THE RELATIONSHIP OF TWO MODELS OF SUPERVISION TO STRUCTURAL FAMILY THERAPY OUTCOME

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF EDUCATION

by

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This study evaluated the relationship between two supervision models (live or delayed) to structural family therapy outcome. Eighteen families participated in this study for a maximum of ten family therapy sessions. Two indices of change were measured before and after family treatment, resolution or non-resolution of the family's presenting problem, and changes in family structure as measured by the FIAT.

The following hypotheses were formulated for this study and tested at the .05 level of significance.

1. There will be no difference in the number of sessions necessary for problem resolution between the live supervision group and the delayed supervision group.

2. There will be no changes in family structure after family treatment associated with both the live supervision group and the delayed supervision group.

3. There will be no difference in the change of family structure after family treatment between the live supervision group and the delayed supervision group.

The Family Interaction Apperception Technique was used as the pre- and post-treatment measure of family structure. Presenting problem resolution or non-resolution was determined by the family's report and demonstration within the
counseling session that the presenting problem was no longer a family concern. Problem resolution was judged by the case supervisor and reported on the Session and Problem Checklist. Hypothesis 1 was tested with a Fisher's Exact Probability Test and was not found to be significant. Hypothesis 2 was tested with a t-test of differences for related samples and was found to be significant. Hypothesis 3 was tested with an analysis of covariance and was not found to be significant. Based on the findings that there was no difference between the live supervision group and the delayed supervision group in the number of sessions needed to assist the family to negotiate problem resolution, both supervision groups were able to effect structural changes in the families, and there was no significant difference between the live supervision group and the delayed supervision group in their ability to effect changes in family structure after family treatment, it was concluded that both live and delayed supervision are effective methods in structural family therapy.
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THE RELATIONSHIP OF TWO MODELS OF SUPERVISION TO STRUCTURAL FAMILY THERAPY OUTCOME

Discovery in science commences with the awareness of anomaly, i.e., with the recognition that nature has somehow violated the paradigm-induced expectations that govern normal science. Assimilating a new sort of fact demands more than an additive adjustment of theory, and until that adjustment is completed, until the scientist has learned to look at nature in a different way—the new fact is not quite a scientific fact at all. (Kuhn, 1970, pp. 52-53)

Such a discovery was made in counseling when traditional individual therapy was observed not to be meeting the needs of many of the people being served (Haley, 1969; Minuchin & Montalvo, 1966). The theoretical adjustment that was made required the abandonment of the linear model of psychoanalysis and the adoption of a systems model which focused upon the interactions between people, and between people and their environmental contexts (Auerswald, 1971). This change in focus necessitated that the family become more involved in the treatment of children's problems since the family serves as the primary context for a child's growth and development (Minuchin & Minuchin, 1975).

Family therapy developed within this context and evolved into a significant mental health field with training available across the country (Flomenhaft & Christ, 1980). Various schools and models of family therapy developed during the 1970's, and one such approach was the Structural Family
Therapy model (Minuchin, 1974). Aponte and VanDeusen (1981) describe structural family therapy as being "founded on the immediacy of the present reality, oriented to solving problems and above all, contextual, referring to the social environment that is both a part of and the setting for an event" (p. 310). Minuchin and his colleagues developed structural family therapy in working with poor, slum families in New York City (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). Upon moving to the Philadelphia Child Guidance Clinic in 1969, Minuchin introduced the staff there consisting of psychiatrists, psychologists, social workers, counselors and pediatricians to structural family therapy. The Philadelphia Child Guidance Clinic became and has remained the center for training, research, and practice of structural family therapy stressing innovative techniques in working with families (Madanes, 1981). The Clinic staff has expanded the use of structural family therapy to include three other major types of families, each having a characteristic pattern of interaction. The psychosomatic family was studied at the Philadelphia Child Guidance Clinic and the Children's Hospital of Philadelphia, and reported by Minuchin and his colleagues (Minuchin, Rosman, & Baker, 1978). The alcoholic family was studied at a Pennsylvania state hospital and reported by Davis and his colleagues (Davis, Stein, & VanDeusen, 1977), and the drug addict family has been studied at the Philadelphia Veterans' Hospital, and reported by Stanton and Todd (1976).
Due to the reported success of structural family therapy with such diverse problems, there appeared to be a need to evaluate some of the major components of the structural model, and one of those components is the use of live supervision during the family session. The elements of successful supervision have not been evaluated in family therapy (Kniskern & Gurman, 1979). Existing information consists of either unreplicated studies (Wells, Dilkes, & Trivelli, 1972), or upon beliefs and assumptions not based upon empirical data (Gurman & Kniskern, 1981). This study provided clinical data concerning the relative efficacy of these two supervisory approaches to structural family therapy outcome. Information regarding the relative efficacy of these two supervisory approaches will assist trainers, teachers, and students interested in learning structural family therapy to select the more relevant supervisory approach for their own context.

Review of the Literature

Ekstein (1964) stated that the trainer's perception of what supervision will dictate the type, scope and adequacy of supervision received by the trainee. Thus, the goals and methods of counselor supervision always reflect the particular theoretical orientation of the training program. Liddle (1980) acknowledged this same trend in family therapy training programs within academic institutions, which on the whole have not been supportive of family therapy. Liddle
described the problems inherent in attempting to establish a training program in structural family therapy in a non-supportive academic setting, and predicted that the trainer and the interested students will experience stress as a result of their interest. Aponte (1982) recently stated that all models of therapy make attempts, explicitly or implicitly, to influence the therapist's development and that it is important for the supervisors and the trainees to know the nature of that influence throughout the training program.

With the discovery and description of general systems theory (von Bertalanffy, 1968), the systems paradigm has been introduced into many different areas such as medicine, business, and psychosocial services. This introduction of a new paradigm has stimulated an evolution within counselor supervision with regard to the conceptualization and provision of supervision. The traditional supervisory approaches, like many of the individual psychotherapies, relied heavily upon a linear espistemology, which focused on the individual and not upon the interactions between people. The systems models of supervision utilize this new circular epistemology, allowing the focus to shift to the interactions between therapist and the client(s), and between the therapist and the supervisor. Hoffman (1981) recently wrote a clear explanation of circular thinking and its implications for family therapists:

The therapist is not an agent and the client is not a subject. Both are part of a larger field in which the therapist, the family and any number of elements act and react upon
Gurman and Kniskern (1979) reported in their massive review of family therapy research that despite this shift in paradigms and the growth of family therapy, the family therapy literature lacks specificity regarding methods and goals.

The evolution of counselor supervision has come from two directions with regard to methods and goals. One major approach in counselor supervision has been the didactic or teaching approach which assumes that the counselor needs to be taught certain therapeutic skills in order to provide adequate service to people seeking both individual and family therapy. This approach has been successfully utilized in the training of undergraduate sophomore psychology students in the use of a basic interview technique (Canada, 1973). This learning of specific skills in counselor education programs has been defined as the ideal goal of any training program within an academic setting (Horan, 1971). In family therapy, Haley (1976) has steadfastly supported the learning of skills in his training of practicing mental health workers in structural and strategic family therapy, but no data exists to substantiate his claims. Cleghorn and Levin (1973) have pro-
posed a tri-level program of learning objectives for psychiatric residents interested in learning to do family therapy, but they, too, reported no supportive data. Only in Haley's (1976) report did the family therapists in training actually work with clients who were not from the same population as the counselors providing treatment.

The second major approach in counselor supervision is the experiential approach which focuses upon providing the counselor with the necessary experiences from which the counselor could develop in individual and family therapy. Arbuckle (1965) has argued theoretically, that the freedom that the student-trainees experience in the training context will enable those trainees to experiment with new methods they might not have considered without that sense of support. Birk (1972) reported that the students' preference for a particular type of supervision was not as significant as was the skill of the supervisor in creating the proper context for the learning of empathic understanding in her training of undergraduate counseling psychology students. LaPerriere (1977) has argued that the experiential approach is the more effective supervisory method to produce multi-faceted family therapists as a result of her training work at the Ackerman Institute in New York, but no data was offered to support her claims.

With the emergence of systems theory, there has been a movement within the counseling profession toward consoli-
dation of theory and practice in individual and family therapy. There also has been a recognition that neither the didactic nor the experiential approach to supervision alone could adequately meet the counselor's needs in either individual or family therapy. The integrative approach in individual therapy has been used successfully in the training of undergraduate and graduate counseling students in empathy, warmth and genuineness (Truax, Carkhuff, & Douds, 1964). Minuchin and Fishman (1981) have recently stated that in their conceptualization of training in family therapy that the trainee needs "not only a set of clearly differentiated techniques but also a few umbrella concepts to give them meaning" (p.10). They have trained a variety of mental health workers including psychologists, psychiatrists, social workers, and counselors in the learning of structural family therapy. Bateson (1977) defined such integrated approaches to learning as wisdom, stating that "Wisdom demands not only a recognition of the facts of circuitry, but a conscious recognition, rooted in both intellectual and emotional experience, synthesizing the two" (p.65).

Traditionally, individual counseling supervision has relied upon subjective reporting by the counselor to the supervisor some time after the actual counseling session. This supervisory format allowed the counselor to experience less stress in supervision because the actual session was completed (Blaine, 1968). Blaine reported the initial reactions
of undergraduate psychology trainees to tapes of themselves in pseudo-counseling relationships, was to either become overcritical of their work or to become unexpressive of what they had done or not done during the session. Clark (1965) argued from his theoretical point of view that the counselor should be given additional time to perceive and utilize the information received in the supervisory process after the counseling session.

More recently, however, the use of videotape feedback in counselor supervision has grown in popularity, allowing the supervisory session to take place at any time after the actual counseling session without the total reliance upon the counselor's memory of the session (Berger, 1978). Berger supported the use of various media in the training of psychiatrists, and is currently researching various aspects of videotape training effects. The use of videotape feedback has been demonstrated as an effective method in training undergraduate counseling psychology students in basic counseling techniques. Frankel (1971) reported that videotape and modeling were more effective in students' self-confrontation of their own work, while O'Connell (1974) reported that immediate feedback when coupled with modeling of the desired counseling behavior was superior to the use of immediate videotape feedback alone. Post-session feedback using videotapes increased the range of potential interventions available to the supervisor since both verbal and non-verbal
behaviors of the client(s) and the counselor could be evaluated by the supervisor (Bailey and Sawder, 1970). More importantly, the utilization of feedback and supervision recognized that those two components are integral parts in the development and maintenance of counseling skills acquired in training (Kniskern & Gurman, 1979).

One way to view the impact of supervision upon the supervisees is the degree of counselor trainee imitation of the supervisors' behavior, even when there is a dissimilarity between the trainees' and the supervisors' theoretical approach to counseling and supervision (Hester, Weitz, Anchor, & Roback, 1976). These authors found that the degree of counselor imitation by graduate counseling psychology students was significantly higher when the trainees perceived the supervisor as skillful, regardless of their own theoretical approach. One problem with counselor supervision, however, has been over-imitation of the supervisor by the trainees resulting in overdependency. Dowling and Frantz (1975) acknowledged this problem in their work with undergraduate undecided majors. They discuss the hazards of modeling specific behaviors for counseling trainees as inviting imitation but not fostering generalization of those same skills to other non-training settings. This potential problem can be significantly reduced by structuring the supervisory relationship to allow for a mutual and reciprocal exchange of ideas and experiences between the trainees and the
the supervisors as Novak and Busko (1974) have implemented in their training of psychiatric residents. They observed that when given the opportunity to express themselves in a non-threatening context the psychiatric residents were much less defensive about attempting some of the needed behaviors in working with families.

A distinct evolution of supervisory techniques parallels the development of therapeutic methodologies, and as supervisory techniques have developed, the supervisor's role within certain models of therapy has become more active. When the supervisor believes that the counselor needs freedom in order to create the necessary therapeutic context, then the delayed supervision model would appear to be more appropriate since this type of supervision allows the counselor to be in charge of the counseling session without anticipation of supervisory interventions. Altucher (1967) and Arbuckle (1965) both have argued from their theoretical positions that it is the freedom of the counselor that makes for successful therapy. When the supervisor believes that the supervisor is also a part of the therapeutic context, then the live supervision model would appear to be more appropriate since this type of supervision allows the counselor to receive direct feedback from the supervisor during the counseling session. Montalvo (1973) argued that mistakes are inevitable, and that this type of supervision allows
the counselor to correct those mistakes immediately by re-
focking upon the presenting problem. Supervision and train-
ing methods thus become a metaphor of one's beliefs, values,
and assumptions regarding how therapy should be conducted
(Liddle & Halpin, 1978).

The emphasis in structural family therapy is upon problem
resolution through the active reorganization of the family
structure. One essential component of the structural model is
the use of live supervision, and one question in family therapy
supervision is whether live supervision is more effective
(Haley, 1980) than delayed supervision (Ferber & Mendelsohn,
1969). Both of these reports investigated the essentials of
family therapy treatment and training at two different settings.
Ferber and Mendelsohn worked at Bronx State Hospital focusing
upon the affective learning of the trainees, while Haley worked
at the Philadelphia Child Guidance Clinic focusing upon the
acquisition of specific clinical skills. Both reports support-
ed the type of supervision that each provided during their
training programs but no empirical data was presented on
either side of this issue. Both live supervision and delayed
supervision as defined in this study focus upon enhancing the
counselors' skills, and upon facilitating a greater use of
the counselor's self, which Gurman and Kniskern (1981) in
their review of the research reported as being critical
elements of successful family treatment. One important
question that was investigated in this study, was what
relationship, if any, does the type of supervision received by the family therapist have with structural family therapy outcome?

**Hypotheses**

Due to the exploratory nature of this study, the following hypotheses were evaluated in the null form.

1. There will be no difference in the number of sessions necessary for problem resolution between the live supervision group and the delayed supervision group.

2. There will be no changes in family structure after family treatment associated with both the live supervision group and the delayed supervision group.

3. There will be no difference in the change of family structure after family treatment between the live supervision group and the delayed supervision group.

**Method**

**Subjects**

Eighteen families from the North Central Texas area, ten of whom were self-referred, and eight of whom were agency-referred, participated in this study. Each of the 18 families had a child between the ages of 7 and 12 years as the identified patient (IP). All families received structural family therapy for a maximum of 10 sessions which included both pre- and post-treatment assessment.

The socioeconomic status (SES) of each family was determined by comparing the family's total income with that of
national norms, and is reported as either lower (L) or middle (M) socioeconomic status (U.S. Census Bureau, 1980). The number of parents in the home was determined by interviewing the family and accepting their statement of the persons living in the home, and the same held true for determination of a family's ethnic origin, and is reported as White (W), Black (B), or Mexican-American (M). The nature of the presenting problem was reported by the family, as was the age of the identified patient (IP). Demographic data regarding the families in both the live supervision group (LS) and the delayed supervision group (DS) is presented in Table 1.

On the socioeconomic status variable the live supervision group had 44 percent middle SES, and 55 percent lower SES families. The delayed supervision group had 55 percent middle SES, and 44 percent lower SES families. The live supervision group had 55 percent two-parent homes, and 44 percent one-parent homes. The delayed supervision group had 66 percent two-parent homes, and 33 percent one-parent homes. The age range of the identified patient was from 7 to 12 years in both groups, with a mean of 9.11 years in the live supervision group, and a mean of 9.88 years in the delayed supervision group. The same presenting problems were reported for each group. The ethnic origins of the families in the live supervision group were 44 percent Mexican-American, 33 percent White, and 22 percent Black families. The delayed supervision
group was 77 percent White, 22 percent Mexican-American, and
no Black families. Race or ethnic origin was not reported by
Aponte and VanDeusen (1981) to be a critical factor in the use
of structural family therapy with multi-racial populations.

Nine masters' level counselors from a large state univer-
sity's counselor education program participated in this study.
Each counselor was participating in a counseling practicum
that focused specifically on structural family therapy. The
counselors varied in age from 23 to 37 years, with a mean of
30 years. Their level of previous exposure to family therapy
was similar, from zero to six months, and none had previously
worked with families in therapy. Each counselor received a
maximum of 10 supervision sessions per case during the study
of either live supervision or delayed supervision but not both.

There were two supervisors in this study, one professor
with an earned doctorate, and one doctoral counseling student
assistant, who had completed all doctoral level requirements
except the dissertation. Both supervisors had received
specialized training in structural family therapy, with the
student assistant receiving his training at the Philadelphia
Child Guidance Clinic where structural family therapy was
developed, and has remained the cornerstone of treatment.
Both supervisors were experienced family therapists with a
range of 2 to 5 years, and a mean of 3½ years. Both super-
visors had had previous experience providing both types of
supervision with a range of 3 to 7 years, and a
mean of 5 years. The student assistant provided the live supervision and the professor provided the delayed supervision for the cases in this study.

Table 1
Demographic Data for Families in both Supervision Groups

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Instruments

The Family Interaction Apperception Technique (FIAT) developed by Minuchin and his colleagues (1967) was used to assess family structure in this study. The FIAT is a set of 10 pictorial cards depicting familial scenes that are designed to elicit information regarding familial interactional
patterns. The FIAT is administered to all family members over the age of 7 years residing in the home. Children younger than 7 years are omitted because they have been observed to respond randomly to the cards, making their FIAT protocols unscorable (Minuchin et al., 1967). The cards were designed so that the racial characteristics of the persons portrayed on the cards is undeterminable, thus the FIAT cards have been used with various racial subgroups within the American society. The effect of race upon responses was evaluated and was not found to be significant across both clinical and non-clinical families of Black, White, and Puerto Rican origins (Minuchin et al., 1967).

Responses on the FIAT are coded into eight major variables: control, guidance, acceptance of responsibility, nurturance, affection, cooperation, aggression, and family harmony. These eight variables were selected by having two raters code 110 responses into major categories with the minimum cut-off score of 25 responses for classification as a major variable. For reliability purposes when the two raters had completed coding the 110 responses, a third psychologist blindly scored the 110 responses, and an overall rater agreement rate of 86 percent was achieved (Minuchin et al., 1967).

The FIAT scores utilize percentages obtained as ratios of individual variable responses to the total number of responses on the entire protocol. The FIAT scores are obtained
across pre- and post-treatment assessments, thus a comparison of the two scores yields a change score between the two assessments. For the purposes of this study, a total Family FIAT score was derived by summing all of the individual family members' FIAT scores and dividing that total by the number of persons in each family. The Total Family FIAT score was used as the general measure of family structure. Each family's score represents that family's tendency to respond to certain familial scenes, and is scored as either positive or negative. A positive family score is more indicative of families that Minuchin (1974) described as enmeshed with diffuse boundaries within the family system. A negative score is more indicative of families that Minuchin (1974) described as normal families. A scoring sheet and the instructions for FIAT administration are presented in the Appendix.

The Family Therapy Analogue (FTA) was designed specifically for this study by the experimenter for the purpose of evaluating the influence of supervision upon the counselor's conceptual skills at the beginning and conclusion of the study. The FTA consisted of an actual family therapy case transcript with only the family members' responses printed on the sheet. For each blank space marked with the word 'therapist', each counselor filled in a response that they believed to be the most therapeutic response at that point in the interview. The case presented in the FTA was completed by a nationally known expert in structural family therapy, thus the original responses were assumed to re-
present an advanced level of therapeutic skills.

This assumption was supported by a three person panel, each of whom had worked with or were working with families using structural family therapy; and who were asked to assess the appropriateness of each therapist response. An inter-rater reliability coefficient of 85.7 percent was computed across all three judges. Two independent raters, who were currently practicing structural family therapists blindly scored the same transcript and an overall rate of agreement of 83.25 percent was achieved. The FTA consists of 20 blank spaces that each counselor must complete within 45 seconds or have that response scored as a zero. All responses were scored as one, one-half, or zero by using the coding system and coding sheet which are presented in the Appendix.

The **Session and Problem Checklist (SPC)** was constructed for this study by the experimenter in order to count the number of sessions involved in each case of this study. The SPC includes a section where the presenting problem is identified at the beginning of family treatment, and a section where the problem is assessed at the conclusion of family treatment. This assessment of presenting problem resolution was made by the supervisor responsible for the case. For the purposes of this study, problem resolution was considered to have been reached when the family reported and demonstrated that the original complaint was no longer of concern. A copy of the SPC is presented in the Appendix.
Procedure

Each counselor completed an FTA prior to counseling with any families, and those scores were compared with each counselor's FTA score at the conclusion of the study. Counselors were assigned to a supervision group on the basis of their pre-treatment FTA score in an attempt to balance the groups in terms of counselor conceptual skill. The live supervision group counselors had a range of scores from 10.5 to 13.5 with a mean of 12.2. and a standard deviation of 1.19 on the FTA. The delayed supervision group counselors had a range of scores from 11.0 to 13.5 with a mean of 12.5 and a standard deviation of .96 on the FTA. Data from the FTA scores were analyzed as a related finding to investigate the impact of either supervision group on the counselor's acquisition of conceptual skill in structural family therapy.

Families were assigned to counselors in each supervision group in an alternating sequence, as the families contacted the clinic. Deviation from this alternating sequence was done in order to balance the two groups in terms of presenting problems. All appointments were scheduled within two weeks of the initial clinic contact.

At the time of the first family session, parents were asked to read, or have read to them, a description of the study, and upon their review they were asked to sign a release form agreeing to participate in the study (see Appendix). Families were also informed at that time that
at the conclusion of the study they would be debriefed as
to the purpose of the study, and any questions that they
had would be answered by the investigator. After consenting
to participate in the study, each family member above seven
years of age was administered the FIAT individually as part
of the first counseling session. The FIAT was readministered
as part of the final counseling session. Each counselor read
the instructions for administration of the FIAT verbatim from
a three-by-five index card (see Appendix). At the time of
the last session and post-treatment assessment the counselor
and case supervisor also assessed the problem resolution
or non-resolution for each family. For the families who
left treatment prior to completing 10 counseling sessions
phone contact was made in order to set up an appointment
for the post-treatment FIAT assessment to be completed.

Each counselor received one hour of training from the
investigator regarding FIAT administration. Training in-
cluded an oral presentation, role-playing activities, and
a question and answer period where the investigator answered
the counselors' questions regarding the FIAT. The coun-
selors obtained a criterion level of 85 percent with a pre-
scored FIAT protocol prior to actual administration of the
FIAT with families.

Both supervisors had a similar focus in their respective
groups, to assist the counselor to help the family resolve
the presenting problem. Both the live supervision group
and the delayed supervision group met with their respective supervisor for planning subsequent sessions utilizing the videotapes, the counselor's reactions to the sessions and to the family, and the supervisor's knowledge and experience. Both supervision groups held a case conference for three hours per week prior to any family sessions that week, and particular concerns or issues regarding the families or the interventions were discussed and agreed upon by the supervisor and the counselor. Counselors in each group met with the supervisor individually for approximately 15 minutes prior to each family session to discuss the specific goal for that session.

The live supervision supervisor used a telephone connected in the actual counseling room to offer suggestions, and directions to the counselor during the counseling session, with a range of 4 to 6 calls per session over the entire treatment program. The live supervision supervisor who had the option of entering the session directly to intervene at any time went into only one session one time throughout the entire treatment program. The counselors in the live supervision group were able to leave the session to confer with the live supervisor and three counselors chose to leave a session one time each. The counselors in the live supervision group were also required to leave the counseling session within the last 10 minutes and to confer with the supervisor, and they did so in every case. The live supervision supervisor supported the counselor directly, and intervened in the
interactional sequence to allow the counselor to refocus on
the session's goal. The delayed supervision supervisor
offered support, discussed the counselor's perceptions of
the case, and discussed possible strategies for subsequent
sessions immediately following the counseling session.

All counseling sessions were videotaped. Each family
referred to the clinic was asked to sign a release form
(see Appendix) giving permission to videotape all of their
counseling sessions, and all families who came to the clinic
signed this release. This videotape release was independent
of the consent to participate in this study form that the
families were asked to sign. The videotape equipment used
in this study was a Panasonic Videotape System, which in-
cluded a Panasonic Color-Video Camera (WV-3100), a Panasonic
Video-Recorder (VCR Omnivision II, VHS-NV 8200), and a
Panasonic Color Television monitor (CT-9040). JVC (T-120)
brand tapes were utilized in this study, and two black
intercom-type phones were utilized by the live supervision
supervisor when necessary during the counseling sessions.

Results

Hypothesis 1 was tested with a Fisher's Exact Probability
Test; Hypothesis 2 was tested with a t-test of difference
measures for related samples; and Hypothesis 3 was tested
with an analysis of covariance. All three hypotheses were
tested at the .05 level of significance.

Hypothesis 1 stated that there will be no difference
in the number of sessions necessary for problem resolution between the live supervision group and the delayed supervision group. The number of cases that achieved problem resolution, and the number of cases that did not achieve problem resolution are presented in Table 2.

Table 2
Cases with Problem Resolution or Non-Resolution

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The number of sessions required to obtain problem resolution in each is presented in Table 3.

Table 3
Number of Sessions Necessary for Problem Resolution in both Supervision Groups

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<tr>
<td>Live Supervision (LS)</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Delayed Supervision (DS)</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

In the 5 cases where the families withdrew from treatment
prior to completing 10 counseling sessions, four of the five families reported no change in the presenting problem at post-treatment assessment, and one of the five families reported problem resolution. This self-report did not meet the dual criterion in this study that stated both family self-report and demonstration to the counselor had to be observed prior to judging presenting problem resolution to have been achieved. Based upon these frequencies of cases with problem resolution, and the corresponding probability of .062 of obtaining such frequencies, no significant difference was found between the live supervision group and the delayed supervision group in the number of sessions necessary for problem resolution, and therefore Hypothesis 1 was retained.

Hypothesis 2 stated that there would be no change in family structure (FIAT) scores after family treatment associated with both the live supervision group and the delayed supervision group. The t-test of difference measures for related samples was computed and the mean for the live supervision group was -9 with a standard deviation of 5.22 for changes in family structure after family treatment. The mean for the delayed supervision group was -1.1 with a standard deviation of 5.46 for changes in family structure after family treatment. The t-ratio of 2.61 was significant at the .05 level, and thus it is reasonable to assume that counselors in both supervision groups of this study were able to effect change in family structure after family treat-
ment as measured by the FIAT, and therefore Hypothesis 2 was rejected.

Hypothesis 3 stated that there will be no difference in the change of family structure (FIAT scores) after family treatment between the live supervision group and the delayed supervision group. The changes between the pre- and post-treatment Family FIAT scores for families in both the live supervision group and the delayed supervision group were analyzed with an analysis of covariance with the pre-treatment Family FIAT score as the covariate variable. This covariate was selected to adjust for initial pre-treatment differences across the families in this study. The analysis of covariance summary table is presented in Table 4.

Table 4
Summary Table of Analysis of Covariance for Changes in Family Structure (FIAT)

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups, $B_{adj}$</td>
<td>341.504</td>
<td>1</td>
<td>341.504</td>
<td>1.99</td>
</tr>
<tr>
<td>Within groups, $W_{adj}$</td>
<td>2699.951</td>
<td>15</td>
<td>179.996</td>
<td></td>
</tr>
<tr>
<td>Total, $T_{adj}$</td>
<td>3041.455</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The F-ratio was not found to be significant and thus it is reasonable to assume that there was no significant difference between the live supervision group and the delayed supervision group in their relative ability to effect structural
change in the families as measured by the FIAT after family
treatment, and therefore Hypothesis 3 was retained.

Related Findings

In this study, FTA scores were collected from the coun-
selors prior to their working with families, and this data
was analyzed as a related finding to evaluate the relation-
ship between the type of supervision received by the coun-
selor in this study and their subsequent acquisition of con-
ceptual skills at the conclusion of the study. A t-test of
differences for related samples was used to evaluate that
relationship. The mean FTA score for the live supervision
group was 12.2 with a standard deviation of 1.19, while the
mean FTA score for the delayed supervision group was 12.5
with a standard deviation of .96. The t-ratio of 4.32 was
significant at the .05 level for the live supervision group
while the t-ratio of 2.29 for the delayed supervision group
was not significant at the .05 level. Thus, in this study,
the live supervision method appears to have been more effect-
ive in helping the counselor to acquire conceptual skills
in structural family therapy as measured by the FTA. This
related finding seems to indicate a potential use of paper
and pencil analogues such as the FTA as one measure of coun-
selor change before, during and after family therapy train-
ing. This type of measurement of trainee change had not
been previously reported in the family therapy literature
(Gurman & Kniskern, 1980).
Discussion

This study explored the relationship of two models of counseling supervision to structural family therapy outcome. The type of supervision received by the family counselor, either live or delayed, was not found to be a major variable in the number of sessions needed for a family to reach problem resolution. All of the cases in both supervision groups that achieved problem resolution attended between 6 and 10 sessions with a mean of 8 sessions. This treatment range is identical to that reported at the Philadelphia Child Guidance Clinic for counseling cases during the years of 1970-1976 where the indices of symptom and psychosocial change in the identified patient were examined through observed behavioral change. The cases from Child Guidance Clinic involved a variety of presenting problems including the four primary types as defined by previous structural family therapy research, the poor, slum family (Minuchin et al., 1967), the psychosomatic family (Minuchin et al., 1978), the alcoholic family (Davis et al., 1977), and the drug addict family (Stanton & Todd, 1976). The providers of structural family therapy in those studies, and in the clinic are from a variety of professional backgrounds such as psychiatry, psychology, social work, counseling and nursing, but all of these professionals received live supervision of their work for at least the first two years of their employment there.
Counselors in both supervision groups in this study were able to effect changes in the family structure as measured by the FIAT after family treatment. This finding appears to support the work of Minuchin and his colleagues who demonstrated problem resolution and structural change in poor families living in New York City slums using delayed supervision (Minuchin et al., 1967), as well as some of his later work with psychosomatic families in the Children’s Hospital of Philadelphia or at the Philadelphia Child Guidance Clinic using live supervision (Minuchin et al., 1978).

The findings in this study that both supervision groups were able to effect structural changes in families, but that there was no difference between the supervision groups in their relative ability to effect those changes in family structure appear to conflict with those of Stanton and Todd (1976) who reported that structural family therapy with live supervision was the most effective treatment in their research in working with male heroin addicts and their families at the Philadelphia Veterans’ Hospital and the Child Guidance Clinic. Stanton and Todd used all Clinic staff therapists and all therapists had the dual role of drug counselor and family therapy for their study. The familial interaction patterns were significantly altered and these findings were supported at both 6 and 12 month follow-up intervals after termination. There appears to be at least two possible reasons for the discrepancy between the findings of the present study and those of Stanton and Todd.
First, the function of any presenting symptom can only be examined within that particular family system. The symptom may be identical in two or more families but the specific function that a particular symptom plays in a particular family at any given point in time will not be identical (Minuchin, 1974). A second possible explanation of the discrepancy could be that the duration of the presenting problem was briefer in the current study with a range of 1 to 2 years while the duration of the heroin addiction in Stanton and Todd's work was 4 to 7 years. Davis and his colleagues (1977) have noted that the duration of the presenting problem often complicates the efficacy of family treatment since the family system has already incorporated the particular symptom into its homeostatic cycle.

In this study, there was an overall improvement rate of 72.2 percent for the families in both supervision groups, and this rate compares favorably with the 73 percent rate reported by Aponte and VanDeusen (1981) in their analysis of previous structural family therapy research which utilized live supervision in 94.5 percent of the cases, and delayed supervision in 5.5 percent of the cases. All of the research reviewed by Aponte and VanDeusen was conducted at the Child Guidance Clinic or at one of their affiliated hospitals and involved such problems as anorexia nervosa, delinquency, and chronic asthma. The therapists who participated in those studies were all staff therapists of the
Child Guidance Clinic from various professional backgrounds such as psychiatry, psychology, social work, and counseling. Therefore, the difference between the clinical setting and the nature of the clients' presenting problem in the current study, and those in previous structural family therapy research, appear to support the use of structural family therapy in clinical settings other than the Child Guidance Clinic, and support the use of structural family therapy by masters' level counselor education trainees in a university affiliated, fully supervised, field-based clinical setting.

In summary, the two supervision groups were not significantly different in the number of sessions necessary to effect problem resolution, both the live supervision and the delayed supervision group were able to effect structural changes in the families, and that there was no difference between the live supervision group and the delayed supervision group in effecting structural changes in the families after family treatment. Therefore, it seems reasonable to conclude that, both live and delayed supervision are effective methods in structural family therapy.

The effectiveness of both supervision groups in bringing about structural changes in the families of this study, may reflect the similarity in the two supervisors' theoretical and clinical expectations that both the families, the counselors, and themselves are continuously changing as they interact with each other. Liddle (1980) and Liddle and
Halpin (1978) have both stated the importance of demonstrating congruence between theory and therapy methods in the selection of an appropriate supervisory model in family therapy. New methods of training therefore should include both theoretical and clinical skills since this integration of both types of skill appears necessary in the training of competent family therapists (Minuchin & Fishman, 1981).

Evaluation of family therapy training should assess the impact of training on the trainees' conceptual and clinical skills. Evaluation of therapeutic methods within and across counseling models such as the live supervision method within the structural model, appears to be necessary so that the most relevant, efficient, and effective techniques and technology will be utilized to promote successful treatment outcome. Ultimately, the evaluation of family therapy training should be focused upon the assessment of treatment outcome. Thus, greater specificity in improvement criteria utilized in outcome studies is needed since family therapy has shown its greatest efficacy when these change criteria have been most objective (Gurman & Kniskern, 1980).

An evolution toward the integration of theory and practice has begun in family therapy, and this evolution must also include integrating research methodology and clinical practice if family therapy is to maintain its cutting edge -- that is, the climate of inquiry, investigation, and discovery from whence it came. In supervision and in therapy
the focus is upon change, whether in the therapist or in the family, with the knowledge that a change in one will result in reciprocal changes in the other (Hoffman, 1981).

Researchers and practitioners must also recognize their own complementarity so that future investigations can benefit from both innovative theories and clinical techniques, and from more relevant research designs and statistical packages that more accurately assess what is being investigated.

Neither researchers nor practitioners, theoreticians nor clinicians should fear or avoid the other for it is with each other that new discovery is possible as Thomas (1981) noted:

> It is the admission of ignorance that leads to progress not so much because the solving of a particular puzzle leads directly to a new piece of understanding but because the puzzle—if it interest enough scientists—leads to work. (p.49)
APPENDIX A

FIAT CARDS
Scoring Sheet

<table>
<thead>
<tr>
<th>FIAT CARD #</th>
<th>VARIABLES (N, BC, G, AF, AG, C, FH, AR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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<td>5</td>
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<td>7</td>
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<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

FIAT Instructions for Administration

Examiner reads: I am going to show you some pictures of families doing various things, and I want you to tell me what is going on in the picture. In your own words, how you see the situation on the cards. I want you to tell me how you think the story got started, what is happening at the time of the picture, and then how the story may turn out for the people in the picture. Do you have any questions? Okay, here is the first family picture.
APPENDIX B

FTA Coding System.

1. One-point: Statement by therapist indicating that the father needs to select one problem.
   
   Half-point: Acceptance of father's statement, and asking family members for their opinion of the problem.
   
   Zero-point: Acceptance of other family members' perceptions of the problem.

2. One-point: Returns the responsibility to the father.
   
   Half-point: Have the father ask the son or wife what the problem is.
   
   Zero-point: Therapist or other family member select the problem.

3. One-point: Returns the focus to the original problem.
   
   Half-point: Responds to mother in an exploratory manner.
   
   Zero-point: Have father talk to mother about her comment.

4. One-point: Therapist acceptance of problem selected by father.
   
   Half-point: Exploration with other family members about the problem

   Zero-point: Non-acceptance of the problem by the therapist.

5. One-point: Reframe mother's behavior as too lenient or easy.
   
   Half-point: Explore 'let him slide' with father.
   
   Zero-point: Interpretation of mother's behavior to father.

6. One-point: Acceptance and extension of statement by the therapist.
   
   Half-point: Acknowledge of statement without extension.
   
   Zero-point: Disagreement with statement by therapist.

7. One-point: Acceptance of statement by therapist.
   
   Half-point: Acknowledgement of statement by therapist.
36

9. One-point: Acceptance and acknowledgement of mother's response and check with father for his reaction to mother's statement.

Half-point: Acceptance and acknowledgement of mother's statement without checking with father.

Zero-point: Acknowledgement but disagreement by therapist.


Half-point: Inquiry about how 'strict' father is with Al.

Zero-point: Inquiry about how 'strict' father is with other family members.

10. One-point: Statement joining with father to elicit Al's help.

Half-point: Talk directly to father about Al.

Zero-point: Talk to Al for father or let others speak for Al.


Half-point: Push father to get more information from Al.

Zero-point: Disagree with father's statement directly.

12. One-point: Statement by therapist to block mother and allowing father to complete his talk with Al.

Half-point: Hearing mother's comment then returning to father.

Zero-point: Encouragement for mother to continue.

13. One-point: Direct father to talk with his son.

Half-point: Talk to father about possible reasons for Al's ways.

Zero-point: Therapist asks Al directly for the father.

14. One-point: Checking for clarification in last statement.

Half-point: Acceptance of son's comment without clarification.
Zero-point: Disagree with son's comment and interpret to father.

15. One-point: Inquiry about what indicates that a child is afraid of his/her parents.

Half-point: Allowance of son to agree with father.

Zero-point: Statement about the father-son relationship.

16. One-point: Emphasis on son having a different opinion than his father and his ability to express that difference.

Half-point: Emphasis on father's ability to allow family members disagree with him.

Zero-point: Therapist asks father 'who speaks for you?'

17. One-point: Direct father to identify areas of conflict between himself and his son.

Half-point: Challenge father's statement directly.

Zero-point: Ask son for the father or ask mother for her opinion.

18. One-point: Discuss importance of disagreement in growing up.

Half-point: Question father about why A1 will not disagree.

Zero-point: Discuss how therapist knew father's problem.


Half-point: Acceptance of statement without clarification.

Zero-point: Disagreement with statement directly.

20. One-point: Summarize interactions between father and son for father, and between mother and son for him. Consolidation of parental styles, and direct father to take charge at this time.

Half-point: Challenge father to have A1 respond now.

APPENDIX C

FAMILY THERAPY ANALOGUE

Score Sheet

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 
11. 
12. 
13. 
14. 
15. 
16. 
17. 
18. 
19. 
20.

Pre-Test Total Score: 

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 
11. 
12. 
13. 
14. 
15. 
16. 
17. 
18. 
19. 
20.

Post-Test Total Score: 

Counselor ID #: 
APPENDIX D

Problem and Session Checklist

Family: #

Identified Client: _______________________

Age: _______________________

Sex: _______________________

Identified Problem: _______________________

Supervision Group: _______________________

Number of Sessions: _______________________

Duration of Treatment: _______________________

          (LS or DS)

Assessment at outcome:

    Identified Problem: 1. Eliminated _____
                         2. Improved _____
                         3. No change _____
                         4. Worsened _____

Assessment at Follow-up: _______________________

Date of Follow-up: _______________________

APPENDIX E

FAMILY CONSENT FORM

Dear Mr. and Mrs.

Your family has been referred for family therapy and the team working with your family wants to meet your goals for change within your family as quickly as possible. In order that we may provide the most relevant service to your family and to other families, I am asking your assistance with a research project regarding the type of supervision that works best in working with families.

The following assessment instrument will be administered during the project at no additional cost to your family:

Family Interaction Apperception Technique, (FIAT): This will be given to each member of your family over 7 years of age at the beginning and the end of therapy. You will be shown 10 picture cards and you will be asked to describe the family scene on each card.

I will answer any questions that you may have about the procedures for this study at the conclusion of the study, and you are free to withdraw your consent and to discontinue your participation in this project at any time.

ANONYMITY:

It will not be necessary for you to put your name on the assessment materials as all families participating in this research project will be assigned numbers, and no attempt will be made to identify or analyze individual data. All data will be grouped for statistical purposes.

INFORMED CONSENT:

Name of Family: __________________________ ID #: __________________________

1. I hereby give consent to Frank Ryan to conduct the above described research project.
2. I have either read or heard this explanation and understand the benefits to be expected from my participation in this project. I understand that the project is investigational and that I may withdraw my consent for my family's participation at any time. With my understanding of this, having received this information and satisfactory answers to the questions that I have raised, I voluntarily consent to the procedure described in the first paragraph.

DATE: __________________________ SIGNATURE: __________________________
The Family Counseling Program serves a dual function: to provide direct service to children and families and to aid in the continuing professional development of counselors. Sessions are audio- or video-taped for the purposes of review, supervision and continued development. Use of these tapes is restricted to the Family Counseling Program professional staff.

The content of the counseling sessions is confidential and is not to be released without permission.

With an understanding of the above statements, I agree to participate in counseling and release the Family Counseling Program from liability.

Date __________________________ Signature __________________________

Address __________________________
REFERENCES


Hester, L., Weitz, L., Anchor, H., & Roback, H.  Supervisor attraction as a function of level of supervisor skillfulness and supervisees' perceived similarity. *Journal*
of Counseling Psychology, 1976, 23(3), 254-258.


