

Unlike Lashley's (1993) research exploring how therapists experienced debriefing interviews as a part of family therapy, this study focused entirely upon client experiences and their suggestions relative to the debriefing process. Of particular interest was the question, “Can therapists successfully conduct debriefing interviews?” The results indicated that they can, and families often prefer the therapist as debriefer.

Todd (1989) suggested that ethnographic interviews facilitate a more equal relationship between therapist and family. The present study supports his research and extends the idea that client dissatisfaction is often a result of unequal hierarchical relationships. Gale and Newfield (1992) proposed that the therapy itself creates an unequal, hierarchical arrangement between the therapist and families. Descriptions (Chenail, 1991; Tannen & Wallet, 1986) of unequal roles existing in patient-doctor relationships portray a negative influence this inequality has on the framework of conversation and the outcome for services. Respondents in the current study expressed that debriefing seemed to generate new information and create a more collaborative relationship between family and therapists. Families reported debriefing as beneficial and allowed them a more active role in the therapy.

When clients preferred the debriefer it was usually with the addendum that it would be difficult to share disappointment with therapy when the therapist is present. This supports
Rennie’s (1992) findings which suggested that clients were reluctant to voice discontent about their therapy to the therapist. Newfield, Kuehl, Joanning, and Quinn (1991) also stated that when families had negative experiences in therapy they seldom brought it to the attention of the therapist. Several individuals in the present study believed that it would be easier to present both negative and positive feedback to someone other than the therapist.

An important result from findings in this study was that some families actually preferred to be debriefed by their therapist. The accepted clinical lore of the family therapy field runs counter to this finding. A widely held belief is that clients will not be open with the therapist regarding discontent about therapy. Results from the present study challenge the popular clinical wisdom that families would be unwilling to be asked about what they liked or did not like about their therapy. The chief recommendation following Lashley’s (1993) work was the need for further research involving therapists who conducted their own debriefing interviews and whether or not those therapists could replicate results achieved by debriefers. The present study found that even when clients said that they might prefer to be debriefed by a third person they simultaneously reported that debriefing by their therapist/s had been successful.

A significant domain was that of debriefing’s influence upon families. Hoffman (1990) stated that ethnographers are not looking for pathology, nor do they need to provide clients with a final prescription or message. This may furnish insight into the unique circumstances that debriefing interviews are able to provide. Families perceived debriefing interviews as giving them more control over the process of therapy and reported experiencing collaboration in therapeutic outcome. This seems to support the assumption that clients are
cooperative, as opposed to uncooperative and resistant, and that their cooperation is inevitable (Walter & Peller, 1992) during therapy. Findings appear to suggest that therapists must find out how people think about their therapy and be flexible enough to utilize their unique input (Bandler & Grinder, 1979).

Information from debriefing interviews tended to concentrate on the process of therapy and not the content of a family’s problems. During debriefing, families tended to modify and assist the procedure of therapy by utilizing special information not generated by their regular therapy. Informants seemed to say that they were more active in the therapeutic process during debriefing yet assumed more passive process roles while involved in their regular therapy. Exchanging information about the process of their therapy places the family in an ‘expert’ position. This posture is in sharp contrast to models which compare the client’s thinking with some normative standard and then suggest that the therapist decide what the client should change and thus determine the direction of therapy (Walter & Peller, 1992).

The therapist/family collaboration relative to process is in keeping with the idea of family empowerment (Becvar & Becvar, 1993) where therapists are no longer skilled technicians powerfully intervening in the family system. The debriefing experience encourages a situation where the therapist need not be a professional actor who plays a prescribed theoretically determined role but a real person who co-participates in the creation of new meaning for the family unit (Anderson & Goolishian, 1990).

Another interesting result is the apparent correlation between client satisfaction and debriefing interviews. Families overwhelmingly claimed that they developed higher levels of satisfaction with their therapy as a result of being debriefed. This finding alone has powerful
implications for the practice of debriefing during the course of therapy. Families agreed that the therapy process became more efficient after debriefing. Debriefing might be construed to correspond with Minuchin's (1974) "joining" where the therapist joins the family and respects its members and its way of organizing itself. This joining and respecting is similar to what anthropologists do when studying a different culture. They attempt to understand a culture from its own perspective and not from the perspective of the anthropologist's culture. In therapy joining is essential, for families must accept their therapist and acceptance is more likely to occur if the therapist debriefs the family, symbolically accepting their view of how the therapy is proceeding. The result is that client satisfaction with the therapy and the therapist is increased.

Family recommendations regarding debriefing frequency pointed to debriefing as a subject of discussion during family therapy sessions. Clinicians who do not conduct debriefing interviews may be missing an entire body of information that can only be discussed through the structure of that interview. However, clinicians who debrief too frequently may be unnecessarily repeating material which the family is saturated with. Families in the present study clearly delineated the benefits of debriefing and just as clearly indicated that too much debriefing should be avoided. Since the saturation point probably varies across families, therapists may need to exercise uncommon discernment as to when and when not to debrief.

Families seemed to sustain an increase in satisfaction with their therapy because they had been regularly asked about the process. Two thirds of respondents said that they believed therapy was going better as an outgrowth of the debriefing. Others concluded that the
deb briefing interviews helped therapist and family to make adjustments, thus increasing its effectiveness. Notably, debriefing helped families become more appreciative of therapy and its benefits.

Families in this study seemed to indicate that debriefing, by therapist or debriefer, should be regularly included in the treatment process. They tended to have difficulty distinguishing between debriefing and therapy, citing debriefing as therapeutic. Newfield, Kuehl, Joanning, and Quinn (1991) suggested that successful therapy requires at least a minimal quantity of sustained benevolent coherence and shared substantive meaning over numerous contacts. Results from the present study suggest that debriefing interviews can assist in determining if therapists and clients are creating mutual meanings. Further, debriefing renders a device for reorganization when the meanings are not consistent.

Compatibility between therapist and family was a shared goal among family members included in this study. Notably, informants equated their debriefing successes with therapist compatibility. Compatibility with therapist may have been inadvertently enhanced by the debriefing. Debriefing seems to allow the family to (1) ventilate and diffuse negative energy, (2) reach a higher level of understanding, (3) recast their thinking into more positive terms, and (4) facilitate additional information. Respondents tended to believe that poor therapist compatibility would negatively impact debriefing and pointed out comfort level as the key to complete therapeutic successes. These same individuals may have been unaware of how debriefing contributed to comfort level with their therapist and their therapy. Todd (1989) found that families became disenchanted with therapy when they were not given options to try at home or if they weren't kept informed of the various rationales for intervention. Kuehl
(1987) found that families were frustrated with violations of time and going over the same topics week after week. Elliot (1985) depicted nonhelpful interventions as characterized by volunteer student clients. Families in the present study explained how debriefing influenced the proceedings of therapy as therapists became aware of their experiences. Findings seemed to imply that debriefing interviews keep therapy focused, keep client comfort level high, and keep family observations positive. Being asked about one's experience may simultaneously raise the satisfaction level with that experience.

Repeatedly, families emphasized their appreciation toward the clinic for its general concern toward their views about the therapy. Each family made at least one comment regarding the clinic's thoughtfulness and attention to the quality of service delivery as demonstrated by way of the debriefings.

Conclusions

The purpose of this study was to compare therapist conducted and debriefer conducted interviews. Results indicated that therapists are capable of eliciting the same information from clients as a third person. However, families in this study speculated that if they had not liked their therapist or if therapy was not going well, the debriefing interviews might not have been as successful.

Clients suggested that debriefing should be used sparingly. They found the interviews helpful but also wanted it understood that a little debriefing would go a long way. Family comments indicated that timing and conditions for debriefing interviews is significant and requires a special sensibility on the part of the interviewer.
Data from this study indicates that debriefing may be conceptualized as an intervention or a joining tool (Minuchin, 1974). The interviews seemed to have a potent effect upon the therapeutic relationship, influencing families in a positive direction. The verbal exchanges which take place between therapist/debriefer and the family are probably new realities co-constructed (Gergen & Davis, 1985) within the debriefing itself.

The present study found that changing rooms for the purpose of debriefing the family made little or no difference. Lashley (1993) reported that changing rooms from where the therapy occurred was important to the clients who participated in his project. This may mean that there is considerable variation among families regarding how debriefing is best performed.

Todd (1989) found that ethnographic interviews facilitated a more isomorphic relationship between therapist and families. The present study supports his research and offers that some families prefer to not be debriefed after the first session but to wait until rapport is established. There was evidence in this study that compatibility and one to oneness was established as a result of the debriefing interview.

Results from this study further collaborate (Brown, 1992; Anderson & Goolishian, 1988) that therapy should not be performed in a manner that seeks to control families. Conversation that takes place in therapy and during debriefing should cooperatively create new meanings among family and clinician. Anderson and Goolishian emphasize that therapeutic conversation is a shared effort taking place among all the participants of family therapy including supervisor, family, therapist, reflecting team, or debriefer. This discourse strengthens the probability of problem resolution and the generation of new meaning for
families. The psychotherapy then progresses to a cooperative, collaborative operation instead of a contest for dominance.

**Recommendations**

This study examined client responses in an outpatient family therapy clinic. Future studies could include settings such as hospitals, mental health agencies, or residential facilities. Methods used in this study could be easily adopted in those environments. Client debriefing is a valuable public relations strategy that should be included as typical treatment protocol.

Additional study should concentrate upon diverse models of therapy and the differences those therapies might have upon debriefing interview success. Results from this study may have been influenced by the customary treatment modality of therapists at the ISU Family Therapy Clinic. Each of the therapists in this project identified themselves as respectful, collaborative clinicians who attempt to conduct therapy in a non-expert, non-hierarchical manner.

Studies may need to focus upon the substantive therapeutic effects of debriefing interviews since findings from the present study were only tentative. Families reported that debriefing had been therapeutic for them and contributed to overall satisfaction with their therapy but did not elaborate upon how this happens. Future investigation might concentrate on what occurs during the debriefing that impacts therapy.

Future formats could schedule debriefings at frequencies other than every session. Of particular importance is the need for further research in debriefing styles. Strategies might
also be utilized which vary the presentation and technique of managing debriefing interviews. There may be a need for further research on paper and pencil debriefings since several of the clients in this study suggested a questionnaire as a debriefing alternative.

Several therapists and debriefers in this study asked for additional training in debriefing citing a lack of confidence and knowledge in how competent debriefing should be performed. Supplementary research is also needed in debriefing training or skill development.

One area for further study might be a debriefing of the debriefing of debriefings. This study could ask respondents what they think not just of the debriefing, but of the very study that is being conducted. Questions might include: Why did these families agree to cooperate in the study? How does the cooperation effect influence the findings? How do respondents see the research process itself? What do they think of the author of the study? Do they think their answers to the author of the study has an influence upon their own therapy? How might these factors have influenced their responses? What effect does the fact that the author only conducts one debriefing of debriefings have on the results of the study?

Studies conducted in the future might focus upon precisely who likes the therapist debriefing, or who likes the ethnographer debriefing. This may require further analysis of class, gender, family structure, or socioeconomic factors. For example, could it be that women in a therapy session conducted by a man prefer to be debriefed by a female third party? Could low income clients prefer being debriefed by someone perceived to be from the same economic level? Other questions to be addressed in the future should relate to the influence of family dynamics upon the debriefing. How might family dynamics influence the
responses people give in debriefing sessions? Would the results have been different had family members been debriefed individually? Studies may also need to address the fact that high satisfaction with the therapist debriefings may not be thoroughly transferable out of an experimental situation. Therapists in the present study knew they were being closely monitored by colleagues who may have also been personal friends. The situation could be entirely different in a less closely monitored arrangement.

Finally, future studies might do well to center on how comfort level affects the debriefing. Families and therapists in this study reported some intimidation or discomfort in relation to the debriefing process. Precisely, what were families intimidated by during their debriefings. What factors contributed to therapist uneasiness during the debriefing process? Do therapists fear negative feedback from families and do they create a context where families may have difficulty expressing disapproving sentiments? How do therapist idiosyncrasies effect a client's ability to openly comment on the therapy? Are some families easier to debrief than others?

Implications for Clinical Practice

This study examined the similarities and differences between therapist conducted and ethnographer conducted debriefing interviews as described by six families. The study seems to have furnished new information to the overall understanding of how these two methods of debriefing compare. The study also explored the utility of debriefing interviews for families and its effect upon families. This research effort has helped to demonstrate how debriefing
interviews can be made more practical for therapists who are interested in the families' perceptions of the therapeutic process.

This study has highlighted an assortment of family responses to two debriefing methodologies. Efforts have suggested that debriefing can be a valuable therapy tool and potentially excellent public relations device. The findings have demonstrated how effective debriefing has proven to be and the need for further research in technique, training, and presentation.
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Tyler, M., & Tyler, S. (1985). The sorcerer's apprentice: The discourse of training in family therapy. Unpublished manuscript. Rice University, Houston, TX.

Ulberg, B. (1994). Beyond Masculinity: A men's group as a partial evolution toward the redefinition and eventual elimination of the concept of masculinity or, Is there a right way to be a man? Ph. D. dissertation, Iowa State University, Ames, Iowa.


APPENDIX A. INFORMED CONSENT STATEMENT: FAMILY

The Department of Human Development and Family Studies and the Iowa State University Family Therapy Clinic supports 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 aware that even if you agree to participate, you are free to withdraw at any time.

PURPOSE: In an effort to improve services for families who visit our clinic, we are interested in your experiences during therapy.

PROCEDURE: We are requesting your permission to ask questions about the therapy process immediately following four of your sessions. These conversations should last approximately 15 to 30 minutes. They will be conducted alternately by your therapist and another interviewer. Each week, either your therapist or an interviewer will talk with you about the experiences of that session. The interviewer will ask your permission to share the information you gave with your therapist. Finally, at the end of four sessions a second interviewer will talk with you about the entire experience.

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

BENEFITS: Participation in the study may provide you the opportunity to have greater input into the service that you receive.

CONFIDENTIALITY: 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 and videotapes will be erased upon completion of the study.

Where individuals under the age of 18 are participating in therapy, the minor’s legal guardian, as well as the minor, must sign the consent form prior to the minor participating in services.

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 Lane Brigham at 233-6824.
I/we understand what participation in this study will involve. I/we also understand that participation is voluntary and that I/we may withdraw at any time without prejudice to me/us.

Signatures of Participant(s)/Guardian & Witness

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Witness:___________________________________________

Date:_____________________________________________
APPENDIX B. PERMISSION TO AUDIOTAPE OR 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 may audiotape or videotape sessions and use therapy consultation teams to observe through a one-way mirror. Those 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) also give permission to be observed by professional family consultation teams. 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) interviewing client families after every other session for four sessions regardless of their perceptions of the services they receive at the ISU Family Therapy Clinic while under my care; 2) these interviews will be approximately 15 to 30 minutes in length and will be audiotaped or videotaped.

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 may reflect negatively upon their experience in working with the therapist. In such cases clinical supervisors will be made available to the therapist to discuss and address these issues. Participation may give the therapist greater insight into how families perceive them as a therapist.

Every effort will be made to ensure the confidentiality of participants. Information gathered in the study will be coded and kept in a locked file cabinet. Neither therapist or client names will be associated with the study without their prior permission. Audiotapes/videotapes of the interviews will be erased upon completion of the study.

Any questions concerning the study may be directed to Lane Brigham at 233-6824 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:__________________________
APPENDIX D. FACES III INSTRUMENT

FACES III

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Almost Never</td>
<td>Once in awhile</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Almost always</td>
</tr>
</tbody>
</table>

In column 1: Describe your family now

In column 2: Ideally, how would you like your family to be:

<table>
<thead>
<tr>
<th>NOW</th>
<th>IDEAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Family members ask each other for help.</td>
</tr>
<tr>
<td></td>
<td>2. In solving problems, the children's suggestions are followed.</td>
</tr>
<tr>
<td></td>
<td>3. We approve of each other's friends.</td>
</tr>
<tr>
<td></td>
<td>4. Children have a say in their discipline.</td>
</tr>
<tr>
<td></td>
<td>5. We like to do things with just our immediate family.</td>
</tr>
<tr>
<td></td>
<td>6. Different persons act as leaders in our family.</td>
</tr>
<tr>
<td></td>
<td>7. Family members feel closer to other family members than to those outside the family.</td>
</tr>
<tr>
<td></td>
<td>8. Our family changes its way of handling tasks.</td>
</tr>
<tr>
<td></td>
<td>9. Family members like to spend free time with each other.</td>
</tr>
<tr>
<td></td>
<td>10. Parent(s) and children discuss punishment together.</td>
</tr>
<tr>
<td></td>
<td>11. Family members feel very close to each other.</td>
</tr>
<tr>
<td></td>
<td>12. The children make the decisions in our family.</td>
</tr>
<tr>
<td></td>
<td>13. When our family gets together for activities, everybody is present.</td>
</tr>
<tr>
<td></td>
<td>14. Rules change in our family.</td>
</tr>
<tr>
<td></td>
<td>15. We can easily think of things to do together as a family.</td>
</tr>
<tr>
<td></td>
<td>16. We shift household responsibilities from person to person.</td>
</tr>
<tr>
<td></td>
<td>17. Family members consult other family members on their decisions.</td>
</tr>
<tr>
<td></td>
<td>18. It is hard to identify the leader(s) in our family.</td>
</tr>
<tr>
<td></td>
<td>19. Family togetherness is very important.</td>
</tr>
<tr>
<td></td>
<td>20. It is hard to tell who does which household chores.</td>
</tr>
</tbody>
</table>
APPENDIX E. THERAPIST QUESTIONNAIRE

Prior to study:

1. Age Gender Marital status Ethnic background
2. Amount of therapy experience?
3. Preferred therapy theory or style?
4. What sorts of clients do you prefer working with? (SES, ethnicity, families or couples or individuals?)
5. How many hours of clinical supervision have you received as a therapist?
6. How many hours of face to face client contact do you have?
7. What experience have you had in debriefing families/clients?
8. What was that experience like? Useful or not useful?
9. What was your experience of being asked to participate in this study and what comments do you have regarding recruitment of families?

Questions asked after the study:

10. What was this study like for you (that is, to experience the debriefing alternatives, etc.)?
11. What suggestions do you have for the debriefing process overall?
12. What suggestions would you have for future studies?
13. How could the present study have been made better?
14. In your opinion, should debriefing interviews be conducted during the session or immediately following the session?
15. What comments would you offer regarding impressions you have about any part of the study? In other words, what questions could I ask to elicit comments you haven’t already made?
APPENDIX F. SAMPLING OF FAMILY COMMENTS

Family One

Selections from transcript

Author: How would you describe the debriefing by the therapist?

Mother: I don’t have a problem with the things he said. I don’t think there have been any negatives that have come out of this so I have nothing but positives to say. I think on the average that if a person had something negative to say they would probably be more likely to say that to a third person versus a therapist. Who wants to stand in front of a person you see weekly and say something negative or say, “I really don’t like this about you.” I probably would never say something like that to someone but if I was giving feedback to another person I would probably be able to say that, or request another therapist.

Author: So, the third person might be someone you could go to request another therapist?

Mother: Yes, if I really had a big major problem where I needed to request another therapist, I would go.

Author: Has that ever happened before?

Mother: No.

Author: What about the approach of being interviewed by the therapist? What did you like about it?

Mother: He was really straight forward.

Author: And what about the debriefer? How did you like his approach?

Mother: They were very similar. They gave us a lot of leeway?

Author: What parts of being interviewed by the therapist did you not like?
Mother: Nothing. Is that all right?

Author: Sure. Was there anything about the ethnographer or being interviewed by the ethnographer that you didn’t like?

Mother: No, nothing.

Author: And how was it? A new person, a strange face, how did that feel?

Mother: The first time it was like meeting a new person. Talking to a new person. The second time it was fine. It was like we had met him once and it was fine.

Author: It was like—when you meet someone in real life for a second or third time? Is that what you’re saying?

Mother: Yes.

Author: If you could change how the therapist conducted the interview, how would that be changed?

Mother: I don’t think there’s anything to change. The questions seem to be straightforward and they weren’t yes or no, or a single answer question. Some of them were. If there was anything you didn’t like, and there wasn’t, you know.

Author: So it was pretty easy for the therapist. Which of the two formats did you prefer? When you were interviewed by the therapist or by the debriefer?

Mother: Maybe the debriefer, because I find this really hard, because when I go to school I know they know it, and they know I know it. I’ve been out there in the work world. I know what they know. I still have to tell them how to do it. I know I know it, but I have to be thorough about it.

Author: What?
Mother: How to be thorough about it. Explaining their procedures or something.

You’ve had a therapist and he’s given you feedback and you’ve given him feedback but then during the debriefing, then you say what did you like most, you have to explain it again to the therapist. You’re assuming the therapist already knows whereas the debriefer was in the other room so he has a good idea too. Instead of stating it over twice to the same person, you went over it once with the therapist and then again with the debriefer.

Author: Is that a bit much?

Mother: No.

Author: How could the therapist do the debriefing differently, in order to best elicit from the family how they experienced therapy?

Mother: Maybe a question and answer page, I don’t know.

Author: Would you prefer that?

Mother: I don’t know. The verbal questioning doesn’t bother me whatsoever.

Author: How much if any information did you withhold?

Mother: None. I had no reason to withhold. I’m happy with the improvement that I’ve seen in him and the household and the situation.

Author: It sounds like you’ve been satisfied with the therapy and your therapist, and you’ve been doing well. Things have gone well in the debriefing. I’m wondering how much your satisfaction with the overall process has to do with that.

Mother: If there’s been an improvement the debriefing would be a reflection on the process.

Author: We did it a lot of times, like after each session. Is that too much?
Mother: No. I would say it is probably not necessary. Probably each case is different, each individual. I think it's somewhat necessary that you can control what's going on, and to find out if the therapy's working, because who wants to keep doing the same thing over and over again if it's not working.

Author: Sure.

Mother: And, you know, how is the therapist going to know that unless they ask?

Author: And would they be more likely to disclose to the therapist or to the debriefer?

Mother: To the debriefer. I'm sure that for the typical standard person if there was something that was not quite right they would probably not say that to the therapist. I don't know, maybe they would. I was not real happy with the therapist we had before we got here. Things didn't progress but now with our therapist, he's pointing out things that I can do. Whereas, the other therapist did not do that.

Family Three

Selections from transcript

Author: What was the debriefing experience like for you?

Wife: Well, I think it helps you realize how much progress you've made. It's not uncomfortable for me. It doesn't bother me at all. It's like a conversation. It helped me realize what we've been coming here for.

Author: Was the debriefing a significant part of the therapy?

Wife: It was a study about it, and was kind of like a security blanket.
Author: How would you describe the approach of being interviewed by your therapists?
Wife: It didn’t bother me. Maybe if somebody had something bad to say, they would be upset about it, but we had nothing but good to say, so it didn’t bother me at all.
Author: Ya’ll were satisfied?
Husband: Well, yeah. Obviously. The way we came in and the way we are now, there’s nothing but good that’s happened out of it.
Wife: You didn’t get to see us last fall, did you?
Author: Yes, I was here.
Wife: Then you could see how awful we were to each other in our marriage. It is a lot better now.
Author: It was a difficult time. How about the experience of being interviewed by the debriefer? What was that like?
Husband: That’s when we came in and I had the frog (referring to his anger).
Wife: Ugh, yeah. It didn’t bother me. We were fairly relaxed with him.
Husband: We have to be if they’re going to change us very much.
Wife: Some people it might bother, but it didn’t bother me.
Author: With someone that you didn’t know?
Husband: She can talk to anybody.
Wife: We feel like we know ya’ll because ya’ll have been in there listening to us and you’ve had input in it. So in a way, it’s not really a stranger. You already know about us.
Author: Yeah, sure. Its like we’ve been eavesdropping for a long time.
Wife: In this atmosphere it feels like its comfortable.
Husband: It's not a stuffy atmosphere.

Wife: We accept you. You're clear. You ask for input.

Husband: When that group came in one time and they were talking ... that was interesting, too. I hadn't seen that before.

Author: Yeah that's a great approach. What did you like about being interviewed or debriefed by the therapist?

Husband: We were comfortable and happy with either one.

Wife: I liked it because we went back over what we discussed. They had first hand information. They were right there.

Husband: They were comfortable and regular to a point.

Wife: They should have been observing the debriefing because there might have been something that they might have missed.

Author: What did you like about being interviewed by the debriefer?

Wife: He said some different things. He has a different approach. He remembers a little different. He had a different view of things.

Husband: He was involved, but not directly involved.

Wife: He was like a third party observer. It was almost like they became part of our relationship and our extension. They were in there with us. Then the third party comes in and it's always better to have a third party mediator.

Husband: The first time he was there it was kind of interesting, but by the last time we had already known him.

Author: Is the debriefing anything at all like therapy?
Wife: It was more directly to the point. The progress we’ve made and what we have and haven’t done. It gave us direction.

Author: So, was it really therapy rather than an interview? Am I reading too much into that?

Wife: No. It helps us realize what’s been going on. We’ve been doing it this way. It made me think about it more.

Author: It made you think of therapy in a different way?

Wife: It made me think about it more. Instead of it being a conversation between us and them it became ... it had points to it, and things we need to think about.

Husband: The therapist we had before, time frame, how we changed and so forth. I don’t remember how it was before .... before therapy. We noticed how much .... how much change really did happen for us.

Author: What did you not like about being interviewed by the therapists?

Husband: It was OK, because if I remember right during the therapy itself we stopped several times and said, “Is this working?” We made changes then, too.

Wife: To me the debriefing felt like when they go out and talk and come back in. It was more like that. It was nice to get that input back. It helped us do more for ourselves.

Author: What did you not like about the approach of being interviewed by the ethnographer?

Wife: Since we had familiarity with him ..... if it was somebody we totally didn’t know it might be upsetting. Its more relaxed this way. We have an idea who we’re working with.

Author: If you could change how the therapist interview was done, how would you do that?
Husband: It was so comfortable. Things went so well for us and things have changed so well for us. There was nothing bad that happened. I wouldn’t have any idea how to change. It was so well done.

Author: What about changing rooms?

Wife: Going to a different room doesn’t mean therapy is over.

Author: Did you just think that the therapy continued on? Or just doing it in a different way?

Wife: We’re just getting pointers. So in a way, the therapy is just continuing. When we’re in therapy its kind of hard to break and go into another room to get our mind off of it. Its nice to have somebody ask.

Author: How would you change the interview by the debriefer?

Husband: He came in. He was more upbeat.

Wife: No, they were both talkative.

Author: They’re both vivacious folks. Which format do you prefer? Which method do you prefer? Therapist or ethnographer?

Wife: If you look at it like we can know the other person, I like it entirely better with them, the therapists.

Author: Is that how you feel on that too? (speaking to husband)

Husband: Yes.

Author: You prefer the therapist?

Husband: We were use to talking to them. If things were going bad with us or something upset us, it might be different. We were comfortable enough to talk to them. If something happened along the line, we (interrupted by wife) ...
Wife: The relationship is between the client and the therapist. If they feel comfortable together, we don't have a problem with how they're working, then it would be fun. If we disagree or didn't like something they said or did ...... in our situation it was not at all that way.

Author: If you didn’t like the therapist would you have told the therapist in the debriefing?

Wife: I hope not!

Husband: We wouldn't change things. We would have gotten split up a long time ago.

Wife: We would have just gone with him. I think he (referring to debriefer) has an excellent personality.

Author: What if you didn’t like the therapist and the debriefer comes in and talks about how the therapy is going?

Wife: I might have been a lot less comfortable with the questions.

Husband: If therapy’s going up and down and there’s a trend, you might bring the third party in and say “Hey what’s going on? What’s the problem? This may need to go in a different direction. Is there a conflict with the people you are working with? Is there something you would change?” I can see that the third person would work out. “Is it something our people are doing or is it you guys in general? If it is our staff and if they change, would that help you out?” If the debriefer said things like that.

Author: I think I hear you saying it might be easier to say to another person that there are some things that aren’t working here. And you think it would be easier to tell someone other than the therapist there was something wrong?
Wife: Oh yeah, if there was something wrong we would, but in our situation things worked out very well.

Author: I see. Well, my next question is, “When the clinic doesn’t have that third party, can the therapist debrief as effectively as a debriefer?”

Husband: We’re two different personalities that would bring two different responses to it.

With me, if I get mad and I couldn’t get over it (wife interrupts)

Wife: He’d stew over it.

Husband: Say, we go to a restaurant. I’ll eat it, whatever. She’s the one that complains. If I had a frog (meaning he was angry) ..... well, in most cases it’s hard for me to be rude. It’s hard for me to openly go against somebody.

Author: That’s a great analogy. Who would you tell? Would you tell the manager, or the waitress, what you didn’t like?

Husband: I wouldn’t.

Author: Anybody?

Husband: I wouldn’t go back.

Wife: If somebody asked him, he might.

Husband: If the manager came out and asked me I might. Well, this was not right or something. She’s got different things (referring to how she might register a complaint). Her French fries. Her steak cannot have any blood.

Wife: I want to get what I paid for.

Author: Right.
Husband: She’s not afraid to take it back. I feel odd doing that. Same way with the service here. If we had never gotten resolved of our problem and the third person stepped in, they could say “Is there something we’re doing wrong? Is there something that could be changed?” We can discuss or get through it. That’s also one way you could do it on your own (referring to the therapist conducting the debriefing). If somebody’s not responding back, you could ask that. They’ll respond like they want to .... but a couple like us.

Wife: For the therapist, I think sometimes it’s a human reaction to say “What am I doing wrong? What’s wrong with them? Why are they not responding to me?” Sometimes, a third party really does help. It’s an objective view point. You still might be friends with the therapist, but they (referring to the debriefer) would be more objective.

Author: Is that because it’s hard to give negative views to someone you may have some thought for? You like the therapist OK, but things aren’t going so well?

Wife: Even if the relationship is not going that well, it’s still the feeling that they are trying to help you. And you wouldn’t want to hurt their feelings.

Author: How could the ethnographer’s interview have been different? How could it be more successfully conducted?

Wife: He could keep from wandering off the topic. He could keep things going at the pace.

Husband: We wandered off and he carried us back for a bit. He had been behind the window watching. He was involved but not directly involved. He could bring it back on line a lot easier.

Author: How much information did you withhold during the debriefings, if any, and for what reason?
Wife: Nothing, that we're aware of.

Husband: No.

Author: Thanks. You've been very helpful.

Wife: Well, if this helps someone else, that's great.

Husband: I've got to say this. I like this debriefing. It brings a new light to me, but if there was one person I feel I can talk to it's the counselor. A lot of counselors came off as if they were God or something.

Wife: It's a fresh outlook to see you're concerned with helping us.

Husband: Ya'll asked what worked with us. You're trying to be more professional as a group

Wife: It really says something that you care. That you change the ways things are being done.

Husband: In your own practice you say "Like, what am I suppose to do when this happens? How should I step back?" That's saying there's always room for improvement.

Wife: I was going to say, every other counselor has brought something of themselves or their relationships into it saying, "This is how my relationship is." And they didn't focus on us. But here, well, I liked them. I care about them and what happens to them, and I don't know much about them but they really helped us focus in on us.

Author: Yes, when the therapist is focused on the couple, it feels good. Well, this has gone well for us. It's a two way street. I'm sure it was good for your therapists to find that the things they were doing were useful and helpful. And your words of encouragement gave them some fresh meaning about their experience with you.

Husband: They pulled their hair out every once in a while.

Therapist: Yeah. I remember.
Family Five

Selections from transcript

Author: So, for you guys, what was the experience of the debriefings like?

Wife: To me it’s helpful, because I get a chance to let the therapists know just how well they are helping without making them embarrassed by telling them ourselves, because I know that some people don’t like to be complimented that way. And so it lets them know that we truly do realize this is working and it is because of them, not just because of magic, as she (the therapist) put it.

Husband: Yeah, because I don’t think it was because of magic. We really needed help and we got it when we got here.

Wife: And it really worked.

Author: What about with the debriefer? What was the experience like with someone other than the therapist?

Husband: I didn’t feel any difference.

Wife: Because I’m so honest with everybody anyway. I’m one of those not to subtle people. I’m very abrupt.

Husband: And I felt there wasn’t anything to gain if we held something back, and if something stinks, I got to tell ‘em because it’s just going to keep on stinking until it’s so bad it runs you out the door.

Author: Stinking means something wasn’t going well in therapy?

Husband: Yeah. The hardest part was that it was working so well. We weren’t finding anything wrong.
Wife: It was hard to find something wrong.

Husband: It wasn’t that something was wrong, but if we thought we could improve it, then all the better.

Author: What did you like about the approach of the debriefing interview by your therapist?
Wife: Well, it gave us a chance to say what was working, and open up the fact that we would like longer sessions on Saturdays because that would be easier to work into our work schedules. We mentioned that. The only thing bad that we’ve been able to find is that we’re just opening something up and it’s time to come to a close because the time is so short.

Husband: Not that it’s not working this way. I don’t think it’s a problem with the therapist. We just keep going and going and going.
Wife: We leave here and we want to keep talking, and it’s like we do. They’re missing out on it back here at the clinic.

Author: So, you wish your sessions were longer. It was an opportunity to say that. What did you like about being interviewed by the debriefer?
Wife: Because he’s funny. I thought he was funny. He mentions things that he did here like when he was behind the mirror and his input is kind of different, so it’s interesting. It’s a way of him letting our therapists know. He did ask if that was OK that he shared that we did like what was going on and that we did see a difference. Plus, we know that its helping other people by doing this with your study, whether its with a therapist or the debriefer, its easier because we know its going to help.

Husband: Its not necessarily more or less beneficial for us because I didn’t see any difference in how the reactions were between us and the debriefer or the therapists. I didn’t make any
distinction between it. It was better for the therapists because if he’s getting the same from us
as the therapists were, then either we’re telling the same story to everyone or we’re saying
what we really feel about what’s going on. That way they know we’re not just saying
something to make them feel good.

Author: So, someone else telling them that might carry more authenticity?

Husband: Yeah, the debriefer says they we’re really complimenting you guys today instead of
it coming from the two of us saying, “Yeah, we thought it was great, you know.” It might
carry a lot more weight. It’s coming from a third person. “Hey I heard you guys were doing
great with them.” To have their peers tell them. I know when I’m at work and somebody
says “Hey, you’re doing good work.” That makes me feel good compared to when a
customer calls up and I help them out and they say “You’ve been most helpful.”

Wife: You never know if they’re being sarcastic.

Author: You never know if they’re just being nice to you and don’t really mean it? I think I
understand what you mean. What did you not like about the approach of being interviewed
by the therapist?

Wife: There wasn’t anything that I disliked about being debriefed by the therapist. It helped.
There was nothing bad about it.

Husband: There was not a lot that I didn’t like about it. I think its a good thing. I think its a
good thing you could do, not necessarily every session, but every other session. Afterward,
just have the third person. I like the third person better. I like the debriefer saying these
guys are saying such and such. Having someone say how its working and how its not
working is beneficial.
Author: What if things were not working well? What if you didn't like the therapist? What if you didn't like this place? What if they were going down roads you didn't think were useful? Which debriefing would you prefer?

Wife: I like the therapist debriefing because, then, because I am a more open person it would be easy for me to tell him. I don't like saying to someone else like "This really stinks." Then it makes them look bad whether they are bad or not. I would not want it to get back to them, "This girl really thinks you're awful." That could hurt a lot of feelings. I'm more open to say, "Hey, I really didn't like that we went down this tangent because it really doesn't seem like it's part of our problem." That's how I am. I would rather talk to the therapist about it.

Author: You'd rather talk to the person you have a problem with?

Wife: Yeah.

Husband: Yeah.

Wife: The problem gets solved and not blown out of proportion between you and the third person. Some people tend to raise their voice when they've got a point to make and I don't know if someone from the North would take that as being angry or rude, whereas, where I come from in (name of southern state) people know that's part of the dialect. Dialect is raising your voice to get your point across in (name of southern state). Here, I know it's different because of his family, or it could get blown out of proportion. "She raised her voice." "She really thinks you're awful." It would come out worse than it really was.

Author: You want it to be first hand, not second hand?

Wife: Yeah.

Author: What do you not like about being interviewed by the debriefer?
Wife: Nothing.

Husband: I guess it's really hard to find any fault with the debriefing system at all because (wife interrupts) ...

Wife: They're really there to help. We know he's there to help.

Husband: I don't know, if this thing weren't working for us if we'd have a different opinion or not. But I don't think there's nothing wrong with it. I guess I want to be debriefed by the therapists because I could say "This is not working out and I need a new therapist."

Author: You prefer saying that to the therapist?

Wife: Yeah because chemistry works in weird ways. God works in weird ways. It could be it wasn't meant to be, for them to be our therapist. And if that's right, it's still giving them a bad name to go to somebody else and say, "We don't want your therapist anymore" than to go to actually them and say, "This isn't working out." You tend to hurt a lot of feelings going through other channels first. To me you always deal with that person first. That's first and foremost, and then if that doesn't work, then go to other channels.

Author: What about changing the room? What if the debriefing had been done in the therapy room every time? As compared to coming to a different room?

Husband: It wouldn't have changed anything at all.

Wife: I like it 'cause it's cooler in here. I like being in here better because it does separate the two. I don't tend to bring up therapy problems when I'm in here.

Author: Is that a continuation of therapy when they debrief or has therapy really ended?

Husband: I think it's definitely broken. When we end with them, we get a question to think about over the weekend. I like that a lot.
Wife: So do I.

Husband: When they do that, that's pretty much the end of therapy. Even if we're still in the same room, we know that's the end of therapy.

Husband: For me, they could say "We're done with the therapy session, now let's discuss how it went for you today."

Author: If you could change how the therapist interview went, how would you do that?

Wife: I like to write things down. I like to think about what I'm going to say. Even though I am abrupt, I miss saying things. Some of the phrases I use nobody uses up here, and they really get confused.

Author: I know, I find that all the time too.

Wife: I like to write things down so I think about it before I write it, and I don't think before I say. Sometimes I say things that don't make sense to other people.

Author: So, you would write things. If you could change how the therapist does the debriefing (to husband), how would you change things?

Husband: That's a hard question. I try to tell them more than one answer so there's more than one answer.

Wife: That why writing would be better because he's not listening to what I'm saying and automatically trying to think of what he's going to say. What if our answers aren't the same? Well, the first week we did have things to write down. It was kept closed. It was a questionnaire on what we'd like to become as a couple, now and ideally. He can't see my answers and we don't know what we've got.
Husband: I'd like that every other or every third but not every time. Sometimes you've got to look them in the eye and tell them exactly how you feel.

Wife: Certain questions, yeah, I do. But certain questions I'd like to write down. He's not automatically thinking of another one. Sometimes that's good because we're thinking of things that are right and are wrong. We are finding out the differences.

Husband: It's not as personal. With your personal counselor, you want it to be one on one. You want to tell them straight, face to face, how you feel about it.

Wife: If you really feel this way, it's written in your own hand writing. It's not like you're saying it to their face and not meaning it.

Author: Which of the two formats do you prefer? Therapist debriefing or ethnographer debriefing?

Wife: I like the therapist because I like what he does know, not a third party. I like letting them know I really enjoy this. This is really helping. I came into this thinking it will be like the other therapy sessions at other places. Clinical. You'll feel like crap the whole time. You're not going to feel like there's any progress.

Author: So, the clinical atmosphere turns you off.

Wife: Yeah.

Author: How much information, if any, did you all withhold?

Husband: We both know that what we tell them is to help. Even if we have something we don't like it still might help the situation in the long run. It might even help the therapist know how we feel on certain issues. I didn't feel the need to hold anything back.
Wife: Because we had to sign the paperwork beforehand, we knew this was for a study so we’d only be hurting the study by holding things back. Why sign all these papers to help the study if we’re not going to help their study?

Husband: It’s been helpful for us. It gives us more to talk about. We not only talk about the last question we get, we also talk about what we talk about here.

Wife: What if right now we don’t see anything wrong with what happened in therapy but we talked about the debriefing, then we talk about what’s wrong.

Author: You not only process your therapy, you also process your debriefing?

Wife: This may have to do with therapy, but I think we actually got to a point in our lives where we had no conversation, except for going to get bread from the store. As our therapists said “It gave us more to talk about that had to do with us.” It gave us something to share in. The therapy and this has had a lot to do with how we progressed so far.

Author: It offers yet even another dimension of talk?

Wife: Yeah, then we go on to other things. Sometimes we discuss our meals. I don’t know what your traditional New Year’s Eve dinner is but I cooked a big pot of black eyed peas and ham hocks and turnip greens and he (referring to her husband from Iowa) doesn’t like none of that stuff.

Author: Yeah. I understand.
APPENDIX G. CHARACTERISTICS OF DOMAINS

Imposed Domains

Characteristics of therapist and debriefer comparisons

"They were very similar; (with the debriefer) it was like meeting a new person; went over it once with the therapist and then again with the debriefer; (being debriefed by the debriefer) some people it might bother but it didn’t bother me; we were comfortable and happy with either one; he was like a third party observer; he (about debriefer) became part of our relationship and our extension; being interviewed by the therapist was OK; I didn’t see any difference; there wasn’t anything that I disliked about being debriefed by the therapist; nothing bad about either one; I enjoyed it; I thought I’d probably end up being really uncomfortable (with the debriefer); we should be given a card (rather than being debriefed by either one); I can honestly say that if I wasn’t pleased I wouldn’t agree to the debriefing; better to be debriefed by a third party; you can be more personal with the therapist; debriefing is probably more personal for the therapist than hearing a report from the debriefer; I have been forthcoming with both; I was more forthcoming with the debriefer; debriefing by either one was positive; I can’t compare, they are pretty much the same."

Characteristics of preference for debriefer

"Once we had met him it was fine, maybe I prefer the debriefer; I would be more likely to disclose to the debriefer; better to brief with a third party; I was more forthcoming with the debriefer; I would withhold information from the therapist; he had a different approach, a different view of things; its always better to have a third party mediator; if there
was something wrong I would rather talk to a third person; she’s not afraid to say she doesn’t like something, but I just wouldn’t come back if there wasn’t a debriefer to tell; telling a debriefer about what we like would carry more authenticity because it’s coming from a third person; it would be easier to tell a debriefer if I was unhappy; I would tell him my true opinions about therapy if I was pleased or not; it’s easier to debrief with the debriefer; if I was unhappy with our therapist and he debriefed us I would be kind of unresponsive; I think on the average that if a person had something negative to say they would probably be more likely to say that to a third person versus a therapist; who wants to stand in front of a person you see weekly and say something negative; I like the third person better.”

Characteristics of preference for therapist

“I was more forthcoming with the therapist; I didn’t withhold anything from the therapist; if its someone we totally didn’t know it might be upsetting; if I’m happy with the therapy then I like the therapist; I liked the therapist debriefing because I’m a more open person; I’d rather talk to the person I have a problem with; to me you deal with that person first and if that doesn’t work out then go to other channels; I like the therapist because of what she knows; God would want me to be truthful and honest so why not be truthful and honest; because I liked my therapist it was easy to talk to him; when I talk with a new person I get uncomfortable; I preferred the therapist; it would give the therapist the opportunity to see how they could change for the next couple; I wouldn’t know how to say that (negative experience) to a debriefer that just came in; there’s some things you don’t want everybody to know about.”
Characteristics of experience of being debriefed

“I don’t have a problem with it; the verbal questioning doesn’t bother me whatsoever; if there’s been improvement the debriefing would be a reflection on the process; it’s necessary to control what’s going on and to find out if therapy is working; very helpful, it’s a two way street; there’s nothing but good that’s come out of it; in this atmosphere it feels like its comfortable; not a stuffy atmosphere; it gave us direction; it made me think about it (therapy) more; it had points to it and things we need to think about; it helped us do more for ourselves; it’s nice to have somebody ask; I like this debriefing; it’s a fresh outlook; to me it’s helpful; it gave us a chance to say what was working and open up the fact that we would like longer sessions on Saturdays; it’s really hard to find any fault with the debriefing system; you knew your contribution was valuable; the therapy and debriefing had a lot to do with how we progressed so far; if a therapist never debriefed at all, he wouldn’t really know that they were doing a good job; I wouldn’t change anything, I am pleased with both of them; I felt pleased you would go to such lengths to see how therapy was going, that’s a step more than most places would go; positive; you get more depth with the therapy; showed genuine interest and not phony.”

Characteristics of how debriefing could be made better

“Maybe a question and answer page; I don’t think there’s anything to change; explain (more) about the procedures or something; use one or the other kinds of debriefing; I wouldn’t have any idea how to change, it was so well done; they could keep us from wandering off the topic; changing the room wouldn’t have changed anything at all; I like it better (changing rooms) because it does separate the two; I like to write things down and
think about things; writing would be better; writing things down is not as personal; we should be given a card or call over the phone and complain; I would like a room that was enclosed without cameras and mirrors, we never knew if they were watching during the debriefing; it would be better if (the therapist) didn’t know about it; don’t need to debrief after the first session; it needs to happen after emotional sessions; should be a form to fill out; early on, let people know when they will be debriefed, we didn’t always know.”

Emergent Domains

Characteristics of frequency of debriefing

“Should establish rapport then debrief and then not too often; it probably is not necessary after each session but probably each is different; probably not after every session; once every five to eight sessions; every two months; not too often because it would be the same thing; its about right I think; you say the same things every week probably; every week is too often; not necessarily every session but every other session.”

Characteristics of influence of debriefing upon families

“You get more depth with the therapy; showed genuine interest and not phony; gives the power back to us; debriefing would be a reflection on the process (of therapy); its somewhat necessary that you can control what’s going on and to find out if the therapy is working because who wants to keep doing the same thing over and over again if its not working; very helpful, I know its a two way street; helps you realize how much progress you’ve made; helped me realize what we’ve been coming here for; it gave us direction; helps us realize what’s going on; made me think about it more; its still the feeling that they are
trying to help you; its a fresh outlook to see you’re concerned with helping us; it really says something that you care; that you change the ways things are being done; it was working so well we weren’t finding anything wrong; the problem gets solved and not blown out of proportion; its really hard to find any fault with debriefing because we know he’s there to help; this is really helping and I came into this thinking it will be like the other therapy (referring to a previous therapist); it gives us more to talk about; its not clinical; it gives a conversation piece; it felt like they cared; I thought he (therapist) cared; that he really cared about the work; he wanted to know personally from us how we felt about the sessions; it feels more like a conversation; you feel like you have to compliment them; if I wasn’t pleased I wouldn’t agree to the debriefing; I thought it was really important; that this whole place was concerned about whether they were doing their job right; a step more than most places would go; more cared about; wanted to make sure everything was clear; helps when the person is respectful; pleased you would go to such lengths to see how therapy was going.”

Characteristics of discomfort with communicating negative experiences

“I’m sure that for the typical standard person if there was something that was not quite right, they would probably not say that to the therapist; if somebody had something bad to say, they would be upset about it but we had nothing but good to say; if the client and the therapist feel comfortable together and we don’t have a problem with how they’re working, then it was fun; (if there was a problem) I can see where the third person would work out; even if the relationship is not that well its still the feeling that they are trying to help and I wouldn’t want to hurt their feelings; I enjoyed the therapists but didn’t want to say anything negative to them; what is important is the way you convey the negative stuff about the
therapy; because you liked your therapist you were happy with what was happening so it was easy to talk to him; If I wasn’t happy with our therapist and he debriefed us I would be kind of unresponsive; I wouldn’t agree to the debriefing; (if unhappy with the therapist) I would be angry if I was debriefed by someone who I was forced to say something nice to; its how I naturally feel if somebody asks me what do I think about what they did or how they look or something; who wants to stand in front of a person you see weekly and say something negative or say I really don’t like this about you.”

Characteristics of client satisfaction with therapy as a result of debriefing

“It helped us realize the progress we’re making; it makes you stop and think how therapy would work for you; positive; positive; debriefing is a reflection on the process; it helped me realize what we’ve been coming here for; it was a study about it (therapy) and was kind of like a security blanket; I liked it because we went back over what we discussed; it gave us a direction; it made me think about it (therapy) more; during therapy itself we stopped several times and said “Is this working?” we made changes then too; it helped us do more for ourselves; I like this debriefing, it brings new light to me, a lot of counselors came off as if they were God or something; (after sharing with the debriefer) we did see a difference; what we tell them is to help; he wanted to know personally from us how we felt about the sessions, I was happy about that too; this whole place was concerned about whether they were doing their job right; it means we’re making progress; we feel more cared about; shows sensitivity.”
Characteristics of debriefing as therapeutic

“We noticed how much change really did happen for us; it helped us do more for ourselves; in a way therapy’s just continuing; its a fresh outlook; concerned with helping us; really helped us focus on us; it gives us a chance to say what was working; helpful for us, gives us more to talk about; the therapy and this (debriefing) had a lot to do with how we progressed so far; it lets you know you’re doing a lot better than you thought; especially helpful after an emotional session.”

Characteristics of compatibility with therapist

“We were used to talking with them (but) if things were going bad with us, or something upset us, it might be different; the relationship between the client and the therapist, if they feel comfortable together we don’t have a problem with how they’re working; I don’t know, if this thing weren’t working for us we’d have a different opinion; If I wasn’t happy I would feel uncomfortable; not everyone is happy with their therapist, if I wasn’t happy with our therapist and he debriefed us I would feel kind of unresponsive; If I wasn’t pleased (with the therapist) I wouldn’t want to say; I would be angry if I was debriefed by someone who I was (unhappy with); debriefing helps when the person is respectful; the therapist should establish rapport then debrief; since we were pleased with the therapists it was more personal to be debriefed by the therapists.”