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EDITOR
Jon Carlson
Governors State University
c/o Lake Geneva Wellness Clinic
101 Broad St., Suite 201
Lake Geneva, WI 53147
(262) 248-7942
(262) 248-1202 FAX
jcarlson@genevaonline.com

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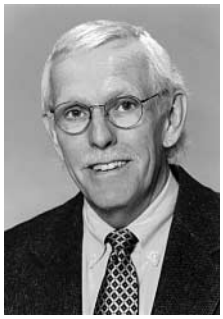

Once the realization is accepted that even between the closest human beings infinite distances continue to exist, a wonderful living side by side can grow up, if they succeed in loving the distance between them which makes it possible for each to see the other whole against the sky.

Rainer Maria Rilke,
Letters to a Young Poet

At a recent national convention I ran into an old friend. Carl Thorsen, as many of the readers know, is a professor of counseling at Stanford University. Carl seemed very different than I remembered him and I asked if something had happened in his life. "Are you okay?" He claimed he has never been healthier and began talking about practicing the eight-step meditation process of Eknath Easwarin (1991). We talked for a while about this process and how he has changed his life view. I immediately went off in search of something about this process. I had practiced meditation (the transcendental meditation variety) for years but have never experienced the profound changes that I noticed in Carl. I have been following this program for several months and have discovered increased concentration and productivity, more energy, less anger, more love, and the increased ability to live in the present.

Since my "run in" with Carl, I have been able to work on a video production with Jon and Myla Kabat-Zinn. They have written a book on parenting entitled *Everyday Blessings* (1997). Jon has also written the best sellers *Full Catastrophe Living* (1990) and *Wherever You Go, There You Are* (1995). The Kabat-Zinn's are known around the world as meditation experts. Jon pioneered the stress reduction program at the University of Massachusetts Medical Center. While working with them, the importance of this work for counselors and therapists became clear. In meditation, the participant focuses on a mantra or passage while in a relaxed state. When the mind wanders or thoughts intrude, you gently let them go and return to the mantra or passage. With extended meditation practice it is possible to live in the present moment with increased awareness. This process has many health benefits for practitioners as well as allowing them to stay in the present and to carefully choose responses. For counselors, they will then be able to treat their clients in a more deliberate fashion. Without such training they will unwittingly use many of the messages that others have used on them. By being aware of intruding thoughts and messages, counselors can respond in the fashion that (based on their training) they believe will benefit clients.

I urge us all to sit and grow! I urge us to honor Rilke's insight and learn to understand and accept the differences that exist between us all as we learn to live side by side.

—Jon Carlson, *Editor*

REFERENCES

Easwarin, E. (1991). *Meditation*. Tomales, CA: Nilgiri Press.

Kabat-Zinn, J. (1990). *Full catastrophe living*. New York: Delacorte.

Kabat-Zinn, J. (1995). *Wherever you go, there you are*. New York: Hyperion.

Kabat-Zinn, M., & Kabat-Zinn, J. (1997). *Everyday blessings*. New York: Hyperion.

Rilke, R. M. (1984). *Letters to a young poet*. New York: Random House.

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❖**Obituary**

Don Dinkmeyer, Sr.

It is with great sadness that I report the passing of Don Dinkmeyer, Sr. Don had been in ill health for the past few years. However, during this time, he was able to develop his spirituality. He died in the Coral Springs, Florida Medical Center on May 17, at the age of 77.

Don consulted in 46 states, Canada, Mexico, South America, England, Europe, and Japan. He received his Ph.D. in Counseling Psychology from Michigan State University, MA from Northwestern University, and a Certificate of Psychotherapy from the Alfred Adler Institute in Chicago.

Don was known as a pioneer in the fields of elementary school counseling, Adlerian psychotherapy, classroom guidance, parent education, group counseling, and marriage enrichment. He received lifetime achievement awards for his work from the American Counseling Association, North American Society of Adlerian Psychology, the American Psychological Association, the International Association of Marriage and Family Counselors, Association of Specialists in Group work, and the Association for Couples in Marriage Enrichment.

According to Pennsylvania State University Emeritus Professors Bernard and Louise Guerney,

> Please count us among the great number of professionals who considered Don Sr. to be not only a great person, but a professional of truly historic accomplishment. Among other things, but most important to us, he was a major pioneer in developing the family education movement. In this way, he has contributed and even after his passing will continue to contribute enormously to the welfare of families around the world. Thus, in a way, he will be greatly missed not only by us and others who knew him personally, but also by multitudes who never had that pleasure.

According to former ACA president Loretta Bradley, "I always enjoyed Don's positive attitude. I was impressed with his many scholastic writings. Truly, he was a giant in the counseling field and will be greatly missed."

According to his longtime friend and co-author, Jon Carlson, Distinguished Professor at Governors State University, "Don was not only an effective writer, but one who lived as he instructed. He was like a father to many children and parents and his deeds will certainly outlive him."

Don wrote 35 books and 125 professional journal articles; However, he is best known for the development of psychological education programs. These programs were distributed worldwide in the areas of parenting (STEP - Systematic Training for Effective Parenting), marriage enrichment (TIME - Training in Marriage Enrichment), classroom guidance (DUSO - Developing Understanding in Self and Others), and teaching (Systematic Training for Effective Teaching). It is likely that through these programs, he has influenced millions of individuals, couples, and families.

Don is survived by his wife (of more than 50 years) Jane and two sons, Dr. Don DinkmeyerJr., Bowling Green, Kentucky and Jim of Parkland, Florida. He is also survived by five grandchildren.

The family is leaving for their summer home in Michigan where burial will take place. Cards can be sent to the family at: P.O. Box 23, Arcadia, MI 49613. A memorial fund has been created in his name at the American Counseling Association, 5999 Stevenson Avenue, Alexandria, VA 22304-3300.

—Jon Carlson, Psy.D., Ed.D.
Governors State University

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❖Articles

Fathers and Sons: The Relationship Between Violence and Masculinity

Mark Pope
University of Missouri–St. Louis
Matt Englar-Carlson
University of Washington–Seattle

Pearl, Mississippi. Jonesboro, Arkansas. Paducah, Kentucky. Springfield, Oregon. Littleton, Colorado. Santee, California. These towns will forever live in the history of the United States at the end of the 20th and beginning of the 21st century. Angry, hurting, and knowing of only one way to handle these feelings, adolescent boys did what their fathers, culture, and society told them to do. Hurt those who are hurting you. Get revenge. Take a gun and blow them away so they can never hurt you again, ever (Schnieders, Hickman, & Pope, 2001).

Fag. Dweeb. Loser. Geek. Wuss. Queer. Different words having the same meaning, "You're different and that is bad," "You're different and not a member of our group," at a time when you so desperately want and need to belong. "Why are you crying? You must be a faggot!" said by a seventh-grade boy to his classmate. Words are powerful. Every one of the boys involved in school shootings was called "faggot," "wuss," "queer," and they were physically as well as verbally harassed (CNN, 1999; Sullivan, 1998; Wilkinson & Hendrickson, 1999). "Jocks pushed them against lockers [and] they yelled 'faggot!' and 'loser!' at them while they ate lunch in the cafeteria" (Wilkinson & Hendrickson, p. 50). This is the lexicon of adolescence in America. This verbal and physical harassment is designed to elicit conformity from those so targeted and security for the deliverer. To be different during a time when conformity to your peer group is the norm is to be a target for verbal and physical harassment from that same group (Allport, 1958; Beymer, 1995; Brown, 1991; Herdt & Boxer, 1996).

Authors' Note: Correspondence regarding this article can be sent to Mark Pope, Ed.D., Division of Counseling, University of Missouri–St. Louis, 8001 Natural Bridge Road, St. Louis, Missouri 63121-4499, USA; e-mail: pope@umsl.edu.

One of the common factors in most of the recent school shootings has been that the perpetrators are overwhelmingly male. Boys today have been viewed as in crisis, as evidenced by fragile, low self-esteem and increased rates of depression and suicide (Pollack, 1998). On the surface and to the outside observer, many boys may appear tough, confident, happy, yet on the inside many are sad, lonely, and confused. Boys who are confused with societal messages about what is expected of them as boys will most likely become men who continue to feel disconnected.

In this article the following issues will be addressed: the extent of the violence, etiology of this violence, masculinity and male gender role stereotypes, and what can be done to stop this violence including such interventions as peer interventions, paternal interventions, and school interventions composed of examples of affective education programs such as bullyproofing, peer counseling, character education, valuing differences and multicultural diversity.

EXTENT OF VIOLENCE

Most violence in American society is done by or to males, and this violence increasingly involves young men and boys. Here are the facts: (a) 1 in 10 boys has been kicked in the groin by age 16; (b) 78% of all unintentional deaths of young people result from automobile accidents and 75% of those are young men; (c) one third of all victims of violent crime are between 12 and 19; (d) murder is the second leading cause of death among adolescents (22% of all deaths among young people between 14 and 25 years old in 1991), with males accounting for 4 times more than females; (e) almost 40,000 young people from 14 to 19 years old died from firearms between 1979 and 1991; (f) the 1994 firearms death rate for young men 15 to 19 years old was 49.2 deaths per 100,000, the highest ever; and (g) suicide is the third leading cause of death among 15- to 24-year-olds and the rate for males is 4 times that of

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females (Sells & Blum, 1996). The statistics show that young men are violent toward other young men, toward young women, and even toward themselves (Gilligan, 1996).

Given the preponderance of violence and aggression in American society and the recent dramatic nature of school homicides, it is easy for the public to assume that school shootings represent the greatest danger to children. Actually, school homicide represents a low frequency but a high-impact expression of violence (Evans & Ray, 2001). Although there has been a decline in the number of homicides in schools, most likely due to the installation of metal detectors and security guards in dangerous areas, the sobering statistic is that the number of homicides with multiple victims has risen sharply (Aronson, 2000). In the past 3 years there have been 10 multiple shootings of students by students, each in a place far removed from the inner city.

Although it is homicide and school shootings that receive widespread attention, numerous acts of violence, intimidation, and hate crimes between boys occur on a daily basis. An Associated Press article dated June 2, 1999, reported that two college preparatory school students, one with an appointment to the naval academy, in Greenwood, Massachusetts, were charged with a hate crime for carving an antigay slur into another student's back because he liked to listen to the British rock band Queen. Jonathan Shapiro, 18, and Matthew Rogers, 20, used a pocketknife to cut "HOMO" into the back of a 17-year-old student at the school. "There was apparently a disagreement over the style of music he liked," said Police Chief David Hastings. "Rogers called it a gay band." Hastings described the wounds as "deep enough to draw blood. When I saw them, they were 3 days old and they were still very visible. The letters were 4- to 5-inches high and ran all the way across his back." The victim, a junior, did not require hospitalization, and initially kept quiet about the May 27 incident. He subsequently left school and returned to his family. Shapiro and Rogers pleaded innocent to charges of assault and battery with a dangerous weapon, assault with intent to maim, and assault with intent to intimidate resulting in bodily harm. The third charge made the incident a hate crime, which would require the suspects to undergo counseling and diversity training if convicted. Each suspect faced a maximum sentence of 25 years in prison if convicted. Rogers had accepted an appointment to the U.S. Naval Academy. "Once we are able to verify the charges we will have to reconsider the appointment," said Karen Myers, an academy spokeswoman.

ETIOLOGY OF VIOLENCE

Miller (1983) believes that violence comes from fear. Boys are made to fear not being aggressive so they will not be less male than their contemporaries, so that they will not be beaten by another male, or (worst of all) so that they will not be like a girl. Each of these constitutes a terrible threat to a core part of men's identity—that part that is called masculinity.

Pollack (1998) writes that "Violence is the most visible and disturbing end result of the process that begins when a boy is pushed into the adult world too early and without sufficient love and support" (p. 338). Young men then become seriously disconnected from their emotions, begin to make their own aggressive facade to protect themselves from further hurt, and learn to express the only acceptable male emotion, which is anger (Pope, 2000). Violence is the final step in a sequence that begins with this emotional disconnection.

Violence may also be a result of feelings and ideas of shame and honor (Betcher & Pollack, 1993). Refusing to fight or not knowing how to fight is considered disgraceful or unmasculine in this view of masculinity. When fathers tell their sons to "not act like a girl," they are trying to shame their sons into accepting these ideas of appropriate male behavior. The expectation is to do whatever is required to protect the young male's honor and to prevent shame. Violence is simply a boy's attempt to stop dishonor and shame by taking the offensive, that is, by hurting another person before they hurt you or when they have hurt you.

Many people believe that such violence in boys is a direct result of testosterone, a male hormone. Pollack (1998) reported that nothing in the research proves this to be true. In his review of this literature, he did come to understand that the behavior of boys is a combination of biological and environmental factors. What biology and heredity are associated with are tendencies for gender-differentiated behavior but only tendencies, not absolutes. Pollack stated that research shows that boys begin their lives with a natural sense of empathy, which is antithetical to violence. Boys as young as 21 months old display a well-developed, natural, "hard-wired" ability to feel empathy, including a wish to help other people who are in pain. Yet by the age of 7 years, boys begin to lose their capacity to express their own emotions and concerns in words as a direct result of a process of "toughening up." This toughening-up process begins when boys begin to feel society's pressure to avoid feelings and behaviors that might bring them shame. This leads to donning a mask of bravado, which contributes directly to violence. The boy has such a phobia of showing his shame that he overcompensates for it by displaying its opposite, which is recklessness, risk-taking, and self-violence.

MASCULINITY AND MALE SEX ROLE STEREOTYPES

Boys are admired by their peers for their physical prowess, intellectual vigor, and adventurous behaviors (Levant, 1992). The boy who can run fastest, kick the ball the farthest, lift the heaviest weight, spar verbally, or successfully cross the street not using the crosswalk receives such admiration. Through socialization, men are taught and ingrained with societal standards, norms, and expectations about gender-specific behavior (Pleck, 1995). This socialization about what it means to be a man begins with the understanding of what it means to be a

boy. One of the major developmental tasks boys must complete is to sort through the multiple and often conflicting messages about maleness and somehow create a personal and coherent male identity (Horne & Kiselica, 1999). This task around gender identity is compounded when cultural and gay conceptualizations of masculinity differ from those of the mainstream culture.

Pollack (1998) formulated the "boy code" as an unwritten set of expectations and guidelines for male behavior. The code is a set of behaviors, rituals, rules of conduct, cultural norms, and lexicon that is inculcated into boys by American society. Boys are held to the boy code standards, and deviation from the code is punishable by being isolated, ostracized, teased, or labeled as gay. Pollack's conceptualization of the boy code is based on the work of Brannon (1976). The four imperatives are (a) no sissy stuff: prohibition of expressing feelings and emotions seen as feminine, (b) the big wheel: strive to defeat others, achieve status by climbing to the top, and always act as if everything is OK, (c) the sturdy oak: never show weakness or pain and have the ability to endure without asking for help, and (d) "give 'em hell," a stance based on a false self of extreme daring, bravado, and attraction to violence.

Addressed: the extent of the violence, etiology of this violence, masculinity and male sex role stereotypes, and what can be done to stop this violence.

The boy code is not a recent addition to gender expectations but essentially is the same code that a boy's father has ingrained and adopted. Although it is true that neither a boy nor his parents have to live by the boy code, it often represents a "gender straightjacket" for a boy's emerging gender role and how parents expect their boy to behave. The boy code, if left unchanged throughout adolescence, can develop into an adult male's blueprint for masculinity.

It is increasingly recognized that the traditional gender role for men has both positive and negative effects (Cournoyer & Mahalik, 1995; Good, Wallace, & Borst, 1994). More traditional masculinity has been associated with characteristics such as the willingness to sacrifice personal needs to provide for dependents and the tendency to think logically and calmly in the face of danger (Levant, 1996), and as fostering psychological well-being as well as positive qualities of self-esteem, assertiveness, confidence, and independence (Bem, 1974; Whitley, 1985). These positive psychological qualities, however, tend to be related to feelings of being masculine, not the adherence to traditional masculine gender norms. Societal prescriptions suggest that men are to behave in a certain manner and that these norms carry the expectation that men be perceived as having these positive qualities (Gilbert & Scher, 1999). The positive feelings associated with masculinity, however, may also be indicative of interpersonal, intrapersonal, and physical difficulties.

Liabilities that have been associated with the male gender role include increased risk taking and self-destructive behaviors (Meth, 1990), stress and anger (Eisler & Skidmore, 1987), and decreased lack of concern for health (Nathanson, 1977). As a result of socialization, men appear to internalize masculine gender ideals that encourage aggressiveness, achievement, and relational and emotional disconnection (Mahalik, 1999). Reviews on the health of men (Eisler & Blalock, 1991; Lemle & Mishkind, 1989) have highlighted the likely contribution of masculinity-related issues to the physical health of men. Moreover, men may not even be aware of the effect that gender role socialization can have or is having on their mental health (Betz & Fitzgerald, 1993; Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996).

Men may additionally be struggling with meeting the expectations of the male gender role. Such conflict or gender role strain may create overwhelming strict gender role expectations that cannot be met. Boys reared in households and family systems that produce gender role strain may internalize inconsistent and disturbing messages about maleness. This can result in a growing number of boys feeling unsure of how they want to define themselves as men, how to relate to women, and how to relate to their peers.

WHAT CAN BE DONE TO STOP THIS VIOLENCE?

Boys who act like girls are labeled quickly by their peers and adults as "sissies" or "gay" and so boys "toughen up," learn how to fight, and adopt society's vision of appropriate male behavior. And yet, some do not. In the following section, many violence prevention methods, including paternal interventions and school interventions composed of examples of affective education programs such as bullyproofing, peer counseling, character education, valuing differences, and multicultural and diversity will be briefly discussed. The interventions outlined here serve as primary preventive messages to curb violence, but also to help parents, school personnel, counselors, psychologists, and anyone involved with boys crack and overcome the boy code.

With the idea of wanting to successfully intervene and overcome the boy code, Pollack (1998) outlined five guidelines to get behind the mask of masculinity and learn to under-

stand and appreciate a boy's deepest feelings and experiences. The starting place is to know the boy code and become sensitive to the early signs of the masking of feelings. When "everything is fine," even though it appears it should not, be in tune with the boy-code dictates of hiding feelings and not appearing to need help. Second, learn new ways to talk to boys so they do not feel ashamed or afraid to share their own feelings. Instead of colluding with language that activates the defenses of the boy code ("You're not hurt, are you?"), look to join with boys with less intimidating language ("What is going on—can you tell me?"). Third, learn how to accept a boy's own emotional schedule and do not force it along. Boys are not girls and they do not express themselves in the same manner. Give boys the time they need and recognize in their words and actions the signals that they are ready. The fourth step involves connecting with boys through action. Connections with boys are formed when they are doing something and not when they are forced to communicate. Activities will naturally lead to a connection that enables a boy to open up. Finally, and potentially most important for men working with boys, men can help boys take off their masks by telling stories and experiences that model the removal of the mask. By showing a boy that other men and boys have felt scared, embarrassed, and sad, a boy can begin to feel less ashamed to let down of his own vulnerable feelings.

Paternal interventions. Fathers can have an essential role in violence prevention with their sons. First, fathers can role model a diversity of male behaviors rather than only gender stereotypic behavior (Miedzian, 1991). Breaking gender stereotypes is not as easy as it sounds, as it requires a father to look inward and observe, report, and express his feelings. For men trapped by their masculine gender role, this can mean confronting their own masks of masculinity. Even when many fathers talk about abhorring violence and aggression, by the time a boy is 3 or 4 years old, he will have begun to notice the incongruity between what his father says and what he actually does. Thus, fathers must model what they expect from their sons.

Second, fathers can develop a "violence-free time" where sons can remove the mask of bravado and speak openly about fighting and violence without fear of being shamed, belittled, or retaliated against. It is important to note that this time may be different for each boy, as each has unique needs. The basic understanding is that a parent needs to be ready to listen when a boy is ready to talk. Whereas parents should not force a boy's schedule, a father can continue to offer invitations for time to talk. For example, even if it is 10 minutes past bedtime, it may be more important to have the father-son conversation than for the boy to sleep (especially when a boy is unable to sleep because of the problems he is experiencing). Developing these new rituals is important to boys. One example might be having both parents tuck him in bed and tell each other one good thing and one difficult thing about your day. This is an important way of preparing your son for adulthood as he learns what it takes to realistically survive every day at work and at family (Jain, Belsky, & Crnic, 1996).

Third, fathers can help to support a son's innate ability to empathize with others. Instead of expressing only anger, fathers can engage their sons in a dialogue, helping them to understand why the others behave the way they do. Empathy education centered around identifying both internal feelings and the feelings of others is a way to facilitate this process. Inviting the son to take the perspective of the other person tends to create empathy and understanding. This helps the son begin to feel less shame about his own vulnerabilities while understanding the emotional experiences of others (Snarey, 1993).

Fourth, this intervention involves targeting the relationship between fathers and sons. Based on successful mother-daughter groups (Englar-Carlson, 2001), father-son groups are designed to bring fathers and sons together to appreciate each other and learn a common language in which to communicate. Such groups can be boy focused, building on the realities of boys today. Fathers can then begin to understand how the boy code is relevant in today's schools and fathers can be tuned in to the issues and problems boys face today.

Finally, parents can talk with their sons about violence in the media. Pollack (1998) issued these guidelines to deal with the chronic problem of violence in the media: (a) Discuss the issue so that your son knows why you think that the viewing of violence is such a problem, (b) restrict and monitor the time, amount, or type of programs that your son watches, (c) watch together the programs that your sons watch so that you will be informed of the content, (d) talk about what you've seen after the show is over, and (e) make better selections that show sons as connected and caring people, not simply violent, angry boys. When looking at television, do not exclude sporting events from discussions about violence. Sporting events can contain some of the most violent and aggressive viewing, but sporting events can also provide opportunities to explore teamwork, sportsmanship, and male bonding.

School interventions. Schools have an important role in the prevention of violence as well as in the maintenance of the boy code (Pope, 2000). Shootings and other acts of violence in schools have increased interest and demands to develop ways to identify youth who may be at risk for committing violence at schools. Often this has translated into oppressive practices such as profiling and labeling of students and punitive, rigid, zero tolerance school policies that are set well beyond a reasonable standard for discipline. These attempts, although often good intentioned, are often knee-jerk reactions based in fear and have the propensity to stray away from the original agenda of protecting students (Spivak & Prothrow-Stith, 2001). The risk with such practices is that children are being negatively labeled for behaviors that have not been shown to reflect risk, and many students are

becoming further isolated from their peers for interests that appear different or fringe (e.g., wearing black clothes, listening to heavy metal music). Although these practices are good intentioned, these solutions that they offer may not address core issues. Aronson (2000) suggested that the recent perpetrators of school violence and homicide were reacting in an extreme and pathological manner to the widespread and common general atmosphere of exclusion, taunting, and bullying. This is an atmosphere pervasive in most schools that children find unpleasant, difficult, and humiliating.

Aronson (2000) outlined comprehensive schoolwide solutions based on research in social psychology. The core of his philosophy is reducing competition in the classroom environment and building cooperation in academics by reducing pressure to separate children into winners and losers. He additionally highlights the importance of teaching empathy as curriculum by furthering teaching and focused emphasis on emotional intelligence. Emotional intelligence is viewed as a person's ability to be aware of and control emotions. It involves the development of self-restraint and compassion in dealing with others, essentially the ability to motivate oneself to work with passion and persistence (Goldman, 1995). Pollack (1998) suggested that parents, schools, and society actually train boys out of their natural emotional or affective intelligence. The development of emotional or affective intelligence is often a duty delegated to school counselors and seldom viewed as equivalent in important to intellectual or cognitive intelligence.

Of the many programs initiated to address violence, almost all fall under the category of affective education. Changing the school culture is imperative to this process of stopping school violence. Each school worker has a role in solving this problem including administrators, teachers, counselors, and cafeteria, maintenance, and transportation workers. School workers need tools to combat this violence that will enable them to at least promote an environment of tolerance or, preferably, to promote an environment of appreciating and valuing all students and all diversities. Just being a sympathetic teacher is not enough; school counselors and teachers needed newer and more knowledge and skills to discuss and teach antiviolence curricula. Affective education incorporates cooperation and reduced competition among peers with a focus on encouraging empathy, understanding, and respect.

Affective education. What connects school violence and father/son relationships is reported in the May 3, 1999 article ("Why? There were plenty of warnings") and cover story in *U.S. News and World Report*: "Surely it is a rare and complicated convergence of factors. Still, experts see some common threads in the spate of shootings: These adolescent boys can't manage their emotions. They feel rejected, enraged, jealous" (p. 19). They were boys who never learned how to identify, accept, and cope with their feelings. Their fathers, their schools, and their communities never taught them.

Boys are not taught how to handle feelings, not by their fathers nor by schools (Pollack, 1998). Pope (1998) stated that elementary and secondary schools do an acceptable job of cognitive or intellectual education, excellent on information and okay on critical thinking, but most schools get an F when it comes to affective education. This is not what is being termed *moral education* or *character education*, it is affective education, psychological education, or psychoaffective education. Teaching these important affective skills such as interpersonal, social, and psychological skills is rarely included in any school curriculum even though such pioneers as Sprinthall (1984) have written about "deliberate psychological education" for many years.

The deliberate psychoaffective education of our children must become a priority or we will continue to see even more school killings by young people who feel they have no hope, no place to turn, no one to talk with, no one who listens, and who have no perspective on life (Pope, 1998). Many children feel that any little personal rejection or emotional hurt encountered is a tragedy from which they can never recover. Primarily in touch with feelings of hurt and emotional pain and having no other interpersonal skills to cope with these overwhelming feelings, some children blast away and explode, taking out those who they feel have caused them that pain. Many times those injured are innocent bystanders, but it is directed at the institution they know best, their school. Many children have seen their parents take their rage to their workplace, as that is their primary institutional focus; children mirror their parents and take their rage to their schools. In the Jonesboro, Arkansas massacre of 10 students and a teacher by two 11- and 13-year-old boys with semiautomatic weapons, many of their classmates now tell how the boys had talked about doing this for a while. What caused this? According to news reports, one of the boys was "enraged" over having been "dumped by his girlfriend."

Pope (1998) reported that many people and our school systems undervalue psychoaffective education. Although the schools cannot cure all the ills of our society, education is more than information and even more than critical thinking. It is also about understanding the people that children are and how children express love and caring during a developmental period (school age) when these questions are numerous and confusing. Not enough attention is given to these issues in our schools. Truly comprehensive education must focus on the heart and the mind, not just the cognitive part. The current culture of violence and lack of empathy can be viewed as the effect of the omission of affective education from our schools.

School counselors are important to the total care and education of our students from elementary school through high school (Pope, 1998). School counselors are often given the task of providing affective education, but they can also be the school personnel to fight for the inclusion of affective education in the curriculum. The following six types of school

counselor activities are examples of affective education in the school: programs such as bullyproofing, peer counseling, character education, valuing diversity, and multicultural/ diversity issues. These interventions are in conjunction with providing mental health counseling, career counseling, and consultation to parents and school staff about mental health issues.

Bullyproofing. At schools around the United States, bullyproofing programs are being established. Spivak and Prothrow-Stith (2001) suggest that an emphasis on bullying must accompany any serious violence prevention attempts. Such programs start by having the students define what a bully is and how a bully behaves. Next they learn what makes the victim of bullying attractive to the perpetrator—lack of self-esteem. Students are then taught what to do when a bully approaches them.

Peer counseling. Other schools have taken the peer counseling approach and have involved their students in a voluntary, extracurricular educational program to develop the students' communication and paraprofessional peer counseling skills. Such programs begin with basic listening and responding skills and teach a language for talking about feelings.

Character education. Character education is a movement to teach values, an aspect of affective education. Such programs use values exercises to help students explore what they might do in a specific situation. Violent situations are prominent in character education curricula as they present common yet traumatic situations that are realistic for many students.

Valuing differences. The respecting, appreciating, and valuing of differences is essential to stopping violence.

> Teachers, counselors, administrators, and parents need to be more outspoken in their desire to teach their children about developing positive self-esteem and greater acceptance of differences. Although most individuals would agree with this on a case-by-case basis, everyone seems to have his or her area of difficulty in the acceptance of diversity. (Besner & Spungin, 1995, p. 36)

Because there is this difficulty, inclusive diversity training workshops have been developed. *Inclusive* is used here to mean that diversity is inclusive of ethnic and racial minorities as well as sexual minorities (Pope, 1995). An excellent tool in teaching individuals to appreciate and value human differences is the Myers-Briggs Type Indicator (MBTI), a Jungian personality inventory. One of the most important outcomes of using the MBTI is to teach the importance of the individual's opposite personality traits. For example, although your personality preference may be for extraversion and others for introversion, there is no inherent hierarchy in which one is better than the other, in fact, both are required for successful functioning in the world (Myers & McCaulley, 1985).

Multiculturalism and diversity. Other tools are available for teaching multicultural and diversity lessons, including GLSEN's "Teaching Respect for All" and Besner and Spungin's (1995) model workshop for educators on homophobia in their Appendix B (pp. 133-153). The National Coalition Building Institute, B'nai B'rith, and the American Friends Service Committee all offer excellent workshops on these topics and more (Owens, 1998).

In terms of the school curriculum, it is important to integrate and infuse other nondominant cultural examples into all courses where appropriate. For example, when discussing U.S. history and the role of Native Americans, it would be appropriate to mention the revered position of *winktes* and *berdaches* (Native American terms for gay, lesbian, bisexual, or transgendered persons) in the spiritual life of American Indians as the shaman or medicine person of the tribe, as well as the many examples of female warriors and chiefs (Katz, 1976; Pope, Portman, & Garrett, in press; Roscoe, 1988). After reading "The Picnic," a story by James Baldwin, an African American author, teachers can discuss Baldwin's gay orientation and the results of having a double oppression (gay and African American). By demonstrating an accepting attitude, school workers can send a strong message to students and create a tolerant environment within the entire school. It is especially relevant to incorporate issues of sexual orientation into these discussions because so much of the anger and violence is directed, especially verbally, toward gays and lesbians or anyone perceived to be gay or lesbian or toward "unmasculine" behavior for boys that their peers attribute to gay men. Breaking down such gender role stereotypes and showing sensitivity to gay and lesbian issues is extremely important in creating such a tolerant environment. These issues of tolerance, acceptance, and value can be explored under the umbrella of diversity.

CONCLUSIONS

The prevention for violence is found in reconnection to friends, family, and community. It is also found in an appreciation for boys and the struggles that accompany an allegiance to the boy code. Since young males in our society perpetrate the most violence, sons and their fathers have been a special focus of this article. The following issues were addressed: the extent of the violence, etiology of this violence, masculinity and male gender role stereotypes, and what can be done to stop this violence, including interventions that include peer interventions, paternal interventions, and school interventions composed of examples of affective education programs such as bullyproofing, peer counseling, character education, valuing differences, and multicultural and diversity.

Young men who have been pushed into the adult world too early and without sufficient nurturing become seriously dis-

connected from their emotions, begin to make their own aggressive facade to protect themselves from further hurt, and learn to express the only acceptable male emotion, which is anger (Pope, 2000). Violence is the final step in a sequence that begins with this emotional disconnection (Pollack, 1998). The role of fathers, schools, and society must be to reconnect the sons to each institution, to teach them how to handle these emotions that are flooding them during adolescence. Affective education, both by fathers and schools, is the foundation to preventing this epidemic of violence.

REFERENCES

Allport, G. W. (1958). *The nature of prejudice*. Garden City, NY: Doubleday Anchor Books.

Anti-gay slur carved on student. The Associated Press (1999, June 2).

Aronson, E. (2000). *Nobody left to hate*. New York: Freeman.

Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology*, *42*, 155-162.

Besner, H. F., & Spungin, C. I. (1995). *Gay & lesbian students: Understanding their needs*. Washington, DC: Taylor & Francis.

Betcher, R. W., & Pollack, W. S. (1993). *In a time of fallen heroes: The re-creation of masculinity.* New York: Athaneum.

Betz, N. E., & Fitzgerald, L. F. (1993). Individuality and diversity: Theory and research in counseling psychology. *Annual Review of Psychology*, *44*, 343-381.

Beymer, L. (1995). *Meeting the guidance and counseling needs of boys*. Alexandria, VA: American Counseling Association.

Brannon, (1994).

Brown, S. (1991). *Counseling victims of violence*. Alexandria, VA: American Counseling Association.

CNN Morning Live (1999, April 22). *Columbine High School female student interviewed on the two shooters in Littleton, Colorado*.

Cournoyer, R. J., & Mahalik, J. R. (1995). Cross-sectional study of gender role conflict examining college-aged and middle-aged men. *Journal of Counseling Psychology*, *42*, 11-19.

Eisler, R. M., & Blalock, J. A. (1991). Masculine gender role stress: Implications for the assessment of men. *Clinical Psychology Review*, *11*, 45-60.

Eisler, R. M., & Skidmore, J. R. (1987). Masculine gender role stress: Scale development and component factors in appraisal of stressful situations. *Behavior Modification*, *11*, 123-126.

Elliott, L., & Brantley, C. (1997). *Sex on campus: The naked truth about the real sex lives of college students*. New York: Random House.

Englar-Carlson, J. M. (2001). *Insights from a mother-daughter group*. Manuscript in preparation.

Evans, G. D., & Ray, J. (2001). In the echoes of gunfire: Practicing psychologists' responses to school violence. *Professional Psychology: Research and Practice*, *32*, 157-164.

Gilbert, L. A., & Scher, M. (1999). *Gender and sex in counseling and psychotherapy.* Boston: Allyn & Bacon.

Gilligan, J. (1996). *Violence: Our deadly epidemic and its causes*. New York: Putnam.

Goldman, D. (1995). *Emotional intelligence*. New York: Bantam Doubleday Dell.

Good, G. E., Robertson, J. M., Fitzgerald, L. F., Stevens, M., & Bartels, K. M. (1996). The relation between masculine role conflict and psychological distress in male university counseling center clients. *Journal of Counseling and Development*, *75*, 44-49.

Good, G. E., Wallace, D. L., & Borst, T. S. (1994). Masculinity research: A review and critique. *Applied and Preventive Psychology*, *3*, 3-14.

Herdt, G., & Boxer, A. (1996). *Children of horizons: How gay and lesbian teens are leading a new way out of the closet* (2nd ed.). New York: Beacon Press.

Horne, A. M., & Kiselica, M. S. (1999). *Handbook of counseling boys and adolescent males*. Thousand Oaks, CA: Sage.

Jain, A., Belsky, J., & Crnic, K. (1996). Beyond fathering behaviors: Types of dads. *Journal of Family Psychology*, *10*, 431-442.

Lemle, E., & Mishkind, M. E. (1989). Alcohol and masculinity. *Journal of Substance Abuse Treatment*, *6*, 213-222.

Levant, R. F. (1992). Toward the reconstruction of masculinity. *Journal of Family Psychology*, *5*, 379-402.

Levant, R. (1996). Masculinity reconsidered. *Independent Practitioner*, *16*, 36-39.

Mahalik, J. R. (1999). Incorporating a gender role strain perspective in assessing and treating men's cognitive distortions. *Professional Psychology: Research and Practice*, *30*, 333-340.

Meth, R. L. (1990). The road to masculinity. In R. L. Meth & R. S. Pasick (Eds.), *Men in therapy: The challenge of change* (pp. 3-34). New York: Guilford Press.

Miedzian, M. (1991). *Boys will be boys: Breaking the link between masculinity and violence*. New York: Anchor Books.

Myers, I. B., & McCaulley, M. (1985). *Manual to the development of the Myers-Briggs Type Indicator.* Palo Alto, CA: Consulting Psychologists Press.

Nathanson, C. A. (1977). Sex roles as variables in preventive health behavior. *Journal of Community Health*, *3*, 142-155.

Owens, R. E. (1998). *Queer kids: The challenges and promise for lesbian, gay, and bisexual youth*. New York: Harrington Park Press.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *The new psychology of men* (pp. 11-32). New York: Basic Books.

Pollack, W. (1998). *Real boys: Rescuing our sons from the myths of boyhood*. New York: Random House.

Pope, M. (1995). The "salad bowl" is big enough for us all: An argument for the inclusion of lesbians and gays in any definition of multiculturalism. *Journal of Counseling & Development*, *73*, 301-304.

Pope, M. (1998, March 25). School counselors and whole person education. *The Education Forum* [Online Listserv].

Pope, M. (2000). Preventing school violence aimed at gay, lesbian, bisexual, and transgender youth. In D. S. Sandhu & C. B. Aspy (Eds.), *Violence in American schools: A practical guide for counselors* (pp. 285-304). Alexandria, VA: American Counseling Association.

Pope, M., Portman, T. A., & Garrett, M. T. (in press). Gender roles, sexuality, and sexual orientation among the Cherokee. *Journal of Multicultural Counseling and Development*.

Roscoe, W. (1988). Strange country this: Images of berdaches and warrior women. In W. Roscoe (Ed.), *Living the spirit* (pp. 48-76). New York: St. Martin's Press.

Schnieders, H. L., Pope, M., & Hickman, E. (in press). The critical role of affective education in preventing school violence. *Journal of Counseling & Development*.

Sells, C. W., & Blum, R. W. (1996). Morbidity and mortality among U.S. adolescents: An overview of data and trends. *American Journal of Public Health*, *278*, 823-832.

Snarey, J. (1993). *How fathers care for the next generation: A four-decade study.* Cambridge, MA: Harvard University Press.

Spivak, H., & Prothrow-Stith, D. P. (2001). The need to address bullying—an important component of violence prevention. *Journal of the American Medical Association*, *285*, 2131-2132.

Sprinthall, N. A. (1984). Primary prevention: A road paved with a plethora of promises and procrastinations. *Personnel & Guidance Journal*, *62*, 491-495.

Sullivan, R. (1998, September 17). A boy's life: Death in the schoolyard (Part 1). *Rolling Stone*, pp. 76-85, 106-107.

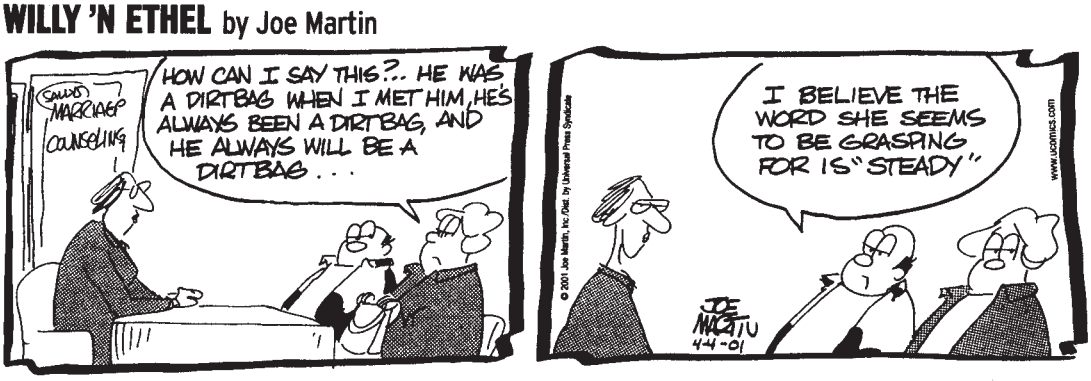
Whitley, B. E. (1985). Sex role orientation and psychological well-being: Two meta-analyses. *Sex Roles*, *12*, 207-225.

Why? There were plenty of warnings, but no one stopped two twisted teens. (1999, May 3). *U. S. News & World Report*, p. 19.

Wilkinson, P., & Hendrickson, M. (1999, June 10). Humiliation and revenge: The story of Reb and VoDkA. *Rolling Stone*, pp. 49-54, 140-141.

Mark Pope *is an associate professor in the Division of Counseling at the University of Missouri–St. Louis.*

Matt Englar-Carlson *is an assistant professor in the Department of Counselor Education at the University of Washington–Seattle.*



Children as Participants in Family Therapy: Practice, Research, and Theoretical Concerns

Lynn D. Miller
Elissa McLeod
University of British Columbia

The inclusion of children in family therapy is an issue that has been largely overlooked in the research literature. Although many of the founders of family systems approaches espouse the inclusion of children in therapy, today family systems therapists are often not working with the entire family. In practice, family counselors more often than not exclude children or include them when convenient or by default. Reasons for this dichotomy are explored and implications for practice and training are discussed. An inventory of questions for professionals to consider including children in their own practice is offered.

Family therapy practitioners and family therapy researchers have not arrived, as a field, at answers to questions about how, if, and when to involve children in family counseling sessions (Stith, Rosen, McCollum, Coleman, & Herman, 1996). The practice of intentionally including or excluding children in therapy appears absent in training programs, in the literature, and at professional educational conferences. Often, family therapy (practice and research) has ignored children altogether, has focused on the adult couple relationship, or has included children in a peripheral way that can be described as "not seeing the children at all" (Diller, 1991, p. 23). Ignoring the importance of the decision to include children or not in therapy is surprising, as the literature discusses the importance and preference of including all family members in therapy (Ackerman, 1970; Diller, 1991; Rober, 1998).

Contrary to what the early system theorists advocated, family therapists currently tend not to include children in sessions. Family counseling more often than not means, for practitioners, counseling individual adults regarding family issues. In a large, randomized study conducted by the Research and Educational Foundation for the American Association for Marriage and Family Therapy (AAMFT), AAMFT participants claimed families formed only 12% of their caseload; the remaining caseload divided as 49% individuals, 23% couples, and 15% combination (Doherty & Simmons, 1996). Korner and Brown (1990) report that in the United States, 40% of family therapists never included children in their therapies, and that 31% of family therapists invited children to the session without really including them. The theoretical notion of having the central focus of counseling be the system, context, or family stands in contrast to the practice of marriage and family counseling in which the majority of the work is done with individuals. Although there is variation in family systems approaches, the founders of systems theory generally believed that a relationship perspective, which looks at how the family communicates, is the best way to understand, intervene, and help change individual behavior. Yet the majority of family practitioners work from an individual perspective.

Children are in need of counseling, as child distress is ubiquitous: Estimates of children who suffer from serious emotional disorders range from 12% to 20%, but less than a third receive help (Benard, 1991; Estrada & Pinsof, 1995; Illback, 1994; Kauffman, 1993; National School Boards Association & American School Counselors Association, 1994). That makes more than two thirds of children who would qualify for help for mental disorders unlikely to receive treatment. Clearly, these children affect the home environment, and those receiving no services presumably have a more deleterious effect. Whether the children's rate of mental distress is in response to marital or home distress or whether the marital distress is in response to the child's behavior is unclear. However, the impact of the circular and reciprocal pattern of stress can be overwhelming for families.

Why don't schools, the most readily accessible venue for intervention with children, provide mental health services? They do—to the extent that manpower, training, and resources are available. Teachers, school social workers, school counselors, and school psychologists work with the student in the school setting in a largely individual approach: The child is called out of class for tests, guidance, checking into case management, and so forth. Indeed, for those chil-

Authors' Note: All inquiries regarding this article should be addressed to Lynn Miller at lynn.miller@ubc.ca.

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dren who are already receiving psychological attention, state and federal laws regulate family contact at minimal intervals. For other students (the two thirds of the population who would qualify for help for mental disorders but do not receive it), the contact with families is less frequent or nonexistent. Schools currently have limited interaction with families, for example, parent-teacher conferences. These limited contacts have limited effects. To have broader, more permanent impact, the family must be involved at every possible juncture. The marriage and family counselor clearly should be at this crossroads.

On one hand, childhood distress and parent involvement appear intricately related. When schools work with children, it is primarily with students but not their families. On the other side of the system, marriage and family practitioners are working largely with adult couples or individuals more often than with families and their children. Systems theory advocates for working with the family system as opposed to exclusively individual intervention. Individual intervention is the focus in today's family counselor's office. Why does this occur? Is this the best practice for helping families with their troubles? Other salient questions beg to be answered: Should family counseling ever include children? When? Would families benefit more from including or excluding children? Are certain presenting problems more appropriate for full family participation? Are certain problems better treated in a couples' format or in individual treatment? Are therapists knowingly excluding children due to session focus, or are they excluding children by "default?" Is it even important, advisable, or effective to work with children and their families in a therapeutic setting? What are the barriers to working with children? What are the benefits? To address these questions, a brief history of both systems theory and school counseling will be reviewed to develop a better understanding of the evolution of our practice. Following this, an inventory of questions for the family counselor is offered to help scrutinize one's own practice in a systemic context.

The inclusion of children may offer a spontaneous, honest, and unique way to open up new alternatives for families in therapy.

ATTENTION TO THE ROLE OF CHILDREN IN SYSTEMS THEORY

The founders of family systems theories such as Ackerman, Satir, Whitaker, and Minuchin (Zilbach, 1986) strongly advocated including children in therapy. In the late 1960s, John Bell suggested a series of stages in family counseling beginning with the child-centered stage followed by the parent-centered stage and finally the family-centered stage. This approach tended to include children and assume a more equal role. Each of these theoretical schools offers a unique style of working with families by maintaining clear *theoretical* stances. Discussions of change, maladaptive patterns, feedback loops, consequences of communication, and a host of other characteristics of family therapy are scrutinized but little is revealed about what to do with children and when to include them as participants in *practice*. In a case study by Whitaker of a mother who felt it would be "criminal to bring the little children in," he stated his position clearly by asking if she wanted to cancel the appointment (Haley & Hoffman, 1967, p. 267). Whitaker clearly supported the inclusion of children in therapy by offering appointments only when the children were present. Ackerman (1970) felt that without engaging the children in a meaningful interchange across the generations, there could be no family therapy.

What the literature and theory define and what happens practically is often divergent. Nichols and Schwartz (1998) admit that in practice, most "family therapists think in terms of units of one, two or three persons" (p. 455), including psychoeducational therapists, narrative therapists, psychoanalytic therapists, and child behavior therapists. Family theorist and practitioner Bowen involved only two family members (usually the husband and wife), often casting himself as the neutral third member in a "therapeutic triangle" (Nichols & Schwartz, 1998, p. 46). They argue that the advantage of thinking in triadic terms (enmeshment or disengagement between two people is almost always a function of reciprocal relationships with a third) permits a more complete understanding of the family interaction. They support thinking triadically even if the people are not in the session (an oblique way of including children). This is a reductionist view of the systems concept of wholeness, or that every part of the system is interrelated; if change affects one part of the system, the other parts of the system are also changed.

The feminist family therapists have added to the debate, criticizing cybernetic concepts such as "circular causality" that imply that each member of the family has equal power and control. The power equality is probably far from typical. The feminist therapists have drawn attention to the power differential in couples, which describes the woman in a less dominant or less powerful stance. One can presume that children probably hold even less power, making the concept of

circular causality less relevant to children's voices. But there is no word from the feminist family therapist camp on what to do with children in these positions of lesser power in the unequal family system.

A BRIEF HISTORY OF CHILD COUNSELING

In the early 1950s, John Bowlby (1969), responsible largely for present-day attachment theory, grew frustrated in his psychoanalysis with individual children. He decided to bring in the parents for one session but saw these useful family sessions as an adjunct to individual therapy. At that time child guidance clinics were operating on the premise that treating emotional illness in childhood was the best approach to truncating mental illness in adults. It was child guidance clinicians who concluded that the presenting problem exhibited by the child was more often a reflection of tensions in the family.

Much research ensued (Nichols & Schwartz, 1998, chap. 2), as in the 1950s family counseling was a growing approach receiving professional attention from the entire field of counseling and therapy. Research was more often conducted in clinical settings with inpatients, and at this time a popular research pool for family therapy was families within whom a member was diagnosed with schizophrenia. Gradually, other family members (most often the mother) were no longer being blamed for a client's problem but simply regarded as being part of a system that clearly experienced disturbance. This shift, from viewing a child either as characterologically disturbed or parents as toxic influences, to one where the system or interaction among family relationships is flawed has obvious implications for seeing children with their family in counseling settings. As Nichols and Schwartz (1998) succinctly state, "Instead of trying—in vain—to separate children from their families, child guidance workers began to help families support their children" (p. 24).

At the same time, guidance counselors were funded for school positions (Schmidt, 1999). This training and these positions, however, were not focused on personal counseling but on preparation for higher education and career selection. Although school counselors currently counsel children regarding personal problems, extraordinary caseloads and overwhelming administrative duties prohibit much individual care (Weist, 1997). Thus, the personal needs of children continue to be overlooked, except in the case of exceptional mental disturbance.

Should Family Counseling Include Children?

Proponents of including children in family therapy have emphasized the importance of research by drawing attention to the gap in the literature on this issue. Perhaps the greatest limitation on supporting the inclusion of children in family therapy is the lack of empirical evidence to support its efficacy. Emerging data concern only how the decision regarding participation is made, focusing on the therapist's role in deciding who should be included in therapy. If therapists have not examined their own values and views on working with children, the likelihood of exclusion continues. By examining how and why a therapist makes the choice of with whom to work, we can begin to look at the factors that may differentiate therapy that includes children from therapy that does not. It may also be useful to have a more intentional approach to working with families and a greater awareness of session participation. Our research base is sparse concerning how, if, and when to include various members of family systems.

Childhood behavior problems are worsening. Achenbach and Howell, in 1993, concluded from their empirical investigations that there are small but pervasive increases in the number of problems exhibited by children and decreases in child competency. A clear finding is that current societal concerns are increasingly manifested by today's youth, and the family is a critical component in prevention and intervention in childhood and adolescent problems. Looking at environmental influences, numerous studies support the finding that psychosocial adjustment of children is directly related to parenting style and communication (Patterson, 1986; Rapee, 1997; Steinberg, 1987). For example, adolescents who regularly engage in at-risk behavior are more likely to come from families with ineffective parenting styles. Likewise, children from homes of positive and democratic parenting styles are likely to be better adjusted and, therefore, successful. If childhood difficulties are on the increase and the home environment can be linked to childhood adjustment, then by systemic extension families are affected in greater numbers by instability. Family counselors should be dealing with these issues, as communication between members is the cornerstone of all systemic theory.

EVIDENCE OF NEED

What are the most pervasive mental disorders in children? Surprisingly, many may erroneously guess it is ADHD (attention deficit hyperactivity disorder). ADHD enjoys a high profile in the press and demands attention from educators for behavioral disturbance despite a prevalence rate of 3% to 5%. Ironically, the two largest categories of childhood mental disturbance in the regular education population (special education students suffer from even higher rates of mental disturbance) are often overlooked precisely because the behavioral difficulties associated with them are more manageable: anxiety and depression. The childhood lifetime prevalence rate of anxiety is 10% to 22% (Dadds, Spence, Holland, Barrett, & Laurens, 1997; Muris, Merckelbach, Mayer, & Prins, 2000) and for depression the rate of prevalence is 2% to 17%, diagnosed with increasing frequency as a child ages (Dubuque, 1998). Given the familial nature of many anxiety and mood disorders, questions emerge about the potential adverse

impact on the behavioral and affective status of children raised by parents with these disorders. Although a couple or individual in family counseling may work on adult issues, the children may not be included because the anxiety or depression suffered by the parent seduces the adults (both the parent and the therapist) into thinking that the children's problems are not as significant or as pressing. They may also overlook the familiar signs of common symptoms evidenced by their children.

Untreated depression and anxiety can have significant deleterious psychosocial effects during adolescence and may lead to poor functioning during young adulthood. These effects can include more severe depressive episodes, substance abuse, lower rates of college completion, lower income levels, and more likely instances of becoming an unwed parent of a child (Lewinsohn & Clarke, 1999). Of course, the worst outcome for untreated depression is suicide. Suicide is the third leading cause of death among 15 to 24 year olds (Canada and the United States) and is thought to be on the increase (National Center for Health Statistics, 1998). Obviously, the less-than-optimum functioning of the child comes back to the family home in the form of increased stress.

To further complicate matters, issues confronting children and families are complex and often interrelated; rarely does a family suffer from one problem in isolation from other problems (Kahne & Kelley, 1993). For instance, a child exhibiting poor academic performance at school often returns to a home characterized by violence, substance abuse, or the confounding effects of poverty. A response to one need may not negate other remaining problems. It is critical to understand that children who fail in the education system often experience difficulties in other areas of their lives (Soler & Shauffer, 1993). For those students who do fail academically, the risks of dropping out of school before attaining a high school diploma are associated with higher rates of unemployment; lower earning potential; greater incidence of medical, psychological, and emotional problems; crime; drug abuse; and violence (Post, 1999). If school success is the barometer we use to judge wellness in children, then why don't we try to influence school variables? Good and Brophy (1986) claim that school curriculum, socioeconomic grouping, individual class size, and physical facilities are less associated with pupil progress than the primary influence, which is the family environment.

WHY FAMILY COUNSELING IS IMPORTANT BOTH FOR CHILDREN AND PARENTS

"Counseling and education for parents and their children can alleviate stress, improve self-concept, and reduce social/behavioral problems" (Kale & Landreth, 1999). Parenting is stressful. When a child experiences more difficulties than other children, the parenting tasks and stressors are exacerbated. Gerald Patterson, a leading authority of parent training as well as childhood emotional and behavioral disturbances, claims that conduct problems "in children and adolescents [are] a behavioral problem, not a mental health problem. The causes lie in the social environment, not in the minds of the youngsters" (Forgatch & Patterson, 1998, p. 85). While many parents shake their heads in confusion about their child and ask, "What in the world is wrong with this kid?" perhaps the more reasonable question should be, "What in the world is affecting my child so profoundly that he [she] is acting this way?" Systems theory hypothesizes that the child is often reacting to the environment and (inadvertently or unknowingly) bearing or manifesting the "symptom" of this stress or dysfunction for the family. As the child's behavior escalates, the circular nature of family systems theory can be easily understood as the family, in turn, experiences the stress of the child's increasingly problematic behavior. This spiraling negative energy continues to fuel both the child's response and the family's stress until something dramatic happens. When families are treated in their entirety, limited success may be claimed.

What Family Therapy Studies Find

There exists a chasm of work priorities between researchers and clinicians. Clinicians are notorious for staggering workloads and little time for formal research. Clinicians seem to have a preference for working with people and less interest in conducting empirical studies. The limited studies that have been conducted have discovered support for working with children and their families, although caution is suggested in interpreting the results. This research suffers from methodological limitations, lack of effect size, unclear implications for cost benefit, and a limited number of robust studies. Having stated these cautions, and looking specifically at family therapy with children, one finds nonbehavioral and behavioral approaches are preferable to no treatment at all, or in 67% of cases (Goldenberg & Goldenberg, 2000; Thompson & Rudolph, 1996). Family therapy interventions are more effective than out-of-home placements in 50% of cases. Significant cost benefits can be associated with family therapy more than with out-of-home placements (Thompson & Rudolph, 1996). Preliminary findings are that family therapy is better than no treatment at all, is preferable to out-of-home placement, and is more cost-efficient than an out-of-home placement.

Family therapy specifically with children exhibiting school problems finds that parent management training (PMT) has shown positive results in reducing targeted behavior problems at home and at school, including up to 14 years later (Nichols & Schwartz, 1998). Parent training combined with individual cognitive therapy for the child has been shown to reduce simple phobias, particularly school avoidance (Nichols & Schwartz, 1998). Psychosocial interventions for child and adolescent anxiety disorders are effective (Kendall & Southam-Gerow, 1996) and enjoy even greater rates of maintenance of improved behavior when family

intervention groups are employed (Barrett, Dadds, & Rapee, 1996). Parents are clearly integral to successful therapeutic outcomes of children.

The systems expert, the family counselor, is trained to understand these phenomena and should be able to intervene. And yet, when they do intervene, the majority of the work is done with only part of the system, the parental subsystem. Why does this happen? The following topics need to be considered by practitioners, educators, researchers, and students for future direction of the field on this salient question of children and counseling session participation.

Considerations for Including Children: Counselor Comfort Level

In a recent study by Johnson and Thomas (1999), therapists' criteria for including children in therapy were examined. The results indicated that many family therapists base their decision about the inclusion of children in sessions on personal comfort level and preference. One of the discriminating factors of this personal choice was whether the child in question was considered to have internalizing (e.g., depression or anxiety) or externalizing (conduct problems, behavioral maladaptations) symptoms. A child was more likely to be included if the behaviors were internalizing.

When considering the finding that personal comfort level and preference are a main determinant in whether therapists include children in therapy, a number of questions emerge. A campaign to include children in therapy needs to look at the variables of this comfort level and preference. Possible routes of investigation could be whether therapists have had sufficient training to work in a family setting. Training practice should include opportunities to conduct supervised family sessions with parents and children of varying ages and of varying problem difficulties. A thorough understanding of child and adolescent development is critical. A therapist's willingness to work with families may increase if the appropriate knowledge base has been developed (Korner & Brown, 1990).

Therapists tended to include children more often when they were working with a single-parent household as opposed to a two-parent household. The researchers hypothesize that when working with single-parent families, having to arrange child care or having a lower income (and thus a reduced ability to pay for child care) results in the children's inclusion or exclusion in the therapy. This speaks to including children as a default mechanism rather than intentionally including children: Single parents are seen with their children in counseling when child care is cost-prohibitive. Another hypothesis is that single parents may more often recognize and feel they need support or intervention with raising children without a partner (Johnson & Thomas, 1999). Whatever the reason, it seems ironic that therapists will see adults and their children more often when the adult fails to have a partner. Is a single-parent household more often considered a system than a couple and their children? Or will counselors treat families if by definition a family is made up of two people, two adults or one adult and one child?

Another important component of therapist comfort level for effective work to be done is that the children and the therapist must develop a therapeutic alliance. Just like adults, children need to sense the counselor's personal characteristics of warmth, personal regard, congruence, and connection in order to develop a working alliance. Counselors need to have an ability to speak to and work with children at their developmental and cognitive level. Korner and Brown (1990) theorize that with specific child training, family therapists are more likely to include children in sessions. Training programs need to include techniques that will facilitate full family participation.

Another aspect of personal comfort level and preference that could benefit from future research is how a therapist's own childhood experiences come into play. It is possible that feelings associated with working with children may be related to one's childhood (Zilbach, 1986). Positive or negative events of childhood may dispose a counselor to include or exclude children. Although the research on this question is scarce, Korner and Brown (1990) found that therapists who included children in therapy more often reported unhappy childhood memories.

Finally, the physical work setting may also be a strong contributor to therapist comfort level and preference. If this environment is not conducive to working with children (e.g., sterile, adult focused, and/or too small), it may be difficult to conduct a relaxed, safe session. Another consideration of children in the session is that most children attend school every day from 8:00 a.m. until 3:00 p.m. Scheduling may be difficult with this constraint. This is an area that must be examined further so that convenience does not become another mitigating factor for excluding children.

Family Systems Advantages of Including Children

An advantage of working with the entire family is the unique dimension children add to the therapy. The child's drive for self-expression can be a constructive and healing influence for the parents or it can be an extremely divisive issue that may not have been obvious before therapy. When family conflict is treated in therapy, it opens a path for new ways of relating not only between parents and children but also between the parents. What may happen is movement toward a deeper and more appropriate kind of emotional honesty among the members (Ackerman, 1970).

By including children in therapy, a therapist is witness to the family dynamics rather than hearing indirectly about family struggles. This will ensure a more balanced understanding that takes into account the views of all family members. Another benefit of including children in the therapeutic work is that a child's presence may encourage parents to be more

responsible for the future, a process Erikson calls *generativity* (Korner & Brown, 1990). Parents may find it easier to look beyond their own perspective when the children are present. Finally, children can have a spontaneous, curious nature, unrestricted by societal constraints, which can facilitate openness to the process of therapy.

Potential Pitfalls of Including Children

It is interesting to note that the literature encourages the inclusion of children in therapy but the reality is that few therapists do. One therapist who did speak out, not specifically on the inclusion or exclusion of children in a session, is Charles Fulweiler.

> I would never see a family of more than three all through therapy. The number of interactions is too great. . . . If you accept the idea of family homeostasis, of a family system, it doesn't matter which section of it you're dealing with. If you change the interpersonal balance of one triad, you will affect the whole system. (Haley & Hoffman, 1967, p. 20)

Fulweiler's stance may be the position that many therapists take currently when they are considering their own conceptualization of systems theory. Fulweiler presents us with the idea of too many interactions in a session when the children are included. Perhaps the energy level of the therapist and pacing of the session would be challenged by this inclusion, potentially having a negative impact on the process.

A therapist may also have to adapt his or her approach in other ways to include children. Many therapists tend to be more comfortable with a verbal mode of communication and perhaps discount other techniques that may be more effective when working with children. Utilizing techniques such as play therapy can facilitate the process of therapy with the therapist and child, the overall family dynamics, as well as the parent-child relationship (Levant & Haffey, 1981). Developing a safe, therapeutic culture that includes children requires knowledge and unique skills of the therapist. When children, their parents, and a play therapy approach are used, treatment groups outperform nontreatment groups on outcome measures of child behavior and adjustment (LeBlanc & Ritchie, 1999).

Many of our training institutes today do not comprehensively prepare therapists for work with both children and adults. Korner and Brown (1990) report that almost half of the family therapists who participated in their study felt that their professional training working with children was inadequate and affected their decision to include children in therapy. An issue that has received little attention in the literature is whether it is ethical for therapists to work with the whole family with so few guidelines and, in many cases, inadequate training. Therefore, in terms of training there is some inconsistency between what family systems theory promotes and what it can realistically offer.

One of the concerns of including children in therapy is the potential for harm to the child due to session content. Weston, Boxer, and Heatherington (1998) have recently looked at children's attributions about family arguments. They establish that children's attributions about interpersonal events are related to their well-being. Because different attributions can lead to different emotions and behavior, it is important that family therapists be aware of circumstances when participation would not be in the child's best interest. The results of the Weston et al. study indicate that children think systematically about family arguments. To explain further, in all three age groups questioned (ranging in age from 5 to 12), the top one and two answers to explain a mock conflict was, "It's both their faults together." Children were not likely to believe that arguments occurred "because they don't like each other." Looking at how children manage information about their family and attributional processes will hopefully lead to learning about how children will comprehend and respond to types of family therapy interventions.

Some therapists feel more comfortable if they can work with children who have reached a certain level of cognitive, moral, and emotional development. Most approaches suggest a minimum age of 5 or 6 years for family participants. If the parent or parents have very young children, it may be difficult for the parents to get the most benefit out of the therapy if they are also taking care of the children. The decision whether to include children in therapy is especially relevant if the therapy is adult oriented. Johnson and Thomas (1999) found that family therapists were evenly divided as to the inclusion of children in therapy when it involved an adult problem. Defining what is an adult issue versus a family issue is an important next step in looking at how family therapists make their decisions about inclusion of children in therapy.

All family practitioners should spend some time thinking about issues that would not be appropriate to discuss with children present. These concerns can be dealt with in an open and respectful manner with the children, emphasizing the importance of the parent-child boundary. For example, imagine a situation where a family comes to therapy to discuss some problems regarding conflict within the family. After a few sessions the parents feel the need to address intimacy issues and speak to the therapist about couples counseling. This request could be negotiated with the therapist and the family, including the children, as to how it would be achieved by either substituting family sessions or adding on marital sessions. This resolution would model open communication and value hearing what each person has to say. Although the inclusion of children in therapy can be complicated, by being creative there are ways to benefit from the challenges it presents. Perhaps the presenting problem is more appropriate for the adults (i.e., an extramarital affair), or it may be a reflection of the counselor feeling more competent in dealing with issues that trouble adults.

PROFESSIONAL INVENTORY FOR PRACTITIONERS: INCLUDING CHILDREN IN COUPLE AND FAMILY PRACTICE

We recommend family and couple counselors address the following questions when considering their own practice of including children and adolescents in family therapy. The first set of questions relates to the counselor or therapist's theoretical orientation. The second group of questions largely focuses on therapist or counselor specific training issues. The third set of questions relates to clinical concerns for children involved in family sessions.

Theoretical Concerns

1. What is my definition of family counseling?
   (a)How do I define family members?
   (b)How does the family define its members?
   (c)Does the family consider the children part of the family system?
2. What is my theoretical orientation?
3 Does my practice match my theoretical orientation? (e.g., am I doing what the founders intended? If not, why?)
   (a)Do I believe children manifest/carry the symptoms of system dysfunction?
   (b)If the children are excluded, does therapy then become a "secret?"
   (c)Is working with the couple dyad the most effective intervention for a family?
   (d)What adult problems might be inappropriate for a child to hear? Why do I single those problems out from other adult problems? Are these developmental concerns, safety concerns, or my own preconceived ideas?

Training Concerns

4. Am I competent to work with children? How did I come by that competency? Do I understand child and adolescent development? Have I been supervised and trained to work with children and adolescents?
5. Would I be able to handle (emotionally, cognitively, and physically) children and adolescents in a session?
6. Can I reframe or make sense of childhood distress so that the adults have a better understanding?
7. Should I involve a cotherapist?
8. What does the law state about confidentiality for minors?
9. When was the last training event I attended that addressed working with children?
10. Is an adult approach (e.g., cognitive approaches) the best method for eliciting information from children?
11. Do children have the attention span to stay focused for my typical approach? Or do I need to change my approach?
12. What happens to the therapeutic alliance? Can I ally with children? How will I know if I don't?
13. What research supports my ideas?

Child Concerns

14. Can children feel safe in my office with their families present?
15. Are the children aware of family problems?
16. What is/are the therapeutic goal(s) of the family? Who voiced these goals?
17. Do the children, if excluded, have an avenue to express their distress?
18. Can children point out change and assess growth where adults cannot?
19. Will the children help to keep the adults more honest?
20. Can children benefit from seeing their adult family members struggle with problems?
    (a)Should children's admiration for the parental subsystem be challenged?
    (b)If others get very emotional, is this threatening or frightening to children?
21. Will the parents feel awkward in front of their children? Is this good or bad?
22. Will children feel frightened by the process of therapy? Can I reassure them sufficiently to develop a trusting environment?
23. Of what boundaries will I have to be especially aware?
24. Can the child use the information from the sessions to pit one adult against another?
25. Will any information or intervention retraumatize the child?

The process of reflecting on one's own beliefs and perspectives about if, how, and when to include children in therapy will assist therapists in making decisions regarding their practice that are best for their clients and themselves. After considering these questions and reflecting on the answers, a good therapist always relies on theory first to guide practice. If a practitioner is challenged by the theoretical concerns, more reading in the area can be helpful. One can attend professional development workshops where theory is stressed over techniques. A supervision group associated with a university may be helpful. University departments of counselor education and preparation are often more focused on theoretical concerns.

Training concerns can be readily addressed by conference attendance, self-directed child development education, and additional coursework. Supervision from practitioners who routinely include children in their work is suggested. Cross disciplinary supervision can also lend breadth to a family counselor's work, for example, supervision from a school psychologist or developmental psychologist that may enhance expertise in child training.

The third area of concern in modifying practice to include children can be seen as an exciting opportunity for true professional growth for the practitioner. Carr (1994) suggests very clear avenues for modifying family practice from the initial interview (complete with juice boxes) to suggestions on how to make systemic concepts understandable to children. Eliana Gil (1996), noted play therapist, has a rich inventory of play therapy techniques to implement and adapt for use with entire families. Parenting programs, such as *Systematic Training for Effective Parenting* (Dinkmeyer, McKay, & Dinkmeyer, 1998) and *Active Parenting Today* (Popkin, 1996), can reinforce basic parenting techniques that a family counselor may want to review. Initially, the counselor needs

to establish roles and guidelines for the sessions so that the chaos of many participants is minimized. Children do better when clear expectations are set and rely on the structure imposed by adults. If parents are unable to do this, the therapist can model these behaviors and gradually train the parents in therapy to assume this function.

CONCLUSION

To be able to provide families with the most effective services, it is necessary to join family systems theory with a base knowledge of research in childhood concerns (Carr, 1994). The integration of these components will, it is hoped, provide therapists with more direction on how to support families (Johnson & Thomas, 1999). The initial concerns in the literature have focused on the importance of the personal comfort level and the therapist's preference in determining whether children will be included in therapy. Personal comfort and preference factors may involve the type of children or family requiring therapy, training, orientation, and work setting of a therapist, as well as a therapist's own childhood experiences. It is also likely that the pacing and energy level required for family therapy influence a therapist's decision. It is vital to research how children respond to family therapy, and part of this endeavor may include looking at how and what therapists define as family issues versus adult issues. Contradiction between today's practice and beliefs advocated by the family systems approach founders such as Ackerman, Satir, Minuchin, and Whitaker lead to confusion. Feminist family theory has suggested that early theoretical formulations in family therapy reflect masculine values and reinforce traditional male/female roles that depreciate other qualities of family members (Goldenberg & Goldenberg, 2000). This inconsistency may damage the theory's credibility and lead practitioners to modify the systems orientation.

The issue of including children in therapy needs to be evaluated so that therapists are able to make informed decisions about their practices. Some theorists are clear about how the therapy should be practiced, but there has been little empirical evidence providing validation. At this point, it is an uncomfortable position of not knowing for family therapists. To change this, the field will need to direct more attention and debate to practice, increase research, and develop a fuller awareness regarding training needs. Despite all these challenges, the inclusion of children may offer a spontaneous, honest, and unique way to open up new alternatives for families in therapy. Therapists who choose this type of work can look forward to creative communication, a dynamic process, and enriching work experiences.

REFERENCES

Achenbach, T. M., & Howell, C. T. (1993). Are American children's problems getting worse? A 13-year comparison. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*, 1145-1154.

Ackerman, N. (1970). Child participation in family therapy. *Family Process*, *9*(4), 403-410.

Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996). Family -based treatment of anxious children. *Journal of Consulting and Clinical Psychology*, *64*, 333-342.

Benard, B. (1991). *Fostering resiliency in kids: Protective factors in the family, school, and community.* Boulder, CO: The Prevention Center.

Bowlby, J. (1969). *Attachment and loss* (Vol. 1). New York: Basic Books.

Carr, A. (1994). Involving children in family therapy and systemic consultation. *Journal of Family Psychotherapy*, *5*(1), 41-59.

Dadds, M. R., Spence, S. H., Holland, D. E., Barrett, P. M., & Laurens, K. R. (1997). Prevention and early intervention for anxiety disorders: A controlled trial. *Journal of Consulting and Clinical Psychology*, *65*(4), 627-635.

Diller, L. (1991). Not seen and not heard. *The Family Therapy Networker*, *15*(4), 18-27.

Dinkmeyer, D, McKay, G., & Dinkmeyer, D., Jr. (1998). *Systematic training for effective parenting*. Circle Pines, MN: American Guidance Services.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy*, *22*(1), 9-25.

Dubuque, S. E. (1998). Fighting childhood depression. *The Education Digest*, *63*, 65-69.

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

Forgatch, M. S., & Patterson, G. R. (1998). Behavior family therapy. In F. M. Dattilio (Ed.), *Case studies in couple and family therapy: Systemic and cognitive perspectives* (pp. 85-107). New York: Guilford Press.

Gil, E. (1996). *Systemic treatment of families who abuse*. San Francisco: Jossey-Bass.

Goldenberg, I., & Goldenberg, H. (2000). *Family therapy: An overview* (5th ed.). Belmont, CA: Brooks/Cole.

Good, T. L., & Brophy, J. E. (1986). School effects. In M. C. Wittrock (Ed.). *Handbook of research on teaching* (3rd ed., pp. 570-602). New York: Macmillan.

Haley, J., & Hoffman, L. (Eds.). (1967). *Techniques of family therapy.* New York: Basic Books.

Illback, R. (1994). Poverty and the crisis in children's services: The need for services integration. *Journal of Clinical Child Psychology*, *23*, 413-424.

Johnson, L., & Thomas, V. (1999). Influences on the inclusion of children in family therapy. *Journal of Marital and Family Therapy*, *25*(1), 117-123.

Kahne, J., & Kelley, C. (1993). Assessing the coordination of children's services: Dilemmas facing program administration, evaluation and policy analysts. *Education and Urban Society*, *25*, 187-200.

PLS. PROVIDE 4 KEY WORDS

Kale, A., & Landreth, G. (1999). Filial therapy with parents of children experiencing learning difficulties. *International Journal of Play Therapy*, *8*(2), 35-56.

Kauffman, J. M. (1993). *Characteristics of emotional and behavioral disorders of children and youth*. New York: Macmillan.

Kendall, P. C., & Southam-Gerow, M. A. (1996). Long-term follow-up of a cognitive-behavioral therapy for anxiety-disordered youth. *Journal of Consulting and Clinical Psychology*, *64*, 724-730.

Korner, S., & Brown, G. (1990). Exclusion of children from psychotherapy: Family therapists' beliefs and practices. *Journal of Family Psychology*, *3*(4), 420-430.

LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy*, *8*(2), 19-34.

Levant, R., & Haffey, N. (1981). Toward an integration of child and family therapy. *International Journal of Family Therapy*, *3*(2), 130-141.

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review*, *19*(3), 329-342.

Muris, P., Merckelbach, H., Mayer, B., & Prins, E. (2000). How serious are common childhood fears? *Behaviour Research and Therapy*, *38*, 217-228.

National Center for Health Statistics. (1998, May). FASTAATS A to Z [Online]. Available: http://www.cdc.gov/nchswww/fastats/suicide/htm.

National School Boards Association and American School Counselors Association. (1994). *Caring connections: Helping young people from troubled homes*. St. Louis, MO: Author.

Nichols, M. P., & Schwartz, R. C. (1998). *Family therapy* (4th ed.). Needham Heights, MA: Allyn & Bacon.

Patterson, G. R. (1986). Performance models for antisocial boys. *American Psychologist*, *41*, 432-444.

Popkin, M. (1996) *Active parenting today.* Marietta, GA: Active Parenting Publishers.

Post, P. (1999). Impact of child-centered play therapy on the self-esteem, locus of control, and anxiety of at-risk 4th, 5th, and 6th grade students. *International Journal of Play Therapy*, *8*(2), 1-18.

Rapee, R. M. (1997). Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review*, *17*(1), 47-67.

Rober, P. (1998). Reflections on ways to create a safe therapeutic culture for children in family therapy. *Family Process*, *37*(2), 201-213.

Schmidt, J. J. (1999). *Counseling in schools*. Needham Heights, MA: Allyn & Bacon.

Soler, M., & Shauffer, C. (1993). Fighting fragmentation: Coordination of services for children and families. *Education and Urban Society*, *25*, 129-140.

Steinberg, L. (1987). Single parents, step-parents, and the susceptibility of adolescents to antisocial pressure. *Child Development*, *58*, 269-275.

Stith, S. M., Rosen, K. H., McCollum, E. E., Coleman, J. U., & Herman, S. A. (1996). The voices of children: Preadolescent children's experiences in family therapy. *Journal of Marital and Family Therapy*, *22*(1), 69-86.

Thompson, C. L., & Rudolph, L. B. (1996). *Counseling children*. Pacific Grove, CA: Brooks/Cole.

Weist, M. (1997). Expanded school mental health services: A national movement in progress. In T. H. Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (pp. 319-352). New York: Plenum Press.

Weston, H., Boxer, P., & Heatherington, L. (1998). Children's attributions about family arguments: Implications for family therapy. *Family Process*, *37*(1), 35-49.

Zilbach, J. (1986). *Young children in family therapy.* New York: Bruner/Mazel.

***Lynn D. Miller**, Ph.D., is an instructor in the Counselling Psychology Department at the University of British Columbia.*

***Elissa McLeod** is a student in the Counselling Psychology Department at the University of British Columbia.*

The Social and Emotional Needs of Gifted Children: Implications for Family Counseling

Gwen L. Fornia
Marsha Wiggins Frame
University of Colorado in Denver

The authors examine the psychosocial dilemmas faced by gifted children and their families and provide family counseling strategies. Definitions and characteristics of giftedness are summarized. Life span and social constructionist frameworks are used for working with gifted clients.

Parents of gifted children often consider themselves both blessed and cursed. Although giftedness entails many strengths, there are a variety of external and internal factors that contribute to struggles in the emotional and social experiences of gifted children and their families (Moon & Hall, 1998). The purpose of this article is to provide the information needed to help family counselors become familiar with the unique issues of gifted families and to offer them techniques for counseling these clients. There are many ways of formally identifying or defining giftedness among children that vary from state to state and even within school districts. However, the bodies of literature do seem to agree on several common characteristics among those who are identified as gifted. Therefore, in this article we are emphasizing these characteristics and describe them in detail below.

DEFINITION OF GIFTEDNESS

Giftedness means different things to different people. Attempts to define giftedness began with Lewis Terman in the 1920s (Walker, 1991; Winner, 1996) and have been revised and broadened since then by many experts in gifted education who have contributed to a conceptualization of giftedness that includes and expands upon the rather narrow definition of IQ. Yet IQ scores or other standardized achievement or aptitude scores remain the prevailing factor in identifying children for gifted programs.

There are shortcomings in using standardized test scores as a sole basis for recognizing high abilities in children. Perino and Perino (1981) described intelligence as having many factors and held that the IQ score is a unitary factor. A person's test score may be affected by factors besides intelligence, such as degree of motivation or state of health. Although a superior-range IQ score remains a strong indicator of giftedness, it may be too narrow a definition, and other realms of exceptionality need to be considered. Smutny, Walker, and Meckstroth (1997) described the challenge of determining what it means to be gifted. They advised looking for a type and degree of exceptionality. They pointed to the need for using several sources for defining giftedness, including a 1972 definition of giftedness provided by the U.S. Office of Education in a publication known as the Marland report (U.S. Department of Health, Education, and Welfare, 1972). This definition of gifted and talented identifies gifted children as those with outstanding abilities in areas of intellectual pursuits, specific academic aptitudes, creative or productive thinking, leadership, visual and performing arts, and psychomotor processing. Psychomotor ability was later removed from the definition (Assouline, 1997).

Smutny et al. (1997) also referred to descriptions of giftedness given by Robert Sternberg, who emphasized how intelligence is applied to real-life situations, and to Gardner (1993) who stressed multiple intelligences. The distinct competencies proposed by Gardner include linguistic intelligence, musical intelligence, logical-mathematical intelligence, visual-spatial intelligence, bodily kinesthetic intelligence, interpersonal intelligence, intrapersonal intelligence, and naturalist intelligence.

CHARACTERISTICS OF GIFTED CHILDREN

Dabrowski's Theory

Dabrowski (1967) studied intellectually and artistically gifted children, providing the first empirical study of gifted children. "Recognizing that creative individuals tend to live more intensely, Dabrowski took the intensity of their

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emotions, the intensity and emotional extremes, as part and parcel of psychophysical makeup" (Piechowski, 1997, p. 366). This intensity generates pain and conflict for gifted children but also gives them an ability to search for a way out of it. This idea is the basis for Dabrowski's theory of positive disintegration. He postulated that the gifted individual's ability to recover from a crisis can result in a higher level of functioning rather than returning to the previous normal functioning (Dabrowski & Piechowski, 1977). The ability to move to a new, higher level depends on the individual's having what Dabrowski terms "overexcitabilities". Dabrowski and Piechowski (1977) highlighted the five forms of overexcitabilities, summarized here as:

> *Psychomotor Overexcitability.* It manifests itself, for example, in rapid talk . . . intense athletic activities, restlessness and acting out on impulse.
> *Sensual Overexcitability.* In children, it may be seen as an increased need for touching and cuddling or the need to be the center of attention.
> *Imaginational Overexcitability.* It manifests itself through association of images and impressions, inventiveness, vivid and often animated visualization . . . dreams, nightmares, mixing of truth and fiction, fears of the unknown, etc.
> *Intellectual Overexcitability.* It is manifested in the persistence to ask probing questions, avidity for knowledge, analysis, theoretical thinking, reverence for logic, preoccupation with theoretical problems.
> *Emotional Overexcitability.* The manifestations of emotional overexcitability include inhibition (timidity or shyness) . . . concern with death . . . fears, anxieties, depressions, feelings of loneliness . . . [and] concern for others. (pp. 30-36)

These overexcitabilities, also known as intensities, that contribute to individuals' psychological development in relation to their strength, stand out "loud and clear in gifted children" (Piechowski, 1997, p. 367). Some of the internal characteristics that may lead to emotional difficulties, and are often mentioned in the literature, include high sensitivity, high intensity, and existential angst.

Emotional Sensitivity

Sensitivity is one of the first and most often cited aspects related to giftedness that deals with the noncognitive or emotional states of the child (Aron, 1996; Lovecky, 1993; Mendaglio, 1995; Perino & Perino, 1981; Walker, 1991; Webb, Meckstroth & Tolan, 1982). These writers hold that gifted children tend to be sensitive, and are often supersensitive.

Gifted children, whose sensitivity lends itself to heightened perceptiveness, are alert to small changes in their environment, and they are very aware of their own unique gifts. This perceptiveness actually can diminish their self-esteem because they focus on how they are different from their peers (Walker, 1991). Because they are more in tune to current events and adult conversation, they may also end up with an abundance of information to process. Their perceptiveness may cause angst or give them worries that, as children, they may not be able to manage adequately.

Also, gifted children's passion for justice and truth makes them especially aware of hypocrisy. They cannot fathom why injustice occurs or why their parents don't protect them from it. In some cases, this awareness of hypocrisy makes children anxious, and they may exhibit what is considered to be immature behavior because it feels safe to them.

Intensity

Intensity refers to the depth of feeling and behavior. Again, Dabrowski provided empirical work to explain these intensities as overexcitabilities. "The degree of emotional intensity is a stable individual characteristic and quite independent of what actually evoked the emotion" (Piechowski, 1997, p. 62).

While examining the intellectual, creative, emotional, or behavioral aspects of gifted children, it is the intensity of the characteristic that is notable. For example, whereas a normally empathic child may frown when she sees someone hurt, an emotionally gifted child may be on the verge of tears for hours, or even days, thinking about how unjust the world is for letting hurt exist. The increased intensity in gifted children helps to explain why stronger emotions and reactions such as depression (vs. sadness) and outbursts (vs. mild dismay) may occur.

Perfectionism and Underachievement

Intensity of thought and feelings can lead to perfectionism, which generally is accepted as one of the most common issues for gifted children. Ironically, gifted children are aware of what is possible (perfection) and may feel defeated before they attempt a task. Defined as the feeling that one's efforts are never enough, negative perfectionism can lead to psychological disorders (Orange, 1997).

Perfectionism can also lead to underachievement, which is best defined by the gifted child's failure to perform at a level equal to his or her measured potential (Baker, Bridger, & Evans, 1998). Gifted underachievers may know that they are intelligent, but they do not feel capable of living up to their *gifted* label. Their low self-esteem may lead them to avoid certain tasks or rebel against those who require that the tasks be done (Rimm, 1997). Underachievement in school can lead to power struggles within the family.

One group that is at risk for underachievement (and that makes up the most common behaviorally disordered group among gifted children) is the group of children who have attention deficit/hyperactivity disorder (AD/HD) (Moon & Hall, 1998). The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV*) (American Psychological Association, 1994) lists 18 criteria for AD/HD in areas of hyperactivity, impulsivity, and inattention. At least 12 of these criteria need to be present for a child to be diagnosed as AD/HD, the onset must be before age 7, and they must be present for at least 6 months.

Many of these behaviors might also be found in gifted children. What may appear to be an inability to sustain attention could likely be boredom with routine tasks, especially if they seem irrelevant. High activity level may appear to be hyperactivity. Likewise, questioning of rules may seem to some to be rude or off task. There is a great potential for misidentification in both AD/HD and giftedness (Webb & Latimer, 1997).

Gifted children who have AD/HD or are otherwise learning disabled (twice exceptional) have very unique concerns in that they may be exceptionally bright but not able to express what they know. This experience can create a feeling of dysfunction or asynchrony in children who may otherwise shine if they could express their talents more effectively.

Asynchrony

According to the Columbus Group (1991), giftedness is asynchronous development in that advanced cognitive abilities and intensities combine to create inner experiences that differ from the norm. This asynchrony increases with increased intellectual capacity and renders gifted children more vulnerable to feeling out of sync with others (Silverman, 1993a).

Lack of synchronicity may also increase inner tension because the child's advanced abilities in one area (e.g., cognitive) are not matched in another area (e.g., physical). Gifted children may feel particularly vulnerable, also, because at times they may seem emotionally advanced and at other times they may seem emotionally immature (Silverman, 1993a). The psychic conflict in self-definition that can result from this uneven development may lead gifted children to give up on themselves (Tolan, 1998).

Another way in which asynchrony is felt by gifted children is in their attempts to reconcile their own intensity and advanced awareness with the knowledge of others. With so many people around them not questioning why things work the way they do, with the same intensity as they do, gifted children may begin to feel isolated and self-doubting, which may lead to withdrawal (Tolan, 1998).

With Dabrowski's theory as a framework, it is clearer why the characteristics presented here are particularly relevant in a discussion of gifted children. The theory provides an explanation of why gifted individuals may exhibit certain social and emotional expressions that are not understood by the population at large and may create conflicts. They also have unique strengths and compensation skills that might enable them to overcome these difficulties.

Although giftedness entails many strengths, there are a variety of external and internal factors that contribute to struggles in the emotional and social experiences of gifted children and their families (Moon & Hall, 1998).

When gifted children are not supported for their differences and their strengths are not emphasized, there is a risk for a number of problems, including depression. Virtually all gifted children experience at least one period of existential depression that may arise from impossibly high standards, feelings of alienation, or problems of human existence that may weigh on their minds more intensely than on others' (Webb et al., 1982).

FAMILY ISSUES

There is little literature available regarding classic family concepts and their role with families of the gifted. One such concept is the family life cycle. Families with young children go through one of the most definitive stages of life. Marriages, which may have been more equal prior to child rearing, must readjust to demands of time and financial and emotional constraints, often causing power imbalances (Carter & McGoldrick, 1999). Parents of young children often become passionate about discipline and protection, doing things for the sake of their children that they would not do for themselves. The next period of major readjustment in the family is during the stage of adolescence. This is a time when parents begin preparing their children for the outside world by increasing flexibility of family boundaries (Carter & McGoldrick, 1999).

Families of gifted children may have an out-of-sync experience with what is the norm. Because of aforementioned levels of intensities and development, for example, it may be difficult to discern between changeable intense moods of adolescence and overexcitabilities characteristic of most gifted children. Parents of precociously independent gifted children may need to work more persistently at maintaining discipline and parental boundaries during the younger years.

How and when a family deals with unexpected changes in the cycle is important, as is the structure and functionality of the family (Minuchin, 1974). Based on the characteristics of gifted children, it is plausible to assume that there is a need for special attention to family issues of gifted children. Unfortunately, family therapists often are not trained or educated about the struggles associated with giftedness, and there is little research conducted to determine the effectiveness of fam-

ily therapy with gifted populations (Moon & Hall, 1998). Empirical research is needed in this area.

Family Functioning and Structure

Families with gifted children have a unique set of endogenous and exogenous concerns stemming from the aforementioned traits. Pressure from outside sources, such as neighbors or the school system, creates internal dilemmas for the child that, in turn, directly affect family functioning and structure. Our case example illustrates how these external and internal forces may interact with each other.

Also, because parents and siblings of gifted children are almost always gifted themselves (Silverman, 1997), examining how giftedness has affected their own lives is an important component in balancing family issues. Thus, transgenerational issues (Bowen, 1978) may need to be considered regarding family interactional patterns and how other family members have met these unique challenges.

Healthy family relationships and parent-child interactions are the most important factors in the development of gifted children (May, 1994). At the same time, giftedness itself may be a stressor that influences and is influenced by the family (May). It is important, then, to recognize the issues of giftedness that are caused by and have an impact on the family.

Family Themes

There are several themes that arise for families of gifted children. They include but are not limited to issues of trust, isolation or alienation, reactions from others, and loss. Recognizing and addressing these issues should be a part of the counseling process.

The issue of trust is central for families with gifted children. Raising a gifted child often requires that a family enter realms that may not affect other families. Cooperation with other systems, such as school and gifted programs, are essential in meeting the needs of the gifted. According to Bennett (1999), because of the unique aspects of meeting the needs of gifted children, parents must learn to trust people at several levels. In the beginning, parents must ask, "Do we trust our own assessment of our child's abilities?" and move on to questions of trust regarding the outside assessments that are designed to test giftedness. After identification, there is still the question of trust with the school and with the identified child as to whether his or her needs will be met (Bennett, 1999).

The gifted can be seen as misfits in a society that values conformity. Gifted children are not average, and often they do not conform to society's ideals. This difference may create social problems, particularly at school (VanTassel-Baska, 1990) but also with the public at large (Walker, 1991). Adolescence may be a time when pressure to conform is particularly problematic, especially for gifted adolescents who are different in many ways from their contemporaries (Perino & Perino, 1981).

Along with conformity, our society values equality. Americans also have supported the notion of excellence and the encouragement of individuals to reach their full potential. These ideals can be seen as contradictory, and for the gifted, they can cause confusion. In general, the public has not been supportive of gifted and talented programs (Walker, 1991). In fact, programs to meet the specialized needs of gifted children often are erroneously perceived as elitist. The same charge rarely is made of programs to meet the needs of children who are learning disabled or who have other specialized needs. This lack of support from society can make gifted children and their families feel isolated (Silverman, 1993b).

Individual characteristics of gifted children may also have an impact on the way others respond to them. Their intensity, sensitivity, and special quirks often evoke strong emotions from others who feel the need to put gifted children in their place or push them down a notch (Webb et al., 1982). Sometimes, adults who are threatened by being corrected or questioned by a child may criticize a child openly by labeling gifted characteristics negatively. Children with traits such as persistence and high energy, for example, may be mislabeled as stubborn or hyperactive. By turning an asset into a liability, some people unwittingly turn major strengths of gifted children against them, causing stress, withdrawal, and poor adjustment. If reframed, these qualities could be considered active displays of strength and exceptional adjustment (Webb et al., 1982).

Lack of support from the community and misunderstandings about the characteristics of giftedness can make parents feel overwhelmed with issues with which other families do not have to deal. In fact, once a child is identified as gifted, the family begins a journey of mourning the loss of a 'normal' child whose needs can easily be met (Silverman, 1997).

CASE EXAMPLE

Scott showed signs of giftedness at the age of 3. He taught himself how to read and was interested in relationships between numbers. His parents and his brother enjoyed his precociousness and encouraged him to learn through games. He did not show signs of stress until he entered kindergarten, when he was labeled immature because of crying spells, which occurred after he asked his teacher a question and she told him to be quiet and finish his coloring. Along with being labeled immature, Scott experienced social difficulties because of a lack of motor coordination that affected his writing skills and his ability to play sports in which other children excelled. Scott became increasingly frustrated with school to such a point that by second grade he had stopped completing assignments and was withdrawing socially from his peers.

Not all children who are gifted are affected by their giftedness in the same way. Scott's brother, Ryan, who was also academically gifted but was more socially adept, became frustrated with and embarrassed by his younger brother, who

was becoming a social outcast. The whole family was affected by Scott's outbursts and seemingly immature reactions and decided to seek help. Independent testing after third grade revealed that Scott had an IQ of 160 and needed much more academic stimulation. School personnel had not tested Scott previously because his poor handwriting and emotional immaturity had masked his giftedness. After Scott's parents enrolled him in a school for gifted children, many of the academic problems were resolved but they were faced with a new set of concerns.

Although Scott began to like school more and was easier to get along with at home, he had developed a pattern of withdrawal from other children that was difficult to change, even among other gifted children. The rest of the family also felt isolation from their community because of the misunderstandings of their neighbors. Community members were proud of their school and did not understand Scott's unique need to be around like-minded peers in another school setting.

Family Counseling Interventions

Early Intervention/Preventive Counseling

With preventive rather than remedial interventions, counselors could plan developmental counseling programs to facilitate the emotional well-being of children and their families before a crisis occurs (Silverman, 1993b). One obstacle that must be overcome in meeting the counseling needs of the gifted is the failure of professionals in the counseling field to acknowledge their needs (Alsop, 1997). A stronger effort in educating counselors about these special concerns is needed.

Because of the early development of cognitive and adaptive skills of gifted children, it is important that counselors recognize giftedness early on in children's development. The family can rally around Scott and become more cohesive rather than increasing family tension by blaming their struggles on his developmental differences. In Scott's case, he developed an adaptive coping skill that led to isolation. When he talked about subjects that were not understood yet by his peers, they laughed at him. He found it easier to keep his thoughts to himself, beginning a pattern of social withdrawal. If he and his family could have been taught more open communication and adequate coping skills and had understood the nature of his giftedness when he was first identified, it is possible that the cycle could have been interrupted.

The family needs to see itself differently from the norm. They have their own construction of who they are. Early intervention that takes giftedness into account will allow the family to thrive in a way that is relevant for them, if not necessarily relevant for the majority of families.

Social Constructionist Model

Ecosystemic counseling takes into consideration the external systems such as school, peer relationships, and neighborhood of the family (Moon & Hall, 1998). These systems are especially important because of the tremendous impact they have on gifted children and their families. It is through these systems that life scripts are developed for the child.

Postmodern social constructionist theory is based on second order cybernetics, which places the therapists in a posture of a *not knower* who will use the client's reality as the basis for change (Atwood, 1997). There is no set of absolute rules that governs what is normal for the family. The counselor and family work together to examine scripts that overlap within the family and to uncover hidden scripts that may be useful in reconstructing the family's reality in a way that benefits all family members. Atwood (1997) described the steps that counselors might take when working within a social constructionist framework. Those steps and their application to Scott and his family are outlined here:

Join with the client's meaning system. The counselor should begin by adopting a stance as a nonexpert, ready to learn from Scott and his family. This goal can be accomplished by providing a safe environment and listening carefully to the stories of each family member. Additionally, an understanding of the unique development of gifted children and their families is crucial. If the family stories include information that is congruent with gifted development, this fact can be validated and normalized for the family. Such information might include examples of high-intensity or asynchronous development, which may seem to be a conflict for the family unless it is normalized as being typical for families of gifted children.

Explore the past and how it has contributed to the current meaning system. Exploring the past will reveal Scott's system of viewing himself as separate from his peers and his family's frustration over not being able to get all of his needs met in the current educational system. The pattern of communication between Scott, his parents, and his brother also will have been affected, as revealed through their interviews. Current scripts and family language also will be evident, as will past coping skills that have been effective in areas other than just problem areas. At this stage, a counselor could engage family members in a dialogue of what giftedness has come to mean to them. Families can then be helped to rewrite their family scripts (White, 1989).

Put the past in perspective. Reframing or letting go of past scripts can be facilitated by educating the family members about giftedness and offering suggestions about why others might respond in negative ways. Focusing the family's energy toward creating new goals based on their own reality will also help in putting the past into perspective.

Invite clients to expand meaning systems through reflective influence questioning. In Scott's case, the family referred to his system of coping as "withdrawal". Using the family's language, the counselor might ask about situations in which

withdrawal did not exist. This line of questioning will help the family explore the process of developing coping mechanisms that they can also apply to other situations. Another example involves the parents' fear of seeming pushy by confronting educators. By asking the parents what the payoffs are for risking confrontation, they may be better able to reframe their feelings of pushiness as a constructive way of meeting Scott's special needs.

Amplify and stabilize the new meaning system. Ryan could create a new meaning system by reframing his brother's anger as his frustration over not being understood and could then develop a new way of responding that would not exacerbate Scott's anger. By asking Ryan how he is going to carry that same type of adaptation into new situations, the counselor hopes for second-order change in which Ryan applies this behavior to new circumstances rather than just changing it this once.

One suggestion for creating a new meaning system for the family is to develop a more supportive social network with like-minded people. Scott and his family might join an organization such as Supporting the Emotional Needs of the Gifted to continue feeling empowered and supported by like-minded people.

Counselors can continue to be enlisted as advocates, when needed. In Scott's case, he may need a professional counselor to meet with school staff members to develop an individualized learning plan to address his special needs.

This model can be used to explore any of the individual or family issues that may be of concern to Scott's family or others like them. It is a flexible and nonjudgmental therapy that does not force families into coercive norms with which gifted children and families often contend.

CONCLUSION

To work therapeutically with gifted children and their families it is important first to recognize the unique attributes of the gifted. These characteristics include a high level of intensity, sensitivity, and moral concern that makes them unique in development and expression of emotion and may create a level of asynchrony that is common among gifted children.

Working within a gifted developmental model and a social constructionist model, the counselor will be knowledgeable about the social impact of being gifted while also allowing the family's reality to dictate how they will or will not respond to given social pressures. This approach allows the counselor to help the family construct a new reality that will lessen the difficulties without directing them to fit into societal norms that cast them as outsiders. Multiple family groups can also help to reduce social isolation and underlying concerns by providing support and education. Family counselors as advocates will help draw in support that can help to form a more positive interaction between family and community.

REFERENCES

Alsop, G. (1997). Coping or counseling: Families of intellectually gifted students. *Roeper Review*, *20*, 28-34.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*(4th ed.). Washington, D.C.: Author.

Aron, E. N. (1996). *The highly sensitive person: How to thrive when the world overwhelms you*. New York: Broadway Books.

Assouline, S. G. (1997). Assessment of gifted children. In N. Colangelo & G. A. Davis (Eds.), *Handbook of gifted education* (2nd ed., pp. 89-108). Needham Heights, MA: Allyn & Bacon.

Atwood, J. D. (1997). *Challenging family therapy situations: Perspectives in social construction*. New York: Springer.

Baker, J. A., Bridger, R., & Evans, K. (1998). Models of underachievement among the gifted preadolescents: The role of personal, family, and school factors. *Gifted Child Quarterly*, *42*, 5-14.

Bennett, B. M. (1999). Giftedness: A family affair: Developing trust in the family process of meeting the needs of the gifted child. *The Kaleidoscope*, 20-21.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Carter, E. A., & McGoldrick, M. (1999). *The expanded family life cycle: Individual, family, and social perspectives*. Boston: Allyn & Bacon.

Columbus Group (1991, July). Unpublished transcript of the meeting of the Columbus Group, Columbus, OH.

Dabrowski, K. (1967). *Personality-shaping through positive disintegration*. Boston: Little, Brown.

Dabrowski, K., & Piechowski, M. M. (1977). *Theory of levels of emotional development: Vol. 1B. Multilevelness and positive disintegration*. Oceanside, NY: Dabor Science.

Gardner, H. (1993). *Frames of mind: The theory of multiple intelligence* (10th ed.). New York: Basic Books.

Lovecky, D. V. (1993). The quest for meaning: Counseling issues with gifted children and adolescents. In L. K. Silverman (Ed.), *Counseling the gifted and talented* (pp. 29-50). Denver, CO: Love Publishing.

May, K. M. (1994). A developmental view of a gifted child's social and emotional adjustment. *Roeper Review*, *17*, 105-109.

Mendaglio, S. (1995). Sensitivity among gifted persons: A multi-faceted perspective. *Roeper Review*, *17*, 169-173.

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

Moon, S. M., & Hall, A. S. (1998). Family therapy with intellectually and creatively gifted children. *Journal of Marital and Family Therapy*, *24*, 59-80.

Orange, C. (1997). Gifted students and perfectionism. *Roeper Review*, *20*, 39-41.

Perino, S. C., & Perino, J. (1981). *Parenting the gifted: Developing the promise*. New York: Bowker.

Piechowski, M. M. (1997). Emotional giftedness: The measure of intrapersonal intelligence. In N. Colangelo & G. A. Davis (Eds.), *Handbook of gifted education* (2nd ed., pp. 366-381). Needham Heights, MA: Allyn & Bacon.

Rimm, S. B. (1997). Underachievement syndrome: A national epidemic. In N. Colangelo & G. A. Davis (Eds.), *Handbook of gifted education* (2nd ed., pp. 416-434). Needham Heights, MA: Allyn & Bacon.

Silverman, L. K. (1993a). The gifted individual. In L. K. Silverman (Ed.), *Counseling the gifted & talented* (pp. 3-28). Denver, CO: Love Publishing.

Silverman, L. K. (1993b). Techniques for preventive counseling. In L. K. Silverman (Ed.), *Counseling the gifted and talented* (pp. 81-106). Denver, Co: Love Publishing.

Silverman, L. K. (1997). Family counseling with the gifted. In N. Colangelo & G. A. Davis (Eds.), *Handbook of gifted education* (2nd ed., pp. 382-397). Needham Heights, MA: Allyn & Bacon.

Smutny, J. F., Walker, S. Y., & Meckstroth, E. A. (1997). *Teaching young gifted children in the regular classroom: Identifying, nurturing, and challenging ages 4-9*. Minneapolis, MN: Free Spirit.

Tolan, S. S. (1998). The lemming condition: Moral asynchrony and the isolated self. *Roeper Review*, *20*, 211-214.

U.S. Department of Health, Education, and Welfare. (1972). *Education of the gifted and talented*. Washington, D.C.: Author.

VanTassel-Baska, J. (1990). School counseling needs and successful strategies to meet them. In J. VanTassel-Baska (Ed.), *A practical guide to counseling the gifted in a school setting* (2nd ed., pp. 66-71). Reston, VA: The Council for Exceptional Children.

Walker, S. Y. (1991). *The survival guide for parents of gifted kids: How to understand, live with, and stick up for your gifted child*. Minneapolis, MN: Free Spirit.

Webb, J. T., & Latimer, D. (1997). *ADHD and childen who are gifted* [Online]. Available: http://www.teleport.com/~rkaltwas/tag/articles/eric522.html

Webb, J. T., Meckstroth, E. A., & Tolan, S. S. (1982). *Guiding the gifted child: A practical source for parents and teachers*. Columbus, OH: Ohio Psychology.

White, M. (1989). *Selected papers*. Adelaide, Australia: Dulwich Center Publications.

Winner, E. (1996). *Gifted children: Myths and realities*. New York: Basic Books.

***Gwen L. Fornia**, M.A., is a national certified counselor working in private practice in Denver, CO. Her primary focus is working with gifted children and their families.*

***Marsha Wiggins Frame**, Ph.D., is associate professor of counseling psychology and counselor education at the University of Colorado at Denver.*

Family Counselors as School Consultants: Where Are the Solutions?

Denyse B. Doerries
Victoria A. Foster
College of William and Mary

A systemic perspective applied to school-based problems examines the interaction patterns between the home and school; the ecological view examines the contextual variables that affect child development. This article presents a home-school collaborative-consultation model for family counselors that combines a systems-ecological approach with solution-focused, problem-solving strategies to facilitate home-school problem-solving meetings. School personnel often perceive the child as the source of the problem, which limits the scope of their interventions and ignores the potentially positive effect of involving families in the problem-solving process. A need exists for mediators who think systemically and can facilitate productive relationships between families and schools. A case study illustrating the application of this model is presented and implications are discussed.

Research in child development indicates that the most important influence on a child's development is the family (Valentine, 1992). The second most important environmental influence is the school (Epstein, 1992). Children whose parents are connected to the school in positive ways have distinct advantages both academically and behaviorally (Christenson & Conoley, 1992; Comer & Haynes, 1991; Epstein, 1986, 1990, 1995; Hoover-Dempsey & Sandler, 1995).

Collaboration between home and school does not always happen automatically. Consequently, mediators who can foster the establishment of productive relationships between the home and the school are needed (Edwards & Foster, 1995; May & Church, 1999). By joining the forces of schools and families, partnerships are developed that foster school and social success for children (Dryfoos, 1994). Reciprocal support for positive home and school practices emerges when parents and school personnel are brought together in a cooperative way (Epstein, 1986). This integration of home and school prevents the isolation of any one institution from other systems of care (Dryfoos).

This article presents a home-school collaborative-consultation model for use by family counselors in school settings and provides specific steps to facilitate a conjoint home-school problem-solving meeting. This orientation invites family counselors to expand their work with families to include the school context (May & Church, 1999). A case study illustrating the application of this model is presented and implications are discussed.

SYSTEMS-ECOLOGICAL MODEL

Often when a student is experiencing difficulty adapting to the school environment, interventions are developed that focus solely on the child and ignore the contexts within which he or she develops (Edwards & Foster, 1995). School personnel may not be knowledgeable about systems theory or family dynamics and may make recommendations that are counterproductive or have negative repercussions (May & Church, 1999; Nicholl, 1992). A systemic view evaluates interaction patterns within a system and among systems (Sontag, 1996). The systems view allows for a new and expanded definition of intervention, moving away from the child as the sole focus of the treatment and toward a proactive, positive stance that promotes growth-producing behavior in the families and schools (Dunst, Trivette, & Deal, 1988; Johnston & Zemitzsch, 1997).

Literature suggests the need for involvement of family counselors when there are potential home-school conflicts because of their systems training and their skills as mediators and facilitators (Woody & Woody, 1994; Woody, Yeager & Woody, 1990). A substantial body of literature also suggests that school counselors trained in systemic interventions can be pivotal in establishing effective home-school relationships (Hinkle, 1993; W. Lewis, 1996; Nicholl, 1992). Mandating family participation does not, however, guarantee parents being integral to the problem-solving process. The family may be present physically, yet still feel external to the process. New strategies to foster collaboration across these two counseling professions as well as between school personnel and families need to be explored.

The counseling literature promotes the virtues of broadening the professionals' perspective by removing children as the source of the problem and looking more closely at the social-

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izing agents responsible for promoting child development (Bergan, 1995; Greer, Greer & Woody, 1995; Hinkle, 1993; Huebner & Gould, 1991; Nicholl, 1992). Both consultation and family counseling research support the effectiveness of employing a systems-ecological paradigm to develop interventions with families and schools (Carlson & Hickman, 1992; Conoley & Conoley, 1992; Evans & Carter, 1997, Fine, 1992; O'Callaghan, 1994; Sheridan, 1997).

Therefore, systems-ecological orientation promotes a wider worldview. The systemic perspective applied to school-based problems examines the interaction patterns between the home and school; the ecological view examines the contextual variables that affect child development. Discordance is defined as a disparity between an individual's abilities and the demands or expectations of the environment—a failure to match a person and a system thus becomes the focus (Fine & Carlson, 1992; Sontag, 1996). The systems-ecological paradigm becomes a framework by which existing techniques such as collaborative consultation, family counseling, instructional modifications, behavioral interventions, and problem-solving strategies are used to facilitate a match between the person and the systems (home, school, community) in which they are developing (Conoley & Conoley, 1992). To implement such an approach, the professionals involved must be skilled in collaborative consultation across systems and disciplines.

CONSULTATION PARADIGM FOR FAMILY COUNSELORS

Consultation differs from counseling in that its focus is on expanding the capacities of organizations to emphasize more proactive, preventive, and systemic strategies rather than traditional intervention strategies (J. A. Lewis, Lewis, Daniels, & D'Andrea, 1998). The model used for consultation by school counselors and family counselors may vary greatly depending on their training and orientation (Keys, Bemak, Carpenter & King-Sears, 1998). The choice of model also affects the nature of the relationship and who is involved in the relationship. The manner in which the interaction between home and school occurs determines whether the consultation process will empower the families and schools to promote student development (Fine & Gardner, 1997).

Collaboration is a style of consultation that assumes that the communication is interactive and reciprocal such that the consultant does not just give but also receives information (Idol, Nevin, & Paolucci-Whitcomb, 1995). Collaborative consultation is a model that allows professionals and nonprofessionals to share expertise and to generate creative solutions to benefit children (Fine, 1990). The collaborative-consultative model engages parents, educators, and counselors as equal participants in a problem-solving process (Nevin, Thousand, Paolucci-Whitcomb, & Villa, 1990). The focus is on multiple experts who come together to jointly identify problems to be addressed as a team and determine strategies and roles of each person in the creation of solutions (Keys et al., 1998). Collaborative consultation is described as a nonexpert model that can foster facilitative liaisons between schools, parents, and the community.

INTERPROFESSIONAL COLLABORATION

Family counselors are in the unique position of having significant training in family systems and are accustomed to helping clients improve their functioning within the unit of the family. As family counselors establish relationships with the schools, they will need to broaden their emphasis to the larger system and to the needs of both the families and the school professionals (Quinn & Cowie, 1995). To do this successfully, family counselors must be skilled in a number of areas: collaborative problem solving, connecting and understanding the structure and interaction patterns of the families and the schools, and solution-focused strategies to provide a positive framework for problem solving. Family counselors will need to provide interprofessional consultation as well as shift their focus to the home-school system of interactions (Edwards & Foster, 1995). A central task is to promote an effective interface between the families and the schools through family-school (teacher, school counselor, principal, etc.) sessions (Hinkle, 1993).

Bridging the gap between the home and school can be a daunting task for professionals within the school and in the community because of the many diverse views regarding the nature of the students' problems. The school counselor is a uniquely valuable resource for any external consultant (Edwards & Foster, 1995). The school counselor could assist the family counselor in understanding the school professionals' view of the student's problem, the interaction patterns between the home and school, as well as the patterns of interaction within the school (Carpenter, King-Sears, & Keys, 1998). The school counselor can also collaborate with the family counselor to develop treatment strategies congruent with school-based interventions (Carpenter et al., 1998).

CONSULTATION + SYSTEMS THINKING + SOLUTION-FOCUSED STRATEGIES

Family systems and systems consultation share a nonlinear, dynamic, complex thinking style that is the basis for understanding and developing intervention strategies. The counseling and consultation literatures cite a number of studies that integrate skills and knowledge in family systems theory with consultation approaches to home-school problems (Aponte, 1976; Evans & Carter, 1997, O'Callaghan, 1994). Although all of these models employ a systemic approach to foster home-school problem solving, typically they describe paradigms derived from family therapies that necessitate implementation over a course of multiple sessions (Aponte;

Evans & Carter; O'Callaghan). However, the process of consultation is typically based on a minimal number of meetings, and therefore, efficient problem-solving strategies are needed. The brief, solution-focused strategies suggested by Carlson and Hickman (1992) seem more conducive to making the transition from family therapist to consultant.

Carlson and Hickman (1992) developed a model for family consultation in the schools. The goal of this model was to assess and intervene in multiple systems. Although the authors found both structural family therapy and strategic family therapy to be successful with school-related problems, their consultation model employed a strategic, brief, solution-focused therapy orientation that emphasized exceptions to the problem and client's strengths needed for dissolving the problem.

The integration of the theoretical knowledge of systems thinking, a collaborative style of consultation, and solution-focused strategies results in a framework specifically applicable for family counselors. Both the techniques of solution-focused interventions and the theory of family systems are conducive to the development of facilitative, problem-solving relationships that are needed to enhance the connections and interactions between families and schools. Such a consultation paradigm builds on the knowledge and skills already available to family counselors. Observing patterns of communication and interrelationships between the family and the school places the family counselor in a position to block dysfunctional communication. Listening to each person's view of a problem while promoting a search for strengths within both the school and family promotes empowerment of both groups. Acknowledging skills, strengths, and expertise in both arenas allows for a collaborative, nonblaming meeting.

The assessment process of family therapy, which examines patterns of interaction, alignments, flexibility, and boundaries, provides helpful information with regard to consultation. However, the processes of consultation need to be task focused in order to establish a collaborative relationship in which all parties have equity and power. Searching for strengths and looking for examples of when the problem does not occur can be integrated into the problem-solving process. The family counselor not only needs to explore the circumstances in which the problem behavior occurs and the responses of significant others in the system, but also needs to explore the times when the problem does not occur and the resulting consequences for the child.

A commitment to continual professional development that integrates the collaboration consultation approach to systemic intervention can help professionals better meet the complex needs of families and children.

The solution-focused family-school problem-solving meeting creates an expectation of change and solutions versus diagnosis and blame. It empowers everyone involved by shifting from blame to shared responsibility and decision making. Just as in family therapy, families and schools can become stuck in rigid patterns and need assistance in trying new paths (Carlson & Hickman, 1992). Counselors (family and school) trained in both collaborative consultation, family systems theory, and solution-focused problem-solving strategies would be ideal for the role as a facilitator of home-school collaboration.

STEPS FOR THE HOME-SCHOOL CONSULTATION MEETING

School problems are the major reason for referrals to family counselors (Lusterman, 1985). Often, family counselors are expected to resolve problems that both the home and the school were unable to solve. For family counselors to fully understand the interaction patterns and the meanings and implication of behaviors, problem-solving meetings with school personnel are needed (Lusterman, 1985). The following steps to problem-solving meeting are an integration of the ideas of Carlson and Hickman (1992), Carlson, Hickman, & Horton (1992), Weiss and Edwards (1992), and the consultation and clinical experience of the authors.

Prior to a conjoint meeting of the family and school personnel, the family counselor needs to accomplish three things, while simultaneously avoiding the role of an expert. First, the family counselor must join with the family and identify the interaction patterns in the family. Second, the family counselor must also establish a connection with a school counselor or student services professional who can provide an understanding of the school's pattern of interactions with the family as well as the policies and organization patterns within the school setting. For example, if the school counselor reports that teachers are experiencing significant frustration with the identified student, the family counselor may need to meet with them in order to avoid a negative blaming meeting between the school and family. The family counselor needs to hear the teacher's point of view and allow the expression of feelings and then clarify and prioritize the problem areas before a conjoint meeting is attempted. The teacher(s) may need assistance in developing ways to describe their concerns that are conducive to enhancing a problem-solving format between the school and the family. Finally, the family coun-

selor needs to be able to identify the strengths and competencies of both the family and school personnel and be prepared to support them.

The family-school "problem-dissolving meeting" has three goals: (a) to focus on the exceptions to the problem, (b) to take a nonpathological view of the problem, and (c) to use the resources and strengths of the client and the involved systems to dissolve the problem. Useful strategies for accomplishing these goals include searching for past problem-resolution success, using language that presupposes change in a positive direction, and identifying the smallest change toward the goals (Carlson & Hickman, 1992). Carlson & Hickman hypothesized that by establishing a group norm that supports strengths and a positive approach, lines of communication between the family and the school can be opened and the interactions between the home and school become more positive. Alternatively, meeting separately with the various parties involved without coming together could encourage negative blame across systems.

Step 1: As noted above, the first contact of the family counselor should be with the person in the school who has identified a problem with a child (teacher, school counselor, etc.) or who has a pivotal relationship with the child and the teacher. The family counselor will need to emphasize that the parents and the school personnel who have contact with the child need to be present and active participants at the meeting(s). The student may be asked to attend depending on the history of intensity of the conflict between the home and school, the presence and degree of blame, and the nature of the problem. If there has already been a significant conflict between the home and school, the student should not attend until the intensity of the disagreement between the home and school has lessened. The meeting should be described to the participants as a way to provide as good a school experience for the student as possible. Everyone should have an opportunity to share his or her concerns, and the outcome should be a concrete plan of action to deal with one or two issues that all can agree upon (Weiss & Edwards, 1992). The counselors need to establish a nonblaming, problem-solving tone that will enhance the joining process.

Formal introductions assure that everyone is given the necessary respect and familiarity with each other. This important process can be another joining opportunity and should not be rushed. Each person's area of expertise needs to be acknowledged and supported. Because the family counselor initiated the meeting, the school personnel will look for some leadership from the counselor; however, the hierarchy in the school needs to be respected. The family counselor may ask who would ordinarily run the meeting and suggest a collaboration of leadership.

Step 2: The next step would be to have each person describe no more than one or two concerns they have about the referred child. The family counselor needs to explore and clarify the historical context in which the problems occur and when these problems do not occur. It is also important to ascertain the meaning that is given to the behaviors. Questions should focus on the circumstances in which the child is successful. Listening intently to each person's point of view and using matching language and metaphors are suggested as techniques that help the joining process (Carlson, Hickman, & Horton, 1992).

Blaming needs to be blocked by acknowledging the frustration and refocusing the discussion on possible solutions by reemphasizing the goals of the meeting. Weiss & Edwards (1992) suggested the following strategies for blocking blame: (a) using reframes, (b) refocusing the discussion, (c) validating the difference between a class of 30 and a child in a family setting, and (d) direct blocking by restating the purpose of the meeting. Asking about past solutions to similar problems, searching for strengths, and searching for exceptions to the problem are all strategies that might be implemented in this phase.

Step 3: Establish a solvable goal. Often, problems seem so overwhelming that people give up before they begin. Narrowing the problem down to a small piece of the original problem, taking baby steps, and encouraging small changes all are ways to negotiate a goal.

Step 4: Elicit multiple strategies or solutions to reach the small goal through brainstorming a number of possible solutions. Brainstorming needs to be explained as a time when all suggestions are acceptable. Piggybacking on someone else's solution is appropriate. After having a number of strategies suggested, the counselor must check for consensus and highlight common themes presented by both the parents and the teachers.

Step 5: Choose the solution to be attempted. Parents and teachers should choose the strategy or strategies with which they are most comfortable. This will increase the likelihood of the strategy's being implemented. Easy strategies are more readily implemented than complex ones.

Step 6: A follow-up meeting should be scheduled for 2 to 3 weeks to increase the likelihood of everyone following through with his or her commitments. The goal is not only to problem solve about a particular child's needs but also to model collaboration between the family and school. The follow-up meeting will also present an opportunity to evaluate the intervention and recycle through the problem-solving steps, if necessary.

APPLICATION OF THE MODEL

A pilot project incorporating the family counselor/consultant framework was developed that built upon another school/university collaborative project currently in place. Advanced graduate students from a counselor education program at a mid-Atlantic university provide counseling services applying a model of family counseling and family-school collabora-

tion. The following case involved a family counselor intern from the program and a school counselor.

THE CASE OF THE FAMILY WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Family B. was referred to the New Horizon Family Counseling Center by the school counselor because of behavior problems of their 11-year-old son, Evan. Evan was diagnosed as having ADHD and was placed in an inclusion model of special education. He was described as impulsive, disrespectful toward adults and peers, and unable to produce adequate work on a consistent basis. Evan's family included a mother, father, 7-year-old brother with severe disabilities, and an 18-year-old brother with ADHD who was about to graduate from high school. The family counselor intern identified stressors on the family related to their small living space, financial concerns, and the family-school relationship regarding their son. There appeared to be a disagreement between the mother and father about Evan's discipline problems. Mom tended to yell and threaten consequences for misbehavior but was too overwhelmed with the day-to-day care of the younger child to follow through. Dad distanced himself from the chaotic family by focusing on the computer when he was at home and ignoring the children. To gain dad's attention, the children misbehaved, at which time the father overreacted in a punitive manner. Mom sympathized with Evan because he did not have an adequate relationship with his father and she believed that the school was picking on him. Dad thought mom was too lenient on Evan and spoiled him.

Step 1: By consulting with the school counselor first, the family therapy intern learned that the teachers in the school believed Evan should be removed from the inclusion setting and placed in a self-contained classroom for children with emotional disturbances. They considered him to be a threat to the safety of the other students in the class because of his impulsive behavior. Classroom-based behavior modification programs had been attempted with little success. The school counselor had been meeting with the teachers and the mother every 2 weeks to try to establish a connection and to coordinate home-school communication. The family counselor intern was asked to attend an individual education plan meeting to discuss possible interventions for Evan.

Step 2: Because the school counselor reported that the teachers were frustrated with Evan, the family counselor first met with the school counselor and teachers to listen to their concerns about Evan. The family therapist employed such strategies as reframing and positive punctuation to assist the teachers. The family counselor reduced the intensity of the teachers' frustrations by acknowledging how challenging Evan was and praising the teachers for their patience. The family counselor attempted to reframe the teachers' view of Evan by presenting him as requiring more support and attention because of the needs of his younger brother. The family counselor described Evan as being sad and craving attention, and the family as overwhelmed, to replace the teachers' frame of Evan being out of control and the family ignoring his behavior. The solution focus process began when the family counselor asked when Evan was behaving appropriately. The teachers reported that if Evan was allowed to sit in a quiet corner in close proximity to the teachers he seemed to perform better. Also, Evan read well and could help other students with their reading. Math and hall behaviors were the most pressing problems for him.

The family counselor's strategy was to integrate her knowledge of the family structure by using the school meeting as a way to involve the father in Evan's life in a more positive way. The family counselor asked the school counselor to be sure to invite the father to come to the meeting, as he had never come to the school with regard to Evan or any of his children. The family counselor and the school counselor agreed that just having the father come to school would be a positive intervention in and of itself. Three meetings were held and each time the father came, Evan's behavior improved in the classroom. The family counselor used this information in a counseling session to suggest to the father that his attention had a powerful effect on his son. In the school meetings, the father's participation was praised and the teachers and school counselor made positive comments about its effects on Evan. The teachers also articulated more empathy and respect regarding the mother's struggles and supported her caring efforts for this son. Mom volunteered that she believed the problem was that Evan wanted more attention from her husband. Mom believed that Evan would benefit from positive attention from male role models. The teachers agreed. The integration of the knowledge of the family structure with the school meeting helped to facilitate growth in both domains.

Step 3: Both the family and the teachers agreed on a goal of increasing the amount of attention Evan received from his father and other male role models.

Steps 4 and 5: A plan was devised in which dad spent special time with Evan, and the school principal, who was male, also volunteered to mentor Evan. It was decided, with the mother's permission, that the father would be the parent of contact for the teachers. Thus, the mother was able to relinquish a stressful responsibility with which she had had no previous assistance. The teachers also liked this strategy because it was congruent with their belief that the father's active role was needed to enhance behavioral control with the child. The family counselor continued to work on reducing the disagreement between mom and dad about Evan's need for attention and discipline in the home. The school counselor involved Evan in a counseling group for ADHD students with social skill deficits.

The teachers placed Evan in an after-school math tutoring program in which high school students tutored the middle school students. Evan was assigned to a male tutor for assistance with math facts and work completion. A buddy system with an older and responsible male student was established to help Evan make his way in the halls.

Evan was able to continue in the inclusion setting. The teachers expressed appreciation for the assistance that the family counselor and school counselor were giving to them regarding this student. The family counselor and school counselor continued to communicate with the teachers and support their efforts to help Evan. The family described the school as supporting them rather than picking on their child.

Finally, the family counselor connected the family with a community agency that provided respite care. The availability of such a resource and the encouragement of the counselor made this option acceptable to the family, as they were reluctant to include anyone outside the family in child care. This resulted in the parents having at least 1 night a month in which they could focus on the two older children or themselves.

IMPLICATIONS FOR TRAINING AND SUPERVISION

To create solutions that have impact across the domains of home and school as well as to produce powerful intervention, all parties affected need to be involved. The solutions are not always in the counselor's office but in the homes and schools where the children spend their days. Developing interventions at the home-school interface requires that all counselors be trained in understanding systemic thinking and systems interventions. Preparation for implementing the collaborative-consultation model in school settings requires an interdisciplinary approach to counselor education. For example, such courses could bring together faculty and students in school, family and community counseling, school psychology, and special education to explore both different and shared perspectives on roles and responsibilities, theoretical orientations, and problem-solving models for working with children and their families. Team approaches to instruction and class activities would also model the ecosystemic perspective and provide opportunities for the realistic application of the intervention skills and concepts through the interaction of the various team members.

Both family and school counselors require ongoing supervision to provide support, maintain acquired skills, and provide an evaluation of professional performance. A commitment to continual professional development that integrates the collaboration-consultation approach to systemic intervention can help professionals better meet the complex needs of families and children. Clinical supervisors need to encourage counselors to take a more expanded role across systems (community, schools, churches, courts, etc.) during the student counselor's internship. School personnel may be very receptive to family counselors visiting and developing partnerships to benefit students. In addition, school counselors with knowledge of systemic interventions are valued members of school-based problem-solving teams. School counselors who redefine their roles to include the broader community can better provide a continuum of services for their students (Keys et al., 1998). Both school counselors and family counselors need to be challenged during their graduate training to step outside of narrowly defined roles in order to provide more comprehensive and integrated programs for children and their families (Keys et al.).

CONCLUSION

Although many family counselors value a family-school collaboration model and share an appreciation of the complexities of family interaction patterns, there is a need for a structured framework that can be systematically applied using collaborative-consultation strategies across systems and disciplines. The home-school-collaborative-consultation model for family counselors has been described in this article as a framework that family counselors can use to establish effective home-school relationships and broaden their conceptualization of family problems. This approach also increases the likelihood of engaging the family in problem-solving activities. Increased communication, more open interactions, and a systems-oriented perspective can create a genuine family-friendly culture throughout the school system. Additional efforts are needed to further this agenda on behalf of children and families.

REFERENCES

Aponte, H. J. (1976). The family-school interview: An eco-structural approach. *Family Process*, *15*, 303-312.

Bergan, J. (1995). Evolution of a problem solving model of consultation. *Journal of Educational and Psychological Consultation*, *6*(2), 111-123.

Carlson, C. I., & Hickman, J. (1992). Family consultation in schools in special services. *Special Services in the Schools*, *6*(3/4), 83-112.

Carlson, C. I., Hickman, J., & Horton, C. B. (1992). From blame to solutions: Solution-oriented family -school consultation. In S. L. Christenson & J. C. Conoley (Eds.), *Home-school collaboration* (pp. 193-213). Silver Spring, MD: National Association of School Psychologists.

Carpenter, S. L., King-Sears, M. E., & Keys, S. G. (1998). Counselors + educators + families as a transdisciplinary team = more effective inclusion for students with disabilities. *Professional School Counseling*, *2*(1), 1-9.

Christenson, S. L., & Conoley, J. C. (1992). *Home-school collaboration: Enhancing children's academic and social competence*. Silver Spring, MD: National Association of School Psychologists.

Comer, J. P., & Haynes, N. M. (1991). Parent involvement in schools: An ecological approach. *Elementary School Journal*, *91*, 271-277.

Conoley, J. C., & Conoley, C. W. (1992). *School consultation practice and training* (2nd ed.). Boston: Allyn & Bacon.

Dryfoos, J. (1994). *Full service schools*. San Francisco: Jossey-Bass.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling & empowering families*. Cambridge, MA: Brookline Press.

Edwards, D. L., & Foster, M. A. (1995). Uniting the family and school systems: A process of empowering the school counselor. *The School Counselor, 42*, 277-282.

Epstein, J. L. (1986). Parents' reactions to teacher practices of parent involvement. *The Elementary School Journal*, *86*(3), 277-294.

Epstein, J. L. (1990). School and family connections: Theory, research, and implications for integrating sociologies of education and family. *Marriage and Family Review*, *15*(1-2), 99-126.

Epstein, J. L. (1992). School and family partnerships: Leadership roles for school psychologists. In S. L. Christenson & J. C. Conoley (Eds.), *Home-school collaboration* (pp. 499-515). Silver Spring, MD: National Association of School Psychologists.

Epstein, J. L. (1995). School/family/community partnerships: Caring for the children we share. *Phi Delta Kappan*, *76*, 701-712.

Evans, W. P., & Carter, M. J. (1997). Urban school-based family counseling: Role definition, practice applications, and training implications. *Journal of Counseling and Development*, *75*, 366-374.

Fine, M. (1990). Facilitating home-school relationships: A family oriented approach to collaborative consultation. *Journal of Educational and Psychological Consultation*, *1*(2), 169-187.

Fine, M. (1992). A systems-ecological perspective on home-school interventions. In M. Fine & C. Carlson (Eds.), *The handbook of family school intervention a systems perspective*. (pp. 1-17). Boston: Allyn & Bacon.

Fine, J. J., & Carlson, C. (1992). *The handbook of family-school intervention a systems perspective*. Boston: Allyn & Bacon.

Fine, J. J., & Gardner, P. A. (1997). Counseling and education services for families: An empowerment perspective. In W. M. Walsh & R. G. Williams (Eds.), *Schools and family therapy: Using systems theory and family therapy in the resolution of school problems*. Springfield, IL: Charles C. Thomas.

Greer, B. B., Greer, J. G., & Woody, D. E. (1995). The inclusion movement and its impact on counselors. *The School Counselor, 43*(2), 124-132.

Hinkle, J. S. (1993). Training school counselors to do family counseling. *Elementary School Guidance & Counseling*, *27*(4), 252-257.

Hoover-Dempsey, K. V., & Sandler, H. M. (1995). Parental involvement in children's education: Why does it make a difference? *Teachers College Record*, *95*, 310-331.

Huebner, E. S., & Gould, K. (1991). Multidisciplinary teams revisited: Current perceptions of school psychologists regarding team functioning. *School Psychology Review, 20*(3), 428-434.

Idol, L., Nevin, A., & Paolucci-Whitcomb, P. (1995). The collaborative consultation model. *Journal of Educational and Psychological Consultation*, *6*(4), 347-361.

Johnston, J. C., & Zemitzsch, A. (1997). Family power: An intervention beyond the classroom. In W. M. Walsh & R. G. Williams (Eds.), *Schools and family therapy: Using systems theory and family therapy in the resolution of school problems* (pp. 23-39). Springfield, IL: Charles C. Thomas.

Keys, S. G., Bemak, F., Carpenter, S. L., & King-Sears, M. E. (1998). Collaborative consultant: A new role for counselors serving at-risk youth. *Journal of Counseling and Development*, *76*, 123-133.

Lewis, J. A., Lewis, M. D., Daniels, J. A., & D'Andrea, M. J. (1998). *Community counseling. Empowerment strategies for a diverse society.* New York: Brooks/Cole.

Lewis, W. (1996). A proposal for initiating family counseling interventions by school counselors. *The School Counselor, 4*, 27-31.

Lusterman, D. D. (1985). An ecosystemic approach to family-school problems. *The American Journal of Family Therapy, 13*(1), 22-30.

May, K. M., & Church, N. L. (1999). Families and communities: Building bridges. *The Family Journal: Counseling and Therapy for Couples and Families*, *7*(1), 51-53.

Nevin, A., Thousand, J., Paolucci-Whitcomb, P., & Villa, R. (1990). Collaborative consultation: Empowering public school personnel to provide heterogeneous schooling for all—or, Who rang that bell? *Journal of Educational and Psychological Consultation*, *1*, 41-67.

Nicholl, W. G. (1992). A family counseling and consultation model for school counselors. *The School Counselor, 39*, 351-361.

O'Callaghan, J. B. (1994). School-based collaboration with families: An effective model for a society in crisis. *The Family Journal: Counseling and Therapy for Couples and Families*, *2*(4), 286-300.

Quinn, K., & Cowie, K. (1995). Supervision of family counselors in the public schools: A systems overlap. *The Family Journal: Counseling and Therapy for Couples and Families*, *3*, 48-56.

Sheridan, S. M. (1997). Conceptual and empirical bases of conjoint behavioral consultation. *School Psychology Quarterly*, *12*(2), 119-133.

Sontag, J. C. (1996). Toward a comprehensive theoretical framework for disability research: Bronfenbrenner revisited. *The Journal of Special Education*, *30*(3), 319-344.

Valentine, M. R. (1992). How to deal with difficult school discipline problems: A family systems approach adapted for schools. In S. L. Christenson & J. C. Conoley (Eds.), *Home-school collaboration* (pp. 357-382). Silver Spring, MD: National Association of School Psychologists.

Weiss, H. M., & Edwards, M. E. (1992). The family-school collaboration project: Systemic interventions for school improvement. In S. L. Christenson & J. C. Conoley (Eds.), *Home-school collaboration* (pp. 215-243). Silver Spring, MD: National Association of School Psychologists.

Woody, R. H., & Woody, J. K. (1994). The fourth revolution: Family systems in the schools. *The Family Journal: Counseling and Therapy for Couples and Families*, *2*, 19-26.

Woody, R. H., Yeager, M., & Woody, J. D. (1990). Appropriate education for handicapped children: Introducing family therapy to school-based decision making. *The American Journal of Family Therapy*, *18*(2), 189-197.

Denyse B. Doerries *is a training specialist in moderate disabilities and behavior at the Technical Training and Assistance Center and an adjunct professor at The College of William & Mary.*

Victoria A. Foster *is an associate professor in the counselor education program at The College of William & Mary and director of the New Horizons Family Counseling Center.*

A Musical Chronology and the Emerging Life Song

Thelma H. Duffey
Southwest Texas State University
Christine A. Lumadue
Sandra Woods
St. Mary's University

Listening to music often evokes in individuals cognitive and affective memories of important life events and significant losses. The authors have observed that music and lyrics significantly contribute to individuals' creation of relationship narratives that restrict their ability to form and/or maintain intimacy. By connecting music with past relationship experiences, individuals' perceptions of the viability of loving relationships are often affected. This connection may serve to support or impede their ability to engage in or commit to a love relationship. The authors present a method, the musical chronology, that can assist clients in identifying and reauthoring restrictive relationship narratives. A case example that demonstrates the method's application is included.

We live in an era in which with the push of a button we can hear a tune on the radio and go back to a time long forgotten. In fact, many popular radio stations include or are solely dedicated to music from the past and target audiences who enjoy experiencing a nostalgic connection with their past. Oldies programming, as it is often referred to, affords listeners an opportunity to recall life events on a regular basis and to experience them once again. In a similar manner, in therapy counselors frequently assist individuals in revisiting their histories (Ansbacher & Ansbacher, 1964; Bowen, 1978) with the goal of helping clients to achieve the changes they seek in their lives.

In this article, we present a method, the musical chronology, that we have used with clients in individual, couples, and workshop settings to address relationship issues with self, others, and/or existential or spiritual concerns. Our focus here will be on resolving issues surrounding relationships with others, particularly romantic relationships. We will use a case study with an individual client who is seeking to resolve relationship issues. We chose to use an individual case study rather than one with a couple to introduce the process of the musical chronology because we felt this format would present the material in its simplest and most succinct form. However, we consider this to be a couple and family issue because the process engages the client's capacity to function within the system and address issues of intimacy within the system. Because struggles with intimacy affect all relationships and are among the leading reasons cited by individuals and couples seeking psychotherapy (Timmerman, 1991), the resolving of these issues by any member of a system is essential to allowing genuine attachment and commitment within a couple or family system to occur. Therefore, it is our position that by focusing on the individual, we would demonstrate an approach that could facilitate one partner's readiness for participation in a relationship and in future couples therapy.

This method evolved out of three factors. The first was our work with clients' restrictive narratives about relationships, especially romantic relationships (White & Epston, 1992).

As Hodas (1994) explains, "Personal narratives are those self-statements and beliefs pertaining to self-worth, personal history, entitlement, and future outcomes" (p. 200). These may take on a life of their own, and unless the restrictive narratives are altered, he believes that positive change will tend to be short term. We often found that our clients' personal narratives about relationships were restrictive. Thus, as Durant (1993) observed in his description of the hold of personal narratives on individuals' experiences, individuals "often do not see the possibility of things being different and so may feel hopeless and defeated, and may get caught up in continuing problem behavior" (p. 27).

The second factor to influence the development of this method is the authors' observations that music and lyrics significantly contribute to clients' creation and/or maintenance of restrictive relationship narratives. Indeed, both men and women commonly connect music with current or past love interests. This connection strongly influences individuals' perceptions of the viability of loving relationships, thus supporting or impeding the individuals' ability to engage in or commit to a love relationship (A. Wells, 1990). The third factor comes from research on the effects of music on mood induction or alteration and memory. This research will be reviewed later in this article.

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The musical chronology has several objectives. One objective is to facilitate clients' access to their emotional responses to past relationships. A second objective is to provide a vehicle for identifying the restrictive narratives (White & Epston, 1992) created by clients in reaction to their past relationships. As patterns of behavior or emotions are discovered through the chronology, the clients' personal relationship narratives are clarified. Helping clients recognize the effects of these relationship narratives on present relationships is the third objective. As Langer pointed out in 1951, "Because the forms of human feelings are more congruent with musical forms than with the forms of language, music can reveal the nature of feelings with a detail and truth that language cannot approach" (p. 199). The fourth objective of the musical chronology is to assist clients to deconstruct restrictive narratives and reauthor their lives through the use of music consciously selected. Despite this narrative focus, the chronology is a creative means of facilitating the working through of unresolved relationship issues that impede current relating. Therefore, this process may be utilized within a variety of theoretical bases including grief therapy, cognitive therapies, and Adlerian and other family and couple therapies.

MUSIC, MOOD, AND MEMORY

Music often plays many different roles in people's lives. Christianson and Lindlof (1983) noted that music has a significant emotional impact on children. According to Larson and Kubey (1983), music reflects the range of emotional experiences that adolescents encounter in their daily lives. Music also has some degree of influence on how teens deal with problems (Schlattmann, 1989). It has been found that secondary and college students use music to relieve boredom, manipulate mood, ease tension, and fight loneliness (Gantz, Gartenberg, Pearson, & Schiller, 1978). Melton and Galician (1987) reported the further uses of music for passing time, relaxation, and forgetting about problems. Adolescents identify strong emotional connections associated with music, and these often vary widely by gender, though both males and females use music for mood management (Wells & Hakanen, 1991). Several studies have focused on adult age groups, consistently finding that music can induce specific emotional states and alter mood (Eich & Metcalfe, 1989; Hanser & Thompson, 1994; Terwogt & Van Grinsven, 1991). These findings support mood management theory in that it is based on the hedonistic premise that (a) individuals strive to rid themselves of bad moods or at least seek to diminish the intensity of such moods, and (b) individuals strive to perpetuate good moods and seek to maintain the intensity of these moods (Zillman, 1990, p. 328).

Love themes are frequent components of Western popular music as well as the music of other cultures (Carey, 1969). Zillman and Gan (1997) hypothesize that

> persons who acutely suffer from romantic disappointments might find solace in the expression of similar disappointment by others. Perhaps it is a desire to feel understood in one's suffering—suffering that is highly personal and private and that cannot be readily shared with friends—that can best be satisfied by love-lamenting songs by co-suffering others whose music can be consumed in the protection of solitude. (pp. 177-178)

Several authors have looked at the emotion of love and the differing ways the genders manage it (Denisoff & Bridges, 1982; Frith, 1981; Hochschild, 1983). In *The Managed Heart*, Hochschild suggested that women may be more in touch with their feelings and more likely to manage them through conscious suppression. Men, on the other hand, have a greater tendency to subconsciously repress their feelings. These forms of emotion management concur with the argument made by Chodorow (1980) that women have greater access to their feelings due to the way they are socialized in childhood. However, accessing feelings is simply one aspect of relationship potential. The ability to both identify and work through feelings of loss in relationships allows individuals to enjoy and maintain relationships in the present. Identifying the means to access emotion is, therefore, a significant relational skill and therapeutic goal.

One means of accessing these emotions is through music. Music has long been considered the language of emotion and has historically been a component in the ancient healing rituals of cultures throughout the world. It has symbolic meaning to people in all cultures. North American Indians and Alaskan Natives have traditionally placed great emphasis on the role of music in shamanic healing practices. Just as the shaman may use music to enter the spirit world, music may influence the psychological and physiological state of the patient or client, allowing access to ordinarily repressed emotions (Moreno, 1995). Summer (1998) suggested that music can be used as a vehicle for travel to the unconscious to uncover and deal with problematic inner material of significance. Moreno states:

> Being open and receptive to the stream of imagery and unconscious feelings that come to conscious awareness in music and imagery therapy also allows music therapy clients a way of expanding their individual consciousness as well as providing a means of relieving pressures that can result from the internalization of significant personal issues. (p. 335)

Certain songs have the capacity to arouse feelings in individuals because of their association with significant autobiographical memories. Baumgartner (1992) investigated the relationship between the emotions that describe the original experience and those aroused in hearing the music that reawakened the feelings. Participants reported that listening to a personally significant piece of music caused particularly vivid and emotional recollections of past experiences that often appeared with images descriptive of the original events. The author also found a positive correlation between the

feelings aroused by listening to the particular piece of music and the affective characteristics associated with the original personal experience. Hale (1990) stated, "Music is rich in its ability to open the storehouse of memoria" (p. 270).

. . . we present a method, the musical chronology, that we have used with clients in individual, couples, and workshop settings to address relationship issues with self, others, and/or existential or spiritual concerns.

LOVE AS A STORY

The musical chronology is based on the premise that individuals create stories about themselves and their relationships (Timmerman, 1991). In fact, Sternberg's (1998) developmental view of love is that love is a story and the individuals involved are the authors. He believes the story to have a beginning, middle, and often an end, and that the ending is often predictable at the beginning of the relationship. The story is continually being revised and rewritten. It is socialized over the individual's lifetime by means of interactions between the individual and his or her environment. The story may serve as a self-fulfilling prophecy: their idealized story being brought into being. Sternberg recommends that efforts to bring about change in the individual must involve changing the story. If this in not done, the counselor ends up treating the symptoms rather than the causes, because creating behavioral change will not be adequate to make an unsatisfactory relationship satisfactory. The story that motivates the behavior is as important as the behavior.

These stories may be reflected in the music to which the individual is drawn. Research has shown a relationship between music and memory and music and mood. A study by Balch and Lewis (1996) attempted to explain why music-dependent memory (memories that are elicited by music) occurs. Although certain problems with reliability in mood-dependent memory (memory linked with mood state) research exist, they were able to confirm that tempo change and mood mediation figure into music-dependent memory. Bower (1992) suggested that mood-state-dependent memory occurs through free recall when autobiographical information is retrieved. Using the specific music connected to a memory to recreate a mood state may provide the stimulus for greater retrieval access so that significant problems arising from the memory can be dealt with therapeutically. Jung was said to have recognized that music could help access archetypal material (Hitchcock, 1987).

In the chronology process, counselors utilize the music to evoke the feelings and help clients to identify life themes and stories that they have created about themselves, others, and relationships. Clients examine their own love story or life story, honor it, and explore ways in which their storying may limit their capacity to enjoy and appreciate life and others. They can then consciously choose to reauthor their stories in a way that will be more empowering and growth-promoting.

NARRATIVE THERAPY

The anthropologist Gregory Bateson suggested that it is the attribution of meaning rather than an underlying dysfunction that determines behavior (Bubenzer, West, & Boughner, 1994; Gladding, 1998; Kurtz, Tandy, & Shields, 1999; White & Epston, 1990). According to Bateson (1972), an objective reality is not possible; therefore, experiences are interpreted from an individual's beliefs, feelings, values, and culturally based attitudes (Kurtz et al., 1999; White & Epston, 1990).

Narrative theory suggests that our personal stories not only reflect our life experiences but also create them (O'Hanlon & Beadle, 1994; Parry & Doan, 1994; White & Epston, 1990, 1992). Stories have long provided the person with a way to structure and make sense of these lived experiences, and choices are shaped by the meaning attributed to the events (Freeman, Epston, & Lobovitis, 1997). These stories either facilitate or impede the success of our goals. White (Bubenzer et al., 1994) suggests that people seek counseling when their ways of being and thinking are experienced as negative and become, in some way, problematic for them. "The evolution of lives is akin to their process of reauthoring, the process of persons' entering stories, taking them over and making them their own" (White & Epston, 1990, p. 13). White and Epston's model suggests that families and individuals can create an alternative story based on lived experience that may have been denied in favor of the dominant story imposed by society (Becvar & Becvar, 1996). As Durant (1993) explains, "People are engaged in a constant process of making sense of themselves, their relationships, and what happens to them. This view of self (or constructs) is what determines how people feel and behave" (p. 27). Although personal narratives may be influenced by numerous factors, they often become autonomous in themselves (Hodas, 1994) even to the point of shaping our lives (White & Epston, 1992).

According to White and Epston, narrative therapy seeks to deconstruct "taken-for-granted realities and practices" (p. 12), thus moving the client beyond narratives that are restrictive. The narrative model allows individuals to objectify the problem, to see the problem as the problem

rather than the person as the problem (Becvar & Becvar, 1996). In deconstructing the narrative, the counselor assists clients in reauthoring or redefining their lives and relationships. In doing so, clients create a new narrative. Reauthoring creates in clients a sense of control or personal agency, because the client has assumed an active role in shaping his or her own life. Individuals can see themselves as being influenced by the problem as opposed to identifying with it. Narrative therapy assumes no right standard, takes an inclusive attitude on human variation, depathologizes the individual, and views personal responsibility as being particularly important (Kurtz et al., 1999).

In "Reversing Narratives of Failure Through Music and Verse," Hodas (1994) advocates the use of music and verse in therapy to promote reauthoring and achievement of personal agency by clients. He notes that "when a song or poem is shared between counselor and client in an intense way that demarcates the experience from usual business, that sharing process constitutes a 'therapeutic sharing ritual'" (p. 201). The counselor is seen as a collaborator with the individual in a nonhierarchical relationship to deconstruct old stories and build more useful stories (Brown, 1994). Problem-saturated themes are brought to therapy without recognition of the strengths inherent in the stories. Stories may be changed when viewed through a different lens and given a different interpretation. Disregarded information can challenge old restraints and the context for change can be found in alternative stories. Unique outcomes can be derived from these accounts that are inconsistent with the individual's view of her own experience. This previously neglected information may be significant contradictory evidence that allows the person to consider reauthoring his or her own life. A sense of personal mastery may be achieved that creates the context in which new possibilities may emerge.

Hodas (1993) explains that music and verse may be used in individual, family, and group sessions and within subsystems of families. Also, he believes that although there are no ethnic or socioeconomic restrictions in utilizing these modalities, it is essential that the counselor be culturally competent in working with different groups. Counselors utilizing expressive arts have offered approaches that are appropriate for or easily adapted to various ages, developmental levels, and cultures (Goldstein, 1990; Hodas, 1991; Rogers, 1993; N. Wells, 1988); various treatment settings ranging from inpatient residential to pastoral counseling (Ambrogne-O'Toole, 1988; Kahans & Calford, 1982; Lehtonen & Niemelae, 1998); and various client problems (Masserman, 1980; Mazza, 1988).

MUSICAL CHRONOLOGY AS RITUAL FOR DECONSTRUCTING RELATIONSHIP NARRATIVES

Love, especially romantic love, is frequently depicted in popular music and in movies or television programs. In this respect, music and the media, to a large degree, influence our ideas about love and condition our emotional responses to loving and being loved (Timmerick, 1990).

From clinical experience we see that many individuals develop a deep attachment to music and form strong associations with the music. These individuals can listen to a song and feel as if they were back in the time period in which they first heard it. They may associate it with a particular life event or loss. And depending on the degree of resolution of the event or loss, their mood may be affected by it (Balch & Lewis, 1996; Baumgartner, 1992). Hearing a song that elicits a memory and triggers a feeling is a common occurrence for many individuals.

Given that love and relationships are primary values for many people in our society (Timmerman, 1991), clients seeking to improve their relationships frequently seek counseling services. It has been our experience that clients often bring up the name of a song during a session to describe a feeling or experience connected to the relationship. If the counselor recognizes the song, the therapeutic bond appears to strengthen. The song serves as a metaphor for the client's experience.

We believe that simply eliciting feelings is only one value of music in therapy. As the feelings of the client are evoked by the music, so are the past associations to the music and with them, the ability to identify the personal narratives that the client has created about relationships. The musical chronology helps clients identify the restrictive narratives by identifying the themes found in the music, either in the emotions it evokes or the memory of the past significant events in their lives, or both.

THE MUSICAL CHRONOLOGY PROCESS

This process was first inspired by the counselor's own love of music and attachment to associations to that music. She also found that several of her clients made reference to music to define a period in their lives. Clients referred to entire classes of music, such as rock and roll, to describe their experiences and to a whole genre of songs from particular periods of music history to describe a stage in their lives. Motown, '70s rock, disco, and '50s hop were all references that clients used to help the counselor connect with their experiences. In time, the counselor would take an opportunity to ask if music had played an important role in the lives of other clients who did not bring forth the concept. Many responded easily and eagerly. Simple phrases facilitated a connection and joining between client and counselor. Very often, the narratives that followed were framed within this context.

The counselor consulted widely with her colleagues and peers. The following were their thoughts:

1. Can we use music to assist clients to experience feelings surrounding certain life events?

2. Can we help clients to look at the music that has been important to them to identify periods of loss or grief that are yet unresolved?
3. Can we use the music to help complete the grief work?
4. Using music, can we help create a life line and look at the themes that have run through their lives? What themes have they lived out? Who are they being in the world? What role do they seem to play in relationships?
5. Could these life themes result in "stories" they have created about themselves, others, and relationships?
6. If, in fact, these stories have been created, would it be helpful for clients to reevaluate them to see if they are the stories by which they wish to continue to live? Do they bring the meaning they wish to have in their lives? Do they give them the opportunity to be their best and most fulfilled selves?
7. Some clients may, in fact, be satisfied with their stories and determine that they will live out their futures as they have their pasts. But for those who would like their futures to take on new themes, they could ask themselves three questions:
   (a) What songs do you wish to use to interpret your story and look at your life themes?
   (b) Who are you being as reflected by the music you choose?
   (c) What new song can you find to represent your vision for yourself, your relationships, and your future?

We found that songs identified by some clients with a musical past or present contained self-destructive or sadistic tones or lyrics. These songs fed their distorted realities and helped define their view of self and others. Their choice of music reflected how they had authored their lives. In working with clients in practice and workshop settings, five prominent themes emerged. Identifying these themes allowed these issues to be approached and addressed in therapy.

Clients found that if the theme in their music reflected unrequited love or love lost, they frequently saw themselves as *searchers for love*. Many had difficulty resonating with those relationships that were available to them. Their identification with the themes of lost love created a comfort level with unfulfilled experiences and prevented them from deciding if, in fact, they wanted an available love partner. A second theme that clients discovered in their music is the theme of *you and me against the world*. They found that this theme often created a temporary collusion between the two people, one that generally resulted in disappointment. Some described their quest to keep looking for that perfect someone who could make it all better, underestimating their own capacities and overlooking someone with whom they could have experienced intimacy without isolation.

Another theme that clients reported was one in which they were the *cool avoiders*. They described their music as having a great beat, with many of the lyrics telling the listener, "You are temporary." This self-portrait would give them permission to view others as temporary means of gratification and pleasure and prevent them from getting to know others or enjoy them in a more meaningful way. A fourth theme that clients mentioned was that of *the heartbreaker*. The words are remorseful but the tone seems to be one of pride. Adopting this theme for some facilitated a false sense of remorse, one in which individuals find pleasure or power in encouraging someone to love them without following through themselves. A fifth theme described the angry but *resolved discarded lover*, one who vows "never again" to be vulnerable. The tone, beat, and lyrics were often animated and validating, but the themes, which often permeated the clients' lives, revealed bitterness and relationship-phobic attitudes and behaviors. As the counselors discovered a consistency in themes, the chronology process was further refined. The following is a description of this process.

This process begins by asking clients to identify significant songs related to romantic relationships. Next, clients compile the list and arrange the song titles chronologically. They then find the lyrics. If possible, they compile a CD or audiotape and bring the tape in to therapy. Clients then play the entire compilation while commenting on memories. The role of the counselor at this point is to listen, engage with the clients, and enjoy the music with them. The counselor may ask some questions but does not, at this point, delve too deeply into the material. He or she allows the story to unfold through the music. In this first phase of the process, the counselor does not stop the process to identify the restrictive narratives. During the next phase, client and counselor listen for themes that may be explored so that the problem may be externalized and its power diminished. Counselor and client work collaboratively to facilitate client's awareness of his or her restrictive narratives. The counselor lays the groundwork for the development of alternative stories by having the client identify a song for the present that reflects his or her current emotional states. Finally, the counselor asks the client to find and play a song for the future, thus reauthoring his or her personal narrative.

CASE EXAMPLE

Bill is a 30-year-old man who presented for therapy because he had recently ended a confusing yet intense relationship with a woman and wanted to explore his relationship history. Bill sustained a long-term relationship with his high school sweetheart but the relationship ended in his 3rd year of college. He reported feeling rejected and angry at the break-up. His pain was exacerbated by his grandmother's death, as they had maintained a very special relationship throughout his life. She died soon after the break-up.

Bill reported another source of grief while in high school, his parents' divorce. Bill chose to live with his father and stepmother, whereas his sister lived with their mother. Bill's father and stepmother traveled extensively so Bill remained at home with the housekeeper much of the time. Still, he maintained a close relationship with his mother and often served as her confidante. In addition, she was a source of information for him regarding dating relationships and often warned him

about the negative intentions of his girlfriends. Bill's father seemed to be absent and unavailable, whereas his mother seemed to be protective of and permissive with him.

Bill presented for therapy distraught because he felt he had cared for his current girlfriend, Sue, but was unable to sustain a relationship with her. He reported enjoying her company but would feel engulfed if she expressed her needs or desire for closeness. They maintained a low-profile relationship. After 3 years of dating, his family still did not know she existed. He sadly reported that the problem must be that she was not "the one." Still, he reported wanting an intimate, committed relationship and wished he had been able to fall in love with Sue.

Bill described Sue as an attractive, warm, friendly, funny, sensitive, and intelligent woman with values similar to his own. He expressed deep feelings for her and was astonished that they could disappear from one day to the next. He had ended the relationship on numerous occasions but would miss her and ask her to resume it. This time, it appeared that they were both weary, and as sad as he appeared to be, Bill was also relieved. His only interpretation of the problem was that she was clearly not right for him.

Bill also reported dating many women casually through the years and expressed hostility when he talked about their desire to deepen the relationship. He was willing to date, enjoy dinners, dancing, movies, and have sex, but was not comfortable becoming "a couple." Still, he longed for closeness, intimacy, and the wonderful feelings that come when "you are in love." He suspected that the right match was hard to find. This led the counselor to note several conflicting feelings in Bill regarding his relationships, as well as the double bind from which he seemed to have suffered.

Therapeutic process. Bill reported an intense connection with music and would often ask the counselor if she had heard a particular song. Many times, the counselor indeed recognized the song, and Bill was able to quickly describe his associations with the music. Music, then, served as a common language for both counselor and client and proved instrumental in the therapeutic work they accomplished together.

Shortly into the therapy, the musical chronology became a specific means for assisting Bill to create a life review and to examine his experiences and their impact on his relationships. Bill began the process by writing down the songs that triggered particularly intense reactions in him. He organized these songs chronologically, beginning with his earliest recollections. Then he searched for the songs and recorded them onto a series of three CDs. He listed the songs in a packet and included the lyrics. He also described what associations the songs triggered. After selecting songs from his history, Bill selected a song that represented his current state. This song was an older song, but the associations were pertinent to his place in the world today and so he chose it as his song for the present. Finally, Bill selected a song that reflected his desires for the future. It was a song he wanted to "live into."

Bill brought the music, lyrics, and his writings to therapy. Using a CD player in the therapy room, client and counselor sat together and informally reviewed these. Sitting with Bill under these circumstances was a moving experience for the counselor. It was akin to sitting with clients who bring scrapbooks of their important family pictures depicting the family's earliest history to the present. The counselor was conscious of the vulnerability inherent in such a disclosure and expressed interest while at the same time allowing the client to proceed at his own pace and in his own manner. For example, Bill turned on the CD and they listened to the first selection. The first song he selected was "Rhinestone Cowboy" (Weiss, 1975). It brought back memories of 5-year-old Bill playing in the backyard, in his fort, imagining all sorts of visions of bad guys and good guys, with him being the star of the show. He noticed, in hearing the song, that although he was the star, he was alone. He was surprised by his memory.

Bill would turn on the CD player, play a song, stop it when he chose to do so, and would comment on the selection. He would tell stories about what was happening in his life at the time of the song and what feelings became stirred by these memories. This process unfolded throughout several therapy sessions, with Bill playing the music and commenting on its associations. It was a powerful experience for both counselor and client. Given Bill's fear of engulfment in other relationships, the counselor was particularly cognizant of the need to respect Bill's process. Their connection came, in large part, from the freedom he had to direct these particular sessions and her availability to process when he was ready to do so.

Several themes emerged through the music. These included loneliness, a need to appear strong, rebelliousness, a desire for connection, a certain amount of pining and lamenting, and hostile, aggressive, put-downs toward others. These themes reflected the current struggle within him as he desired relationship but defended against it.

The music served as a venue for accessing feelings, memories, and themes in Bill's life. He described his belief system regarding relationships and women, beliefs that appeared to be influenced by his father's rejection of his mother and himself, his mother's attachment to him, and his grandmother's doting love. It also seemed to reflect restrictive narratives of the break-up with his high school girlfriend, one in which he assumed very little responsibility for his choices at that time.

Bill's double binds. Although Bill idealized relationships and being in love, the counselor concluded that Bill's belief system and interpretation of his relationship history appeared to keep him in a position to expect women to be of service to him, available when he wanted them to be and removed when he did not want them around. He expressed not being comfortable discussing relationship issues with women so they were left to interpret his moods, much as the women in his family had done when he was younger. Also, his mother's admonitions about the self-serving needs of girls his age kept

him on guard against possible intrusions. By all accounts, Bill's relationships were characterized by one-way relating. He would not allow himself to be vulnerable in dating relationships. However, he would express his vulnerability with people at work, people who he believed did not need anything from him but who appeared to humor him. As much as he saw himself as independent, he was clearly dependent on detached others to provide for his needs rather than being available for a mutual give-and-take relationship.

Through listening to the music, identifying themes and belief systems, and exploring his feelings for the women who were not "the ones," Bill eventually concluded that there had been many possible "ones." However, his lack of readiness for relationship, coupled with his restrictive narrative, prevented relationships from developing into mature, committed ones. He was able to process the grief of seeing his mother hurt in the marriage, feeling his father's abandonment, and his own failed attempts at connection. Finally, Bill experienced his own feelings of rejection and inadequacy. At the same time, he was able to see that more often than not, he projected this inadequacy onto the women he dated and could not fully accept or enjoy the relationships with them.

Much of the therapy revolved around gaining these insights, triggering these memories, and the concomitant beliefs that conflicted with his desire for intimacy. Therapy also included working through these beliefs, both intellectually and emotionally. It also included addressing aspects of himself that sabotaged his desires for closeness in an effort to maintain his personal self-concept as a "good guy" who simply had not found the right woman. Bill's loneliness and confusion, coupled with his courage and tenacity, helped him see more clearly how grief, entitlement, and self-deception have played parts in his relationship history. He has reframed several past relationships that he began with the intention that they be short-term. He no longer blames these women for being inadequate nor does he dismiss the break-ups as inconsequential. He sees that his pain over his high school sweetheart hurt his pride as much as it did his feelings and that he has punished other women for situations for which they were in no way connected. He accepted responsibility for minimizing their value to him from the start, insuring that the relationships would be short term. Finally, Bill reaffirmed his desire for a wife and family, a desire that became a strong motivator in reconstructing his personal narrative. Bill was able to clear out many of the distortions that impeded his relationship goals. He is now more aware, humble, and receptive, even though he is still sensitive to perceived intrusions. He can, however, discuss these issues as they come up so he does not have to recreate restrictive narratives. Bill's love for music has been a significant force in enabling him to deconstruct the restrictive narratives and reauthor his life and relationships.

OTHER USES OF THE CHRONOLOGY

This method, as presented in this article, can be applied to couples by having each member create his or her own chronology and process with each other both individual and jointly held themes. Although addressing the process in detail is beyond the scope of this article, we recognize that using the chronology within a couple's context would require special considerations. These include the couple's compatibility of music styles and interests and differences in age or cohort groups.

Clients may also use this process to resolve grief issues around previous relationships and increase communication and intimacy between partners. The chronology can be used with couples to identify depressive themes, to see their expectations and concomitant disillusions, and to explore fears such as being like their mother or father. It has also been used to assist clients in differentiating from their parents and distinguishing between their story and the client's.

RECOMMENDATIONS AND CONCLUSIONS

Counselors who use this technique must ideally have an appreciation, and whenever possible an understanding, of the music of diverse cultures. However, because the client selects the music that makes up the chronology, and because the focus of the process is to have the client identify the meaning of the music and the emerging themes, the counselor need not be an expert in the music of the client's culture. Additionally, the counselor need not be familiar with the songwriter's meaning of the song. It is not the counselor who determines the meaning for the client. Thus, the client may find meaning in the beat, the singer's voice, or the fact that the song was played at the couple's first dance together.

Because this is an expressive approach rather than a diagnostic or clinical intervention, training in music therapy is not deemed necessary. A counselor may offer this approach to clients who have expressed some interest in or affinity for music or if a counselor utilizes expressive arts in therapy. The counselor who is uncertain of whether the chronology would be appropriate with a client, whether individual, couple, or family, may offer an array of modalities for expression and allow the clients to determine which they would prefer. We have seen that this technique may be used with a wide variety of ages from adolescents to the elderly. There is no determined number of songs that must be included in the chronology, nor is there a set period of time that must be spanned. Also, access to expensive technology is not necessary. Clients may utilize whatever means they have to share with the counselor the music that is significant to their process.

We recommend further research on the utilization of this technique with individuals, couples, and families with respect to various personal, social, spiritual, and existential issues. We also recommend further research into how this technique might be applied to facilitating the personal awareness and professional growth of family therapy and counselor education students. For example, we have piloted this technique with counselors in training. In doing so, we had two goals in mind. The first goal has been to introduce and teach the technique. The second goal has been to help students facilitate their own experience of the chronology and identify their own relationship narratives. The ultimate goal of such an exercise would be to identify relationship patterns that may interfere with or impede their therapeutic effectiveness. Given that supervision is not a therapeutic relationship, ethical aspects of this process unique to training must be addressed. We are conducting further investigation into utilizing the musical chronology with counselors in training. Further research may also involve its use with specific populations and/or specific problems such as life-span developmental issues or traumatic events.

Listening to music often evokes in individuals cognitive and emotional memories of important life events and significant losses (Hodas, 1994). Simply hearing a song associated with a particular event or loss has the potential of evoking strong feelings. These feelings can range from intense pleasure to acute pain. In this respect, music can serve as both an auditory and physiological scrapbook of a life history, holding past events and the feelings surrounding these events. Evoking these memories or their corresponding feelings often brings forth memories of historical hopes and dreams, whether these were actually realized or ultimately thwarted.

The musical chronology is a tool that can be used by counselors who share with their clients a love of music. It is one means for clients to conduct their grief work, reframe belief systems, and clear the way for relationships with others. Individuals can essentially "get stuck" in a song, repeating self-destructive themes that disconnect them from potential partners. In an era when intimacy may be as elusive as it is desired, the chronology can facilitate clients' process, enabling them to heal their restrictive relationship narratives and construct narratives that support intimacy.

REFERENCES

Ambrogne-O'Toole, C. (1988). Exploring female sexuality through the expressive therapies. *Arts in Psychotherapy*, *17*, 125-130.

Ansbacher, H. L., & Ansbacher, R. R. (Eds.). (1964). *The individual psychology of Alfred Adler.* New York: Harper & Row (Torchbooks).

Balch, W. R., & Lewis, B. S. (1996). Music-dependent memory: The roles of tempo change and mood mediation. *Journal of Experimental Psychology: Learning, Memory, & Cognition*, *22*(6), 1354-1363.

Bateson, G. (1972). *Steps to an ecology of mind*. New York: E. P. Dutton.

Baumgartner, H. (1992). Remembrance of things past: Music, autobiographical memory, and emotion. *Advances in Consumer Research*, *19*, 613-620.

Becvar, D. S., & Becvar, R. J. (1996). *Family therapy: A systemic integration*. Boston: Allyn & Bacon.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Bower, G. H. (1992). How emotions affect learning. In S. Christianson (Ed.), *The handbook of emotions and memory: Research and theory* (pp. 21-23). Hillsdale, NJ: Lawrence Erlbaum.

Brown, L. S. (1994). *Subversive dialogues*. New York: Basic Books.

Bubenzer, D. L., West, J. D., & Boughner, S. R. (1994). Michael White and the narrative perspective in therapy. *The Family Journal: Counseling and Therapy of Couples and Families*, *2*, 71-83.

Carey, J. T. (1969). Changing courtship pattern in the popular song. *American Journal of Sociology*, *74*, 720-731.

Chodorow, N. (1980). *The reproduction of mothering*. Los Angeles: University of California Press.

Christianson, P. G., & Lindlof, T. R. (1983). The role of the audio media in the lives of children. *Popular Music and Society*, *9*(3), 25-40.

Denisoff, S. R., & Bridges, J. (1982). Popular music: Who are the recording artists? *Journal of Communication*, *12*, 132-142.

Durant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design*. New York: Norton.

Eich, E., & Metcalfe, J. (1989). Mood dependent memory for internal versus external events. *Journal of Experimental Psychology: Learning, Memory, and Cognition*, *15*, 443-455.

Freeman, J., Epston, D., & Lobovitis, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families*. New York: Norton.

Frith, S. (1981). *Sound effects: Youth, leisure, and the politics of rock 'n roll*. New York: Pantheon.

Gantz, W., Gartenberg, H. M., Pearson, M. L., & Schiller, S. O. (1978). Gratifications and expectations associated with pop music among adolescents. *Popular Music and Society*, *6*, 81-89.

Gladding, S. T. (1998). *Family therapy: History, theory, and practice*. Upper Saddle River, NJ: Prentice Hall.

Goldstein, S. (1990). A songwriting assessment for hopelessness in depressed adolescents: A review of the literature and a pilot study. *Arts in Psychotherapy*, *17*, 117-124.

Hale, S. E. (1990). Sitting on memory's lap. *The Arts in Psychotherapy*, *17*, 269-274.

Hanser, S. V., & Thompson, L. W. (1994). Effects of music therapy on depressed older adults. *Journal of Gerontology*, *49*, 265-269.

Hitchcock, D. (1987). The influence of Jung's psychology on the therapeutic use of music. *Journal of British Music Therapy*, *1*, 17-21.

Hochschild, A. R. (1983). *The managed heart*. Los Angeles: University of California Press.

Hodas, G. (1991). Using original music to explore gender and sexuality with adolescents. *Journal of Poetry Therapy*, *4*, 205-220.

Hodas, G. (1993). *Stretch yourself! Songs for coping* Philadelphia: Second Chance Press.

Hodas, G. (1994). Reversing narratives of failure through music and verse in therapy. *The Family Journal: Counseling and Therapy for Couples and Families*, *2*, 199-207.

Kahans, D., & Calford, M. (1982). The influence of music on psychiatric patients' immediate attitude change toward therapists. *Journal of Music Therapy*, *19*, 179-187.

Kurtz, P. D., Tandy, C. C., & Shields, J. P. (1999). Narrative family interventions. In A. C. Kilpatrick & T. P. Holland (Eds.), *Working with families: An integrative model by level of need* (pp. 171-191). Boston: Allyn & Bacon.

Langer, S. K. (1951). Philosophy in a new key (2nd ed.). New York: New American Library.

Larson, R., & Kubey, T. R. (1983, Spring). Television and music: Contrasting media in adolescent life. *Youth and Society*, *14*, 13-33.

Lehtonen, K., & Niemelae, M. (1998). Does popular music promote mental health? *Psykologia*, *33*(3), 173-181.

Masserman, J. (1980). Poetry and music in flight from futility. *Arts in Psychotherapy*, *7*, 3-9.

Mazza, N. (1988). Poetry and popular music as adjunctive psychotherapy techniques. In P. Keller & S. Heyman (Eds.), *Innovations in clinical practice: A source book (Vol. 7, pp. 485-494). Sarasota, FL: Professional Resources Exchange.*

Melton, G. W., & Galician, M. (1987). A sociological approach to the pop music phenomenon: Radio and music video utilization for expectation, motivation and satisfaction. *Popular Music and Society*, *11*(3), 35-46.

Moreno, J. J. (1995). Ethnomusic therapy: An interdisciplinary approach to music and healing. *The Arts in Psychotherapy*, *22*(4), 329-338.

O'Hanlon, B., & Beadle, S. (1994). *A field guide to possibility land: Possibility therapy methods*. Omaha, NE: Possibility Press.

Parry, A., & Doan, R. E. (1994). *Story re-visions: Narrative therapy in the postmodern world*. New York: Guilford Press.

Rogers, N. (1993). *The creative connection: Expressive arts as healing*. Palo Alto, CA: Science and Behavior Books.

Schlattmann, T. (1989). Traditional, non-traditional, emotionally/ behaviorally disturbed students and popular musical lyrics. *Popular Music and Society*, *13*(1), 23-40.

Sternberg, R. J. (1998). *Love as a story.* New York: Oxford University Press.

Summer, L. (1998). *Guided imagery and music in the institutional setting*. St. Louis, MO: MMB Music.

Terwogt, M. M., & Van Grinsven, F. (1991). Musical expression of mood states. *Psychology of Music*, *19*, 99-109.

Timmerick, T. C. (1990). Overcoming the loss of a love: Preventing love addicting and promoting positive emotional health. *Psychological Reports*, *66*, 515-528.

Timmerman, G. M. (1991). A concept analysis of intimacy. *Issues in Mental Health Nursing*, *12*, 19-30.

Weiss, L. (1975). Rhinestone Cowboy [Recorded by Glen Campbell]. On *Rhinestone Cowboy* [Record]. Nashville, TN: Capitol Records.

Wells, A. (1990). Popular music: Emotional use and management. *Journal of Popular Culture*, *24*(1), 105-117.

Wells, A., & Hakanen, E. A. (1991). The emotional use of popular music by adolescents. *Journalism Quarterly*, *68*(3), 445-454.

Wells, N. (1988). An individual music assessment procedure for emotionally disturbed young adolescents. *Arts in Psychotherapy*, *15*, 47-54.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

White, M., & Epston, D. (1992). *Experience, contradictions, narrative, and imagination*. Delaide, South Australia: Dulwich Centre Publications.

Zillman, D. (1990). Mood management through communication choices. *American Behavioral Scientist*, *31*, 327-340.

Zillman, D., & Gan, S. (1997). Musical taste in adolescence. In D. J. Hargreaves & A. C. North (Eds.), *The Social Psychology of Music*. New York: Oxford University Press.

***Thelma Duffey**, Ph.D., is an assistant professor in the Department of Educational Administration and Psychological Services at Southwest Texas State University. She received a B.A. and an M.Ed. from Trinity University and an M.A. and Ph.D. from St. Mary's University. Dr. Duffey is a licensed professional counselor and a licensed marriage and family therapist in Texas. She is also a clinical member of the American Association of Marriage and Family Therapists. Dr. Duffey's research interests include issues of diversity, relationship, and spirituality, and the use of music in the therapeutic setting to address these issues. She maintains a private practice counseling individuals, couples, and families in San Antonio, Texas.*

***Christine Lumadue** is assistant professor at St. Mary's University in San Antonio, Texas. She teaches master's and doctoral students in community counseling and mental health and counselor education. She has a private practice in San Antonio. She has had articles published in* Counselor Education and Supervision *and* The Journal for the Professional Counselor

***Sandra J. Woods** is a registered nurse, and currently a doctoral student in counselor education and supervision at St. Mary's University in San Antonio, Texas. Her particular counseling interests are victims of family violence and empowerment of women..*

Adolescent Perceptions of Cohesion, Adaptability, and Communication: Revisiting the Circumplex Model

Linda M. Perosa
Sandra L. Perosa
The University of Akron

One hundred eighty young adults completed measures of family cohesion and adaptability, communication expressiveness and clarity, and problem solving. The results of polynomial regression trend analyses yielded a linear relationship between cohesion and communication expressiveness, clarity, and problem solving whether cohesion was defined linearly as emotional bonding or curvilinearly as family togetherness. There also was a linear relationship between adaptability, defined linearly as flexibility to master family life cycle stage transitions and these facets of family communication. However, the relationship for communication clarity was curvilinear when adaptability was defined in a curvilinear way as the degree of power, control, and organization in the home. Overall, these results tend not to support Olson's circumplex model of couples and family systems.

Olson's circumplex model of marital and family systems (Olson, 1986; Olson, Russell, & Sprenkle, 1983; Olson, Sprenkle, & Russell, 1979) incorporates three core dimensions of family functioning: cohesion, adaptability, and communication. In the circumplex model, cohesion is defined as the degree of emotional bonding between family members. Balanced or midrange levels of cohesion indicate a healthy sense of both connectedness and separateness in family relationships. Extreme high or low levels lead to either enmeshment (too much closeness) or disengagement (too little closeness) (Olson, 1994; Olson et al., 1983). Adaptability was defined until recently as "the ability of the family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (Olson et al., 1983, p. 70). However, this definition recently was changed in meaning from "the ability to change" to "the amount of change in leadership roles, and rules in a family system" (Olson, 1994). Balance on this newly defined dimension of adaptability (which Olson, 1994, now calls flexibility) represents a family organization typified by healthy levels of both structure and flexibility. High or low extremes lead to either chaos (too much change) or rigidity (too little change). Thus, cohesion and adaptability are considered to be curvilinear rather than linear concepts, and families with balanced levels of both are hypothesized generally to evidence more effective functioning. Family members feel close to yet independent from each other. In periods of crisis or changing conditions, they are able to adjust appropriately.

Communication, the third important dimension in the model, is seen as a facilitating factor; that is, the dynamic component aiding or hindering the movement of families on the other two dimensions. Positive communication skills include sending clear and congruent messages, responding empathically, offering supportive comments, and displaying effective problem-solving strategies in family transactions (Olson et al., 1983).

Whereas positive communication paves the way for families to move to different types of organization and helps family members to feel connected and supported, a lack of communication skills is believed to inhibit the family system's ability to change when needed. Olson et al. (1979, 1983) hypothesize that balanced couples and families will tend to have more positive communication skills than extreme families. Hence, Olson believes that a curvilinear relationship exists between positive communication and healthy levels of cohesion and adaptability.

Since the mid-1980s, researchers have begun to investigate whether there is a curvilinear or a linear relationship between healthy levels of cohesion and adaptability in families and the use of more positive communication skills by family members. The findings from these research efforts so far have been inconsistent and inconclusive. The purpose of this study is to partially test Olson's hypothesis by overcoming some of the weaknesses in the research described below.

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PROBLEMS WITH PREVIOUS RESEARCH

Faulty Research Designs

First, much of the research supporting a curvilinear hypothesis has been flawed because researchers have contrasted a balanced group of participants with another group representing only one extreme (rather than both high and low extremes) on the cohesion or adaptability dimensions (Anderson & Gavazzi, 1990). With this research design, only a linear model may be what is tested rather than a curvilinear model. In addition, several researchers (Anderson & Gavazzi; Dundas, 1994; Perosa & Perosa, 1990b; Thomas & Olson, 1993, 1994) recommend using polynomial regression analysis as the appropriate statistical procedure to test for both linear and curvilinear models. Other designs and procedures used in many previous studies were incorrect.

For example, Rodick, Henggeler, and Hanson (1986) compared 58 mother-son dyads from clinical and nonclinical families on the Family Adaptability and Cohesion Evaluation Scales (FACES) (Olson et al., 1979) and interaction tasks in which their communication patterns were rated. Although the authors stated that the results supported a curvilinear model, only one extreme group (chaotic enmeshed) participated, so that the curvilinear model was not adequately tested.

. . . the findings from this study and the results of previous research alert the family counselor to the close linear relationship between cohesion and communication.

Intrafamily Differences in Perspective

Second, efforts to test Olson's hypotheses have been hampered because of intrafamily differences in perspective. For instance, Morrison and Zetlin (1988) administered FACES III (Olson, Portner, & Lavee, 1985) and the Parent-Adolescent Communication Scale (PACS) (Barnes & Olson, 1985) to 30 parents and their adolescents with a disability and 30 parents and their adolescents without a disability. Although both adolescents and parents reported a linear relationship between cohesion and communication, they disagreed over the relationships between adaptability and communication. Adolescents viewed this relationship as linear, whereas parents saw it as curvilinear. Morrison and Zetlin argued that the curvilinear hypothesis appeared not to have been supported, especially for adolescents. However, no firm conclusions could be drawn because participants from different extreme groups were lumped together into one category (so the curvilinear model may not have been tested). Moreover, although differences between adolescents and parents were apparent, no within-group gender differences were examined, so that the full range of intrafamily differences was not explored.

Two studies have investigated some within-group gender differences, but not specifically for the curvilinear hypothesis. In one study, Barnes and Olson (1985) compared the views of mothers, fathers, and adolescents from 426 nonclinical families, first, on the levels of communication, adaptability, and communication in the home as measured by FACES III and the PACS. Mothers rated their families as more cohesive, flexible, and open in communication than did fathers. Thus, there were gender differences for parents on these dimensions. Within the adolescent group, no gender differences emerged; both male and female adolescents saw less cohesion than parents did. Next, specific tests of the curvilinear hypothesis revealed that parents saw a curvilinear relationship between cohesion, adaptability, and communication, whereas adolescents saw a linear one. Here, generational differences appeared; unfortunately, no tests were conducted to detect within-group gender differences comparing the perceptions of husbands and wives and male and female adolescents on this hypothesis.

A second study (Anderson, 1986) looking at gender differences compared the reports of 70 husbands and 80 wives from nonclinical families on cohesion and adaptability (as measured by self-report instruments other than FACES) and communication clarity and expressiveness. The results of polynomial regression analysis supported a curvilinear relationship for cohesion and communication clarity and expressiveness for wives. There also was a curvilinear relationship between adaptability and communication clarity and expressiveness for the wives. However, for the husbands, extreme scores on cohesion and adaptability were associated with higher levels of perceived communication expressiveness, which supported a linear, not a curvilinear, model.

A comparison of the Morrison and Zetlin (1988), Barnes and Olson (1985), and Anderson (1986) studies indicates that mixed results were obtained when parents' scores were combined to test the circumplex model hypothesis. In the first study, both parents saw a linear relationship between cohesion and communication, but in the second, a curvilinear one.

However, when the views of husbands and wives were contrasted, as was done in Anderson's study, gender differences appeared. Broadening the definition of communication in that study beyond the concept of openness to include com-

munication clarity and expressiveness helped to differentiate the perspective of these adult men and women. In the one study examining gender differences for adolescents (i.e., Barnes and Olson, 1985), no gender differences were revealed, though in that study the assessment of communication was limited to openness versus unresolved problems and conflict. Perhaps expanding the definition of communication in future studies to include variables other than openness may help to identify gender differences appearing in adolescents. Lee (1988) and Perosa and Perosa (1990b) also have suggested broadening the definition of cohesion to include conflict resolution and boundaries to understand the relationship between cohesion, adaptability, and communication more fully.

Perceptions of Insiders Versus Those of Outsiders

Third, definitive conclusions about the curvilinear hypothesis have been difficult to arrive at because of differences in perspectives held by insiders (i.e., family members) and outsiders (i.e., raters) describing family interaction. Closely tied to this issue is the question of the types and validity of the measures used to assess the circumplex model (see Cluff, Hicks, & Madsen, 1994). Olson (1994) conceded that the three versions of the self-report FACES instrument responded to by family members are linear in nature because they contain a Likert scale format. Yet he still contends that the underlying circumplex model is curvilinear.

Instead, Olson (1988) believes that the Clinical Rating Scale (CRS), a rating scale based on a bipolar item format used by outsiders observing families, is a more valid measure of his model. Two studies, using two samples of clinical and nonclinical families, were employed to compare FACES III and the CRS (Thomas & Olson, 1993, 1994). The results of polynomial regression analysis indicated a linear pattern for the relationships between cohesion, adaptability (flexibility), and communication with FACES but a curvilinear pattern with the CRS. A third study by Thomas and Ozechowski (2000) using a clinical sample to compare the fit of polynomial regression models with CRS Cohesion and Adaptability as independent variables and CRS Communication as the dependent variable also supported the curvilinearity of the CRS subscales.

Again, however, definitive answers as to whether the underlying circumplex model is curvilinear or linear cannot be ascertained because of questions about the validity of the CRS raised by Cluff and Hicks (1994), who argue that the descriptors for the enmeshed and disengaged endpoints on the cohesion dimension of the CRS are not clean. Rather, enmeshed families are described as demonstrating "high affective responsiveness" (i.e., emotional bonding or cohesiveness) "and control" (i.e., lack of flexibility or adaptability). Therefore, according to Cluff and Hicks, Olson combines cohesion with adaptability in the same descriptor and blurs the distinction between the two dimensions. The confounding of variables and the confusion in meaning that results mirror problems discussed by other researchers (see Dundas, 1994, Lee, 1988, and Perosa & Perosa, 1990b) regarding the FACES measures and cannot be solved by simply adopting a bipolar rather than a Likert response format (see Eckblad, 1993, and Perosa & Perosa, 1990b), as Olson has suggested.

Distinctions Between First-Order and Second-Order Changes

Fourth, the concepts of first-order changes (which are surface changes among family members that do not alter underlying structural functioning) and second-order changes (which are changes in family structure itself) need to be taken into account in future studies on the circumplex model as well. Lee's (1988) commentary on the circumplex model and Perosa and Perosa's (1990b) critique of FACES III pointed to logical inconsistencies in the definition and operationalization of the concept of adaptability involving the blurring of first- and second-order changes that has contaminated previous studies using the FACES measures. More recently, Olson (1991) has cautioned readers to note differences between first-order and second-order changes in applying his new three-dimension circumplex model that he links with FACES III.

Distinctions Between Nonclinical and Clinical Families

Fifth, confusion has arisen in understanding the curvilinear versus linear nature of the circumplex model because Olson revised his theory in 1989 (Olson, 1989) to say that in nonclinical families there is a linear relationship between cohesion, adaptability, and communication, but in clinical families the relationship is curvilinear. The relationship is linear in nonclinical families because these families represent only a narrow spectrum of the range of behavior on the dimensions of cohesion and adaptability. Therefore, researchers need to compare nonclinical and clinical families on these dimensions.

STRENGTHS OF THIS STUDY

In this study we attempted to overcome some, though not all, of these weaknesses. First, the sample includes both adolescents who had sought counseling and had received a *Diagnostic and Statistical Manual of Mental Disorders* 4th edition (American Psychiatric Association, 1994) diagnosis and nonclinical participants, thereby increasing the likelihood of obtaining a broad range of extreme types from every segment of the circumplex model. Second, polynomial regression procedures are employed that include both linear and curvilinear

values for each predictor. Third, gender differences for the relationship between cohesion, adaptability, and the communication variables are investigated. Fourth, a broad array of measures is used which assess both linear (i.e., first-order change) and curvilinear (i.e., second-order change) definitions of cohesion and adaptability. (Each measure, however, uses a Likert, not a bipolar, item format, as suggested by Eckblad [1993] and Perosa and Perosa [1990b]). In addition, the concept of cohesion has been expanded to include conflict resolution (as suggested by Lee, 1988, and Perosa & Perosa, 1990b) and boundaries (as suggested by Anderson, 1986). Support for the idea of adding items assessing conflict resolution to other elements of cohesion came from the fact that Perosa and Perosa (1990b) found correlations ranging from .59 to .65 between scales measuring conflict resolution among family member and the cohesion scales on FACES III and the Family Environment Scale (FES) (Moos & Moos, 1981).

Given the fact that previous research investigating the relationship between cohesion, adaptability, and communication from the adolescent's perspective has shown both cohesion and adaptability to be related linearly with open communication (but has found mixed results for the association between adaptability and communication), we expected similar results. Based on Anderson's (1986) findings for adults described previously, we anticipated that gender differences for adolescents would occur in their perceptions of relationships between cohesion, adaptability, and communication.

METHOD

Participants

The participants consisted of 88 seniors from a suburban high school and 92 freshmen from a midsize university located in the Middle Atlantic states. Sixty-four percent (115) were females and 36% (65) were males. They tended to be Caucasian (94%) and middle class (85%). Six percent were Black. Fifteen percent came from working-class backgrounds, as determined by Hollingshed's (1975) Four Factor Index of Social Status, with modifications suggested by Wasser (1991). Most (89%) had resided with their natural parents or in a two-parent home in which one parent was a stepparent. Six percent grew up in single-parent families but had weekly contact with their absent parent, who usually was the father.

Chi-square analyses indicated that there were no significant differences between the participants from the two settings in terms of social class, $\chi^2(4, N = 180) = 5.08$, $p > .05$; race $\chi^2(2, N = 180) = 0.51$, $p > .05$; or by gender, $\chi^2(1, N = 182) = 13.55$, $p > .05$. Moreover, the results of multivariate analysis of variance indicated that there were no significant differences between the two groups on any of the family assessment scales, Wilks's $\lambda = .91$, $F(8, 171) = 2.11$, $p > .05$.

Measures

Family Cohesion

Family cohesion was conceptualized in two ways.

Cohesion L (linear). Cohesion L, which depicted linear aspects of cohesion based on the concept of emotional bonding, comprised scale items reflecting (a) conflict resolution between mother and child, father and child, and husband and wife; (b) family support and concern; and (c) the degree of emotional involvement or intrusion between family members. Scales from several inventories were combined to develop Cohesion L. The conflict resolution dimensions on Cohesion L consisted of three scales from the Structural Family Interaction Scale–Revised (SFIS-R) (Perosa & Perosa, 1990a) (i.e., Mother-Child Cohesion/Estrangement, Father-Child Cohesion/Estrangement, and Spouse Conflict Resolved/Unresolved). The family support dimension was assessed by the Cohesion scale from the FES (Moos & Moos, 1981). The third element of Cohesion L, looking at the degree of emotional involvement and intrusion among family members, consisted of the Affective Involvement scale from the Family Assessment Device (FAD) (Miller, Bishop, Epstein, & Keitner, 1985).

Because these various subscales typically are used to assess similar yet distinct dimensions of families' environments, a principle components factor analysis for the combined five scales forming Cohesion L with varimax rotation was conducted. The obtained one-factor solution accounted for 66% of the total variance among the subscales. This result plus the acceptable internal reliability coefficient of .86 for the total scale supported the summation of the subscale items into one scale. The determination that this scale represented a linear unidimensional direction (that is, the more that this variable is present in the family, the healthier the family will function) rather than being curvilinear or ambiguous was based on the ratings of three family therapists. Each of the family therapists had a master's degree from an American Association for Marriage and Family Therapy-accredited program and had been working in the field an average of 4.2 years.

Cohesion C (curvilinear). Cohesion C, which indicated curvilinear facets of cohesion based on the concept of family togetherness, included five items from the FACES III Cohesion scale that the three family therapists had rated as being clearly curvilinear or ambiguous (rather than being linear). The internal reliability coefficient for these items was .70, which was judged to be acceptable for research purposes (Nunnally, 1950). The item content for Cohesion C covered facets of family togetherness, boundaries, time spent together, and approval of friends.

When this scale was factor analyzed together with the linear cohesion scale (i.e., Cohesion L) two factors emerged. The first (i.e., Cohesion L) explained 64% of the variance and

the second (i.e., Cohesion C) 15%, indicating that the two scales are assessing different facets of cohesion.

Family Adaptability

Family adaptability also was split into two categories.

Adaptability L (linear). Adaptability L, reflecting linear dimensions of flexibility (i.e., the ability of the system to change its structure over time), was measured by the Flexibility/Rigidity scale of the SFIS-R. This scale assesses "the degree to which the family is able to adapt and change as conditions warrant in response to demands imposed by the growth of autonomy in developing youth or by stress associated with situational crises impacting the family" (Perosa & Perosa, 1990a, p. 4). The scale was judged to focus on second-order or linear elements of change by the three family therapists. Its internal consistency reliability estimate of .77 fell within the acceptable range.

Adaptability C (curvilinear). Adaptability C, representing curvilinear aspects of change (i.e., the amount of change within the ongoing structure of the system) was measured by the Control and Organization subscales from the FES (Moos & Moos, 1981). The Control scale reports individuals' perceptions of "the extent to which set rules and procedures are used to run family life" (Moos & Moos, 1981, p. 2). The Organization subscale measures "how important clear organization and structure are in planning family activities and responsibilities" (Moos & Moos, 1981, p. 2).

In this study, the Control and Organization subscales were combined to form one measure of the amount of parental control and organization in the home. It displayed an acceptable internal consistency reliability estimate of .74 and was judged to assess curvilinear aspects of change by the three family therapists. In addition, a factor analysis of the newly formed Adaptability C scale yielded one factor, indicating that it could stand alone as a separate scale. Next, a factor analysis of the Adaptability L and Adaptability C scales resulted in two factors; the first explained 28% of the variance and the second, 25%. Hence, these two scales do appear to be measuring separate dimensions of adaptability.

Family Communication

Three facets of family communication were included as dependent variables.

Communication expressiveness. Communication expressiveness was assessed by joining the Conflict Expression/Avoidance subscale from the SFIS-R and the Expressiveness subscale from the FES. Conflict Expression/Avoidance looks at the degree to which family members express or avoid differences that may lead to arguments, whereas Expressiveness assesses the extent to which family members are allowed and encouraged to act openly and to express their feelings directly. The internal consistency of the combined Communication Expressiveness scale was .81. When the newly formed scale was factor analyzed, one factor emerged explaining 62% of the variance. These internal consistency and factor analysis results support the summation of the subscale items into one scale.

Communication clarity. Communication clarity was measured by the Communication scale from the FAD. Communication clarity, therefore, focuses on whether verbal messages are clear with respect to content and direct in the sense that the person spoken to is the person for whom the message is intended. The internal reliability estimate for communication clarity in this study was .73.

Problem solving. Problem solving was defined as the family's ability to generate alternative solutions and resolve problems. The Problem Solving scale from the FAD was used to assess this variable. The internal consistency reliability estimate for this scale was .76.

PROCEDURES

High school students were solicited by presentations in study halls and 12th-grade social studies and English classes. Presentations also were made in several university undergraduate classes. In addition, letters describing the study were given to clients in the university counseling center. Volunteers were given the opportunity to take part in a raffle for various prizes such as a $100 bill and gift certificates for use at local fast-food restaurants.

Participants met individually with a researcher and completed a personal data sheet followed by the Cohesion, Expression, Control, and Organization scales from the FES, the FAD Affective Involvement, Communication, and Problem Solving scales; the Flexibility/ Rigidity, Conflict Avoidance/Expression, Mother-Child Cohesion/Estrangement and Father-Child Cohesion/Estrangement, and the Spouse Conflict Resolved/Unresolved scales from the SFIS-R; and the FACES III in random order. Participants were asked to complete the family measures by thinking of their current family. High school seniors and college freshmen were chosen as participants because during the late adolescent and launching stages of the family life cycle when the adolescent is preparing to psychologically leave home, covert issues and dysfunctional relationship patterns surface (Bowen, 1978; Haley, 1980; McGoldrick & Carter, 1982).

We scored each measure according to directions given by their authors, except for the FES. Our decision to employ a four-choice format (*very true*, *more true than false*, *more false than true*, *very false*) for the Cohesion, Expression, Control, and Organization scales on the FES was made to keep the response options consistent for all questions.

The power for this study, using a sample size of 180 participants, an alpha of .05, and a medium effect size, was calculated to be .98. This means that 98 times out of 100 the statisti-

TABLE 1

Polynomial Regression Results for Cohesion L and Adaptability L (second-order or linear definitions) and Gender on Communication Variables for the Whole Sample ($N = 180$)

	Communication Expressiveness			Communication Clarity			Problem Solving		
Circumplex Model Variable	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change
Cohesion (L)									
Linear model	.54	.54	211.74***	.51	.51	185.94***	.60	.60	267.14***
Curvilinear model	.56	.02	6.43**	.52	.01	4.03*	.60	.00	.71
Adaptability (L)									
Linear model	.58	.02	9.30**	.54	.02	6.26**	.63	.02	11.65***
Curvilinear model	.59	.01	2.35	.54	.00	.47	.63	.00	.48
Interaction	.59	.00	2.39	.54	.00	.47	.63	.01	.11
Gender	.59	.00	.19	.54	.00	.10	.63	.00	.02
Gender × Cohesion interaction	.59	.00	1.20	.54	.00	.11	.63	.00	.13
Gender × Adapability interaction	.59	.00	.00	.54	.00	.05	.63	.00	.35

NOTE: Cohesion I = Mother-Child Cohesion/Estrangement, Father-Child Cohesion/Estrangement, and Spouse Conflict Resolved/ Unresolved subscales from the Structural Family Interaction Scale-Revised (SFIS-R), the Cohesion Scale from the Family Environment Scale (FES), and the Affective Involvement Scale from the Family Assessment Device (FAD); Adaptability I = the Flexibility/Rigidity Scale from the SFIS-R; Communication Expressiveness = the Conflict Expression/Avoidance Scale from the SFIS-R; and the Expressiveness Scale from the FES; Communication Clarity = the Communication Scale from the FAD; Problem Solving = the Problem Solving Scale from the FAD.
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

cal procedures used would be capable of detecting the relationship if it exists (Cohen, 1977).

RESULTS

Preliminary Analyses

Because it is necessary to include participants from each of the four extreme categories in the circumplex model to adequately test the curvilinear hypothesis, we calculated the joint frequency distribution of all participants for each cell according to directions in the FACES III manual. Forty participants, or 22% of the whole sample, scored in the extreme range on both Cohesion and Adaptability on FACES III. Of the 40 participants scoring in the extreme range on both Cohesion and Adaptability on FACES III, 18, or 10% of the whole sample, were categorized as enmeshed-chaotic; 12, or 6.9% of the total sample, were categorized disengaged-chaotic; 6, or 3% of the total sample, were categorized disengaged-rigid; and 4, or 1.9% of the total sample, were categorized enmeshed-rigid. Therefore, the extreme group segment of the total sample did include every extreme type in the model.

Primary Analyses

Polynomial regression trend analyses were conducted using Statistical Package for the Social Sciences (SPSSX) to determine whether a curvilinear equation is more predictive of the relationship between cohesion, adaptability, and communication than a linear one. The regression model used in this study included first degree, second degree (i.e., squared), and third degree (i.e., cubed) terms for cohesion and adaptability, an interaction term (i.e., between the cohesion and adaptability scales), gender, and gender interaction terms (with cohesion and adaptability scales) as independent variables. The first-degree terms reflect a linear relationship between the dependent variable and the independent variables, whereas the squared terms indicate a curvilinear relationship (with one bend in the curve) and the cubed terms indicate an S-shaped curve (with two bends).

The series of stepwise regression procedures were conducted with the linear definitions of cohesion and adaptability (i.e., Cohesion L and Adaptability L) and then with the curvilinear definitions of cohesion and adaptability (i.e., Cohesion C and Adaptability C) as independent variables. These regression procedures were run first with communication expressiveness as the dependent variable, then with communication clarity, and finally with problem solving as the dependent variable. The resulting R^2 changes for each procedure indicate how much variance in a communication variable is accounted for by the linear terms of a measure and how much by their curvilinear terms. (Because none of the cubed terms were significant, however, no results for these tests are presented on the tables.)

Results for Linear Definitions of Cohesion and Adaptability

The results for the total sample for Cohesion L and Adaptability L, which represent linear definitions of cohesion and adaptability, regressed first on communication expressiveness, then on communication clarity, and finally on problem solving are displayed in Table 1.

Results for Communication Expressiveness

Cohesion L (linear definition). The R^2 for the regression of Cohesion L (or the concept of emotional bonding) on communication expressiveness is .54 ($p < .001$), which indicates a significant linear relationship between the two variables (see Table 1). Thus (according to the view of these adolescents), 54% of the variance in communication expressiveness among family members can be accounted for by cohesion or emotional bonding in the family. The squared term representing the curvilinear model test is also significant (R^2 change = .06, $p < .01$). However, because the curvilinear model accounts only for an additional 2% of the variance accounted for by the linear model, we consider the relationship between communication expressiveness and family cohesion, when cohesion is defined as emotional bonding, to be linear.

Adaptability L (linear definition). The R^2 change for the regression of Adaptability L or flexibility over time (i.e., a linear definition of adaptability) on communication expressiveness is significant (R^2 change = .02, $p < .01$), indicating a significant linear relationship between Adaptability L and communication expressiveness. Thus, an additional 2% of the variance above that accounted for by Cohesion L (i.e., emotional bonding) is accounted for by Adaptability L (i.e., flexibility) for communication expressiveness. The curvilinear model is not significant, nor are gender differences apparent.

Results for Communication Clarity

Cohesion L (linear definition). The R^2 change for the regression of Cohesion L (i.e., emotional bonding) on communication clarity is .51 ($p < .001$), which also indicates a significant linear relationship; from the perspective of these adolescents, 51% of the variance in the ability of family members to communicate clearly and directly with each other can be explained by family cohesion. Although the squared term for the curvilinear test also is significant ($p \leq .05$), this model has no practical significance because only 1% of the variance in communication clarity can be accounted for by Cohesion L. Consequently, we regard the nature of the relationship between Cohesion L (i.e., emotional bonding) and communication clarity to be linear.

Adaptability L (linear definition). The R^2 change for the regression of Adaptability L (i.e., flexibility over time) on communication clarity is significant (R^2 change = .02, $p < .01$), indicating that an additional 2% of the variance above that accounted for by Cohesion L (i.e., emotional bonding) is accounted for by the linear relationship between Adaptability L (i.e., flexibility) and communication clarity. Neither the curvilinear model for Adaptability L nor gender are significant.

Results for Problem Solving

Cohesion L (linear definition). The R^2 for the regression of Cohesion L on problem solving is .60 ($p < .001$), which also indicates a significant linear relationship between the two variables. From the vantage point of these adolescents, 60% of the variance in the families' ability to solve problems is accounted for by cohesion or emotional bonding in the home. Again, the squared terms for the curvilinear model and for gender are not significant.

Adaptability L (linear definition). The R^2 change for the regression of Adaptability L on problem solving is significant (R^2 change = .02, $p < .001$), again indicating a linear relationship between these two variables. Hence, an additional 2% of the variance above that accounted for by Cohesion L (i.e., emotional bonding) is accounted for by Adaptability L (i.e., flexibility over time) on problem solving. The curvilinear model for Adaptability L is not significant. Gender differences are not significant either.

Summary for Linear Definitions of Cohesion and Adaptability

In sum, according to the view of these adolescents, when cohesion is defined as emotional bonding (i.e., as a linear concept) and adaptability is defined as flexibility over time (i.e., also as a linear concept), then both cohesion and adaptability are related in a linear fashion with communication expressiveness, communication clarity, and problem solving. Also, the relationship between cohesion and these various aspects of communication is much stronger than the relationship between adaptability and each of them; that is, a much larger percentage of variance in communication expressiveness, communication clarity, and problem solving is accounted for by cohesion than by adaptability. These results for the linear definitions of cohesion and adaptability do not support Olson's curvilinear hypothesis.

Results for Curvilinear Definitions of Cohesion and Adaptability

Cohesion. The results for the total sample for Cohesion C (i.e., family togetherness) and Adaptability C (i.e., the amount of control and organization in the home), which represent curvilinear definitions of cohesion and adaptability, the interaction of Cohesion C and Adaptability C, gender and gender interaction with Cohesion C and Adaptability C regressed first on communication expressiveness, next on communication clarity, and then on problem solving are presented in Table 2.

Results for Communication Expressiveness

Cohesion C (curvilinear definition). The R^2 for the regression of Cohesion C or family togetherness on communication expressiveness is .42 ($p < .001$), indicating a significant linear relationship between the variables. Based on the reports of these adolescents, 42% of the variance in the families' tendencies to express feelings and thoughts (which may risk conflict) is accounted for by the degree of cohesion (i.e., family togetherness) in the home. The squared term testing the

TABLE 2

Polynomial Regression Results for Cohesion C and Adaptability C (first-order or curvilinear definitions) and Gender on Communication Variables for the Whole Sample ($N = 180$)

	Communication Expressiveness			Communication Clarity			Problem Solving		
Circumplex Model Variable	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change
Cohesion (C)									
Linear model	.42	.42	129.33***	.48	.48	168.87***	.60	.60	271.69***
Curvilinear model	.42	.01	1.96	.49	.00	1.45	.60	.00	.75
Adaptability (C)									
Linear model	.47	.02	7.55**	.50	.01	3.77*	.60	.00	.54
Curvilinear model	.47	.00	.35	.51	.01	3.62*	.60	.01	.01
Interaction	.47	.00	.41	.51	.00	.08	.60	.01	.01
Gender	.47	.00	.02	.51	.00	.08	.61	.00	1.80
Gender × Cohesion interaction	.47	.00	.02	.51	.00	.26	.61	.00	.19
Gender × Adapability interaction	.47	.00	.00	.51	.00	.06	.61	.00	1.11

NOTE: Cohesion II = five items from the Cohesion Scale of the Family Adaptability and Cohesion Evaluation Scales (FACES III) that three family therapists rated as curvilinear or ambiguous rather than linear; Adaptability II = the Control and Organization subscales from the Family Environment Scale (FES). Communication Expressiveness = the Conflict Expression/Avoidance Scale from the Structural Family Interaction Scale-Revised (SFIS-R) and the Expressiveness Scale from the FES; Communication Clarity = the Communication Scale from the Family Assessment Device (FAD); Problem Solving = the Problem Solving Scale from the FAD.
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

curvilinear model is not significant (see Table 2). Thus, even when cohesion is defined as family togetherness, a curvilinear concept, the relationship between cohesion and expressiveness is linear. These findings also do not support Olson's predictions.

Adaptability C (curvilinear definition). When adaptability is defined in a curvilinear way as the amount of control and organization in the home, the relationship between adaptability (i.e., Adaptability C) and communication expressiveness is linear (R^2 change = .02, $p < .01$). An additional 2% of the variance (above that accounted for by Cohesion C) in the families' willingness to express feelings and face rather than avoid conflict is accounted for by the amount of set rules or procedures and clear structure in the home. The test for the curvilinear model is not significant and there are no gender differences. Thus, the relationship between Adaptability C and communication expressiveness is linear according to the perception of both males and females. Again, Olson's curvilinear hypothesis is not supported.

Results for Communication Clarity

Cohesion C (curvilinear definition). The regression of Cohesion C on communication clarity is .48 ($p < .001$), which also indicates a significant linear relationship, with 48% of the ability of family members to voice thoughts clearly and directly to each other being accounted for by family cohesion or togetherness. Here, too, the curvilinear model for the relationship between the two variables is not significant, and Olson's hypothesis is not supported.

Adaptability C (curvilinear definition). The R^2 change for the relationship between Adaptability C and communication clarity is .01 ($p < .05$), indicating a significant linear relationship for the two variables. This time an additional 1% of the variance in clear communication patterns among family members (above that explained by Cohesion C or family togetherness) can be explained by Adaptability C or the amount of set rules or procedures and clear structure in the home. However, the R^2 change for the test of the curvilinear model also is significant (R^2 change = .01, $p < .05$). Therefore, because both the linear and curvilinear model for Adaptability C explain approximately the same amount of additional variance (i.e., 1%), we regard the nature of the relationship between Adaptability C or parental control and communication clarity to be curvilinear. Again, gender differences are not apparent. This finding does support Olson's curvilinear hypothesis.

Results for Problem Solving

Cohesion C. The R^2 for the regression of Cohesion C on problem solving is .60 ($p < .001$), indicating a significant linear relationship between both variables. Therefore, according to the descriptions of these adolescents, 60% of the variance in the families' ability to problem solve can be explained by the level of cohesion or togetherness among family members. The test for the curvilinear model is not significant. Consequently, even when cohesion is viewed as curvilinear in nature, or as the amount of time spent together, the relationship between cohesion and the families' problem-solving

TABLE 3
Polynomial Regression Results for Cohesion L and Adaptability L (second-order or linear definitions) on Communication Variables for the Subsample ($n = 20$)

	Communication Expressiveness			Communication Clarity			Problem Solving		
Circumplex Model Variable	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change
Cohesion (L)									
Linear model	.29	.29	7.50**	.42	.42	12.92**	.35	.35	9.91**
Curvilinear model	.30	.01	.20	.42	.00	.03*	.36	.01	.17
Adaptability (L)									
Linear model	.38	.08	2.13	.42	.00	.01	.37	.01	.23
Curvilinear model	.57	.18	6.36*	.50	.08	2.41	.46	.08	2.34

NOTE: Cohesion I = Mother-Child Cohesion/Estrangement, Father-Child Cohesion/Estrangement, and Spouse Conflict Resolved/Unresolved subscales from the Structural Family Interaction Scale-Revised (SFIS-R), the Cohesion Scale from the Family Environment Scale (FES), and the Affective Involvement Scale from the Family Assessment Device (FAD); Adaptability I = the Flexibility/Rigidity Scale from the SFIS-R; Communication Expressiveness = the Conflict Expression/Avoidance Scale from the SFIS-R and the Expressiveness Scale from the FES; Communication Clarity = the Communication Scale from the FAD; Problem Solving = the Problem Solving Scale from the FAD.
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

skills is linear. These results do not support Olson's assertions.

Adaptability C. The R^2 change for the linear relationship between Adaptability C or parental control and problem solving is not significant ($p > .05$); nor are the curvilinear model and gender significant.

Summary for Curvilinear Definitions of Cohesion and Adaptability

In sum, from the perspective of these adolescents, even when cohesion is defined as family togetherness (i.e., as a curvilinear concept) and when adaptability is defined as parental control (i.e., also as a curvilinear concept), cohesion still is related in a linear way with communication expressiveness, communication clarity, and problem solving. These findings fail to confirm Olson's hypothesis. The relationship for adaptability and these variables is mixed. Adaptability is related in a linear way with communication expressiveness; it is not related to problem solving; however, it is related in a curvilinear fashion with communication clarity. This finding for the curvilinear relationship between adaptability or parental control and communication clarity does support Olson's prediction.

Results for Subsample Who Had Sought Counseling

Cohesion L (Linear Definition) and Adaptability L (Linear Definition)

Because Olson (1986) suggested that the curvilinear relationship between cohesion, adaptability, and communication holds only for problem families but not for normal families (who represent a narrow range of behavior), we repeated the polynomial regression trend analyses on a subgroup of the original sample ($n = 20$) whose members reported on the personal data sheet that they had sought counseling within the past 2 years. They reported that they had been diagnosed as having problems with alcohol or drug abuse, eating disorders, depression or anxiety, and had difficulties in relationships with other family members. Table 3 displays the results of the polynomial trend analyses for Cohesion L or emotional bonding and Adaptability L or flexibility over time that represent linear definitions of cohesion and adaptability.

Three significant findings emerged for Cohesion L. The R^2 for the regression of Cohesion L on communication expressiveness is .29 ($p < .01$); for communication clarity, .42 ($p < .01$); and for problem solving, .35 ($p < .01$) (see Table 3). These results indicate a linear relationship between Cohesion L or emotional bonding and these different facets of family communication. Thus, these findings do not support Olson's contention. Only the R^2 change for the curvilinear model for Adaptability L or flexibility over time and communication expressiveness is significant (R^2 change = .18, $p < .05$), indicating a curvilinear relationship between these two variables. This findings does support Olson's beliefs.

Cohesion C (curvilinear definition) and Adaptability C (curvilinear definition)

Table 4 shows the outcomes for the polynomial trend analyses for Cohesion C or family togetherness and Adaptability C or control and organization, which represent curvilinear definitions of cohesion and adaptability.

The results indicate a linear relationship for Cohesion C and communication expressiveness ($R^2 = .37$, $p < .01$), for

TABLE 4

Polynomial Regression Results for Cohesion C and Adaptability C (first-order or curvilinear definitions) on Communication Variables for the Subsample (n = 20)

	Communication Expressiveness			Communication Clarity			Problem Solving		
Circumplex Model Variable	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change	R^2	R^2 Change	F Change
Cohesion (L)									
Linear model	.37	.37	10.46**	.52	.52	19.78**	.51	.51	18.28**
Curvilinear model	.38	.01	.39	.59	.07	2.58	.52	.02	.68
Adaptability (L)									
Linear model	.42	.04	.10	.59	.00	.08	.60	.07	2.80
Curvilinear model	.43	.02	.43	.65	.06	2.43	.65	.06	2.47

NOTE: Cohesion II = five items from the Cohesion Scale of the Family Adaptability and Cohesion Evaluation Scales (FACES III) that three family therapists rated as curvilinear or ambiguous rather than linear; Adaptability II = the Control and Organization subscales from the Family Environment Scale (FES); Communication Expressiveness = the Conflict Expression/Avoidance Scale from the Structural Family Interaction Scale-Revised (SFIS-R) and the Expressiveness Scale from the FES; Communication Clarity = the Communication Scale from the Family Assessment Device (FAD); Problem Solving = the Problem Solving Scale from the Family Assessment Device (FAD).
*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

communication clarity ($R^2 = .52$, $p < .01$), and for problem solving ($R^2 = .51$, $p < .01$) (see Table 4). No significant results are indicated for either a linear or a curvilinear model for Adaptability C and communication expressiveness, communication clarity, or problem solving. None of these findings support Olson's hypothesis.

Summary for Subsample

In summary, for the subsample of 20 adolescents who had sought counseling, when cohesion is formulated as emotional bonding (i.e., as a linear concept) and adaptability is defined as flexibility over time (i.e., also as a linear concept), then cohesion is related in a linear fashion with communication expressiveness, clarity, and problem solving. These findings do not support Olson's view. In contrast, family adaptability, or flexibility over time, is related in a curvilinear way with communication expressiveness but is unrelated to communication clarity and problem solving. This last finding for communication expressiveness does provide some support for Olson's curvilinear model for the clinical subsample.

When cohesion is conceptualized as family togetherness (i.e., as a curvilinear concept) and when adaptability is defined as parental control and organization (i.e., also as a curvilinear concept), then cohesion is related linearly with communication expressiveness, clarity, and problem solving. Family adaptability is not related to any of these aspects of family communication. These findings for the clinical subsample do not support Olson's curvilinear hypothesis.

DISCUSSION

The mixed results obtained from this study tend, in general, to contradict Olson's curvilinear hypothesis. Overall, the findings for the whole sample of adolescents suggest that there is a linear relationship between cohesion and communication expressiveness, clarity, and problem solving. These results hold up whether cohesion is defined linearly as emotional bonding or curvilinearly as family togetherness. This linear correspondence for cohesion and communication expressiveness, clarity, and problem solving also is seen in the symptomatic subsample of participants who had sought counseling. These consistent findings for cohesion are contrary to Olson's predictions.

They are, however, consistent with the findings of other researchers, such as Barnes and Olson (1985), who found a linear relationship for open communication and family cohesion for adolescents in a large national sample of nonclinical families. The adolescents in that study had a mean age of 16.4 years; hence, they were somewhat younger than the adolescents in this study. Our findings also parallel those of Morrison and Zetlin (1988), who found a linear relationship for open communication and family cohesion in a younger sample of adolescents with and without learning disabilities.

The findings for adaptability are less clear. For the whole sample of adolescents, there is a linear relationship between adaptability and communication expressiveness, communication clarity, and problem solving when adaptability is defined linearly as flexibility to master family life cycle stage transitions. In other words, from the perspective of these adolescents, there is a direct correspondence between the families' capacity to alter behaviors, roles, and rules over time and their comfort with expressing thoughts and feelings, their use of clear and direct messages, and their ability to manage stressful situations. These patterns do not follow Olson's predictions.

However, when adaptability is defined curvilinearly so that it refers to the degree of power, control, and organization in the home, there is a curvilinear relationship between adapt-

ability and the clarity of family communications. In the eyes of these nonclinical adolescents, too little or too much parental control is associated with less straightforward communication of feelings, opinions, and beliefs about sensitive issues. Apparently, these adolescents accurately voice their feelings and thoughts only at those times when they perceive that parental control is neither too stringent nor too lax. This finding for a curvilinear relationship between adaptability defined as power and control (i.e., Adaptability C) and communication clarity does provide some, albeit weak, support for Olson's predictions.

The subsample of adolescents who had sought counseling perceived the relationship between adaptability and family communication in a slightly different way. They reported a curvilinear relationship between adaptability, defined linearly as flexibility over time (i.e., Adaptability L) and the openness with which they expressed feelings and thoughts in the home. In contrast to the sample as a whole (who reported a significant curvilinear relationship between Adaptability C or parent control and communication clarity) this clinical subgroup reported a significant curvilinear relationship between Adaptability L and communication expressiveness. It appears that for this subgroup of adolescents who had sought counseling, too little or too much expression of opinions, feelings, and beliefs interferes with the families' capacity to alter the system when necessary to master life cycle stage transitions. For them, optimal flexibility is associated with a balanced level of communication. Thus, this finding likewise provides some, though weak, support for Olson's contentions.

The ambiguity found in this study regarding Olson's curvilinear hypothesis for the relationship between adaptability and communication mirrors the inconsistent findings from previous research. For example, Morrison and Zetlin (1988) reported a linear relationship between these variables, whereas Rodick et al., (1986), using a clinical sample of juvenile offenders, found a curvilinear one. Perhaps these conflicting results occurred because different versions of FACES (with different definitions of adaptability) were administered in each study. Or perhaps the inconsistent findings resulted from the fact that although both studies used raw scores for Cohesion and Adaptability, in the Rodick et al. study, mothers and sons' scores were averaged together for each scale score. Perhaps they also occurred because different clinical and nonclinical samples were used in each study. Future research using similar measures with similar definitions of adaptability and similar scoring procedures may help to clarify these contradictory findings.

Although the results for the relationship between adaptability and various aspects of communication are inconclusive, they do highlight Olson's arguments that researchers should pay attention to differences between first-order and second-order aspects of change inherent in different definitions of adaptability as well as to differences between clinical and nonclinical populations. In this study, first-order changes, which are superficial changes that do not alter family structure itself, are depicted in the curvilinear definitions of cohesion (i.e., family togetherness) and adaptability (i.e., parent control and organization). Second-order changes are represented by the linear definitions of cohesion (i.e., emotional bonding) and adaptability (i.e., flexibility to change structure over time). The fact that differences between the whole sample and the clinical subsample were found on the tests of Olson's curvilinear hypothesis and that different definitions of adaptability led to different results for each group points to the need to continue to employ both linear and curvilinear definitions of adaptability in future studies.

The fact that no significant gender differences were found for the communication variables is noteworthy in light of the importance attributed to differences in communication for husbands and wives in Anderson's (1986) study. Unfortunately, although a number of studies have shown that parents rate their communication (with their children) as more open and less problematic than do their adolescents (Callan & Noller, 1986; Noller, Seth-Smith, Bouma, & Schweitzer, 1992), few studies have examined gender differences in the ratings of the quality of communication, and none has looked at the issue of gender differences in testing Olson's curvilinear hypothesis. As a result, we are left wondering whether gender differences in communication evolve slowly as adolescents mature into adulthood and assume new roles as parents in the family. The role of mother or father may be more differentiated than the role of adolescent male or female and may call for different types of communications in different situations. Future research will have to ascertain whether this process is, in fact, what does occur.

Before definitive conclusions can be drawn regarding Olson's curvilinear hypothesis, future research must overcome limitations in this study. First, the generalizability of our findings is limited to White, middle-class, high school– and college-age youths from middle-class backgrounds. Other youth from different backgrounds and in different settings may have different perspectives. Second, the descriptions of family dynamics in this study rest on self-reports by one family member, making them vulnerable to bias and inaccuracy. Future studies need to include reports by other family members and ratings of interaction by external observers. Third, although all extreme groups were represented in this study, the enmeshed-rigid group contained only 1.9% of the total sample. More participants in these extreme categories are needed in future research designs. Finally, because of moderate (rather than low or zero) correlation among some of the predictors, the problem of multicollinearity may have influenced some of the data outcome, perhaps making the results for R smaller for some of the variables (see Stevens, 1992).

How are these findings relevant for family counselors? First, the findings from this study and the results of previous research alert the family counselor to the close linear relation-

ship between cohesion and communication. Whether the clinician focuses on communication skills (and teaches family members how to respond empathically, how to reflect feelings, or how to offer supportive statements to each other) or chooses to strengthen emotional bonds or feelings of togetherness (through appropriate homework assignments such as taking time to go see a movie together), both areas of family functioning (i.e., cohesion and communication) will tend to improve or deteriorate together. Second, the inconclusive findings for the relationship between adaptability and the various facets of communication serve as a warning to counselors to pay attention to each family member's perspective as to the amount and type of change desired. Previous research indicates that parents and adolescents hold different views regarding the amount and type of control parents should utilize. Perhaps administering both real and ideal forms of FACES III (or of some of the other scales used in this study) would help the clinician remain sensitive to differences in perspective among family members. As the family counselor focuses on changing communication patterns related to adaptability, such as teaching assertiveness skills, negotiation strategies, or problem-solving abilities, he or she should carefully monitor threshold points when continuing such interventions is no longer beneficial. The results of this study suggest that these threshold points will differ depending on whether the family counselor is attempting to encourage flexibility in the home over time, or is trying to foster the open expression of feelings and thoughts, or is seeking to help family members to clarify the meaning of their words and behaviors.

REFERENCES

Anderson, S. (1986). Cohesion adaptability and communication: A test of an Olson circumplex model hypothesis. *Family Relations*, *35*, 289-293.

Anderson, S., & Gavazzi, S. (1990). A test of the Olson circumplex model: Examining its curvilinear assumption and the presence of extreme types. *Family Process*, *29*, 309-324.

Barnes, H., & Olson, D. (1982). Parent-adolescent communication scale. In D. Olson et al. (Eds.), *Family inventories: Inventories used in a national survey of families across the life cycle*. St. Paul, MN: University of Minnesota, Family Social Sciences.

Barnes, H., & Olson, D. (1985). Parent-adolescent communication and the circumplex model. *Child Development*, *56*, 438-447.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Callan, V., & Noller, P. (1986). Perceptions of communicative relationships in families with adolescents. *Journal of Marriage and the Family*, *48*, 813-820.

Cluff, R., & Hicks, M. (1994). Superstition also survives: Seeing is not always believing. *Family Process*, *33*, 479-482.

Cluff, R., Hicks, M., & Madsen, C. (1994). Beyond the circumplex model: I. A moratorium on curvilinearity. *Family Process*, *33*, 455-470.

Cohen, J. (1977). *Statistical power analysis for the behavioral sciences*. New York: Academic Press.

Dundas, I. (1994). The Family Adaptability and Cohesion Scale III in a Norweigian sample. *Family Process*, *33*, 191-202.

Eckblad, G. (1993). The "circumplex" and curvilinear functions. *Family Process*, *32*, 473-476.

Haley, J. (1980). *Leaving home*. New York: McGraw-Hill.

Hollingshed, A. (1975). *Four factor index of social status*. New Haven, CT: Yale University, Department of Sociology.

Lee, C. (1988). Theories of family adaptability: Toward a synthesis of Olson's circumplex and the Beavers systems models. *Family Process*, *27*, 73-85.

McGoldrick, M., & Carter, E. (1982). The family life cycle. In F. Walsh (Ed.), *Normal family processes* (pp. 167-195). New York: Guilford Press.

Miller, I., Bishop, D., Epstein, N., & Keitner, G. (1985). The McMaster Family Assessment Device: Reliability and validity. *Journal of Marital and Family Therapy*, *11*, 345-356.

Moos, R., & Moos, B. (1981). *Family Environment Scale and preliminary manual*. Palo Alto, CA: Consulting Psychologist Press.

Morrison, G., & Zetlin, A. (1988). Perceptions of communication, cohesion, and adaptability in families with and without handicaps. *Journal of Abnormal Child and Psychology*, *16*, 675-685.

Noller, P., Seth-Smith, M., Bouma, R., & Schweitzer, R. (1992). Parent and adolescent perceptions of family functioning: A comparison of clinic and non-clinic families. *Journal of Adolescence*, *15*, 101-144.

Nunnally, J. (1950). *Psychometric theory.* New York: McGraw-Hill.

Olson, D. (1986). Circumplex model: VII. Validation studies and FACES III. *Family Process*, *25*, 337-351.

Olson, D. (1988). *Clinical Rating Scale (CRS) for the circumplex model of marital and family systems* (rev. ed.). St. Paul, MN: University of Minnesota, Family Social Science.

Olson, D. (1989). Circumplex model of family systems VIII: Family assessment and intervention. *Journal of Psychotherapy and the Family*, *4*(1), 7-49.

Olson, D. (1991). Commentary: Three-dimensional (3-D) circumplex model and revised scoring of FACES III. *Family Process*, *30*,74-79.

Olson, D. (1994). Curvilinearity survives: The world is not flat. *Family Process*, *33*, 471-478.

Olson, D., Portner, J., & Lavee, Y. (1985). *FACES III*. St. Paul, MN: University of Minnesota, Family Social Science.

Olson, D., Russell, C., & Sprenkle, D. (1983). Circumplex model of marital and family systems: VI. Theoretical update. *Family Process*, *22*, 69-83.

Olson, D., Sprenkle, D., & Russell, C. (1979). Circumplex model of marital and family systems: I. Cohesion and adaptability dimensions, family types, and clinical applications. *Family Process*, *18*, 3-15.

Perosa, L., & Perosa, S. (1990a). *The revision and validation of the Structural Family Interaction Scale*. Paper presented at the American Psychological Association Convention, Boston.

Perosa, L., & Perosa, S. (1990b). The use of a bipolar item format for FACES III: A reconsideration. *Journal of Marital and Family Therapy*, *16*, 187-199.

Rodick, D., Henggeler, S., & Hanson, S. (1986). An evaluation of the Family Adaptability and Cohesion Evaluation Scales and the circumplex model. *Journal of Abnormal Child Psychology*, *14*, 77-87.

Stevens, J. (1992). *Applied multivariate statistics for the social sciences*. Hillsdale, NJ: Lawrence Erlbaum.

Thomas, V., & Olson, D. (1993). Problem families and the circumplex model: Observational assessment using the Clinical Rating Scale (CRS). *Journal of Marital and Family Therapy*, *19*, 159-175.

Thomas, V., & Olson, D. (1994). Circumplex model: Curvilinearity using Clinical Rating Scale (CRS) and FACES III. *The Family Journal: Counseling and Therapy for Couples and Families*, *2*, 36-44.

Thomas, V., & Ozechowski, T. (2000). A test of the circumplex model of marital and family systems using the Clinical Rating Scale. *Journal of Marital and Family Therapy*, *26*(4), 523-534.

Wasser, T. (1991, August). *Statistical correction of Hollingshed's Four Factor Index of Social Status*. Paper presented at the American Psychological Association Convention, San Francisco.

Linda Perosa *received her Ph.D. in Counseling Psychology from The State University of New York at Buffalo. She is an assistant professor in the Department of Counseling at The University of Akron.. Her research interests include family structure and individuation in adolescents at risk, family factors associated with adolescent identity development, and family measurement issues.*

Sandra Perosa *received her Ph.D. in Counseling Psychology from The State University of New York at Buffalo. She is an associate arofessor in the Department of Counseling at The University of Akron. Her research interests include separation - individuation issues in adolescents, and family factors influencing career development.*

❖**Literature Review—Theory**

Tweaking the Euro-American Perspective: Infusing Cultural Awareness and Sensitivity Into the Supervision of Family Therapy

Angela Banks
University of Virginia

Psychotherapy theories have their foundation in the Euro-American perspective. The feminist movement and changing demographics require consideration of the impact of cultural diversity in couples and family therapy and the appropriateness of current theories for both therapy and supervision. The purpose of this article is to discuss briefly the Euro-American worldview in theory-based models of supervision. Suggestions for infusing cultural awareness and sensitivity into training and supervision are offered.

Theories of counseling and psychotherapy, the standards used to judge normality-abnormality, and the actual process of mental health practice reflect an ethnocentric, monocultural, and inherently biased perspective or worldview of the helping profession (Sue et al., 1998; Sue, Ivey, & Pedersen, 1996). Worldviews are defined as how people perceive their relationship to the world around them. Individuals' cultural backgrounds, sociopolitical histories, and life experiences all affect their worldview (Brown & Landrum-Brown, 1995). In the United States, those who possess a Euro-American worldview receive constant validation of their beliefs and values as a result of functioning within the same cultural context (Sue et al.). Some characteristics of the Euro-American culture worldview are individualism, competition, mastery and control over nature, universality, and religion based on Christianity. In comparison with the Euro-American worldview, the cultural components of many racial and ethnic groups reflect an Eastern philosophy and consist of interdependence and collectivism, harmony with the universe, and concern for the group rather than self-development and growth (Bankart, 1997).

Similar to the dominance of the Euro-American worldview in our society, American psychology and psychotherapy, including family therapy, are rooted in the idea of universality or sameness.

> The cultural components of Western counseling and psychotherapy encompass the following characteristics: (a) healthy functioning is equated with autonomy and independence, (b) clients can and should master and control their lives and the universe, and (c) self-awareness and personal growth are goals of the therapeutic process. (Sue et al., 1998, p. 22)

Consequently, some practitioners and researchers have criticized therapy as being inappropriate for work with culturally diverse populations (McGoldrick, 1998; McGoldrick, Giordano, & Pearce, 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1998).

Although there is nothing harmful about the Euro-American worldview in and of itself, the concern is its appropriateness for therapy with culturally diverse populations.

> When the Euro-American worldview in psychology is used to determine normality and abnormality, then the cultural values of racial/ethnic minority groups may appear "pathological." When practiced therapeutically with minority populations, counseling and psychotherapy may be truly described as a form of cultural oppression. (Sue et al., 1998, p. 22)

In recent years, family therapy has been shaped by the emergence of the feminist movement that represents an overall epistemological transformation of the field (Hardy, 1993). The feminist movement changed the way therapy is conceptualized and practiced. It has elucidated the many ways in which gender issues and sexism pervade couples and family therapy theory and practice. Due to the feminist movement, family therapy requires the reconceptualization of traditionally held assumptions (i.e., concepts of power, boundaries, hierarchy, emotional overinvolvement, and differentiation), beliefs, and practices regarding family therapy. The shift caused by the feminist movement opened the door to exploration of other cultural perspectives affecting the profession.

Hardy (1993) states that cultural relativism emphasizes the importance of considering attitudes, perceptions, and behav-

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ior within a cultural context. "Implicit in the cultural relativism worldview is the belief that everyone is a cultural being and all attitudes, perceptions, and behaviors gain their meaning from culture" (p. 13). Therefore, all aspects of one's life are influenced by culture. Emergent trends toward cultural relativism continue to encourage the field to examine "the assumptions underlying the assumptions" regarding health and pathology in family therapy.

MODELS OF SUPERVISION

Two broad categories of supervision models are recognized in the literature: those based on psychotherapy theories, including systemic theories, and those developed specifically for supervision, which are referred to as developmental models (Bernard & Goodyear, 1998). However, family therapy supervision is considered its own specialty, and its development occurred independently of the supervision models developed specifically for supervision (Liddle, Becker, & Diamond, 1997). Systemic supervision is the model primarily utilized by family therapy supervisors, and family therapy supervision is often based on and is a direct extension of the supervisor's own theory of family therapy (Liddle et al.). "At least some of the content, focus, and process of supervision inevitably will be grounded in the supervisor's particular counseling model" (Bernard & Goodyear, p. 16). It is reasonable to assume that because family therapy supervision approaches have their bases in therapeutic models, the cultural biases within the therapeutic models will be reflected in supervision. However, supervision models are typically portrayed as free of cultural biases (McGoldrick et al., 1996).

Furthermore, McDaniel, Weber, and McKeever (1993) argue that supervision should be theoretically consistent. For example, if family therapy focuses on clear boundaries between parents and children, and the therapist (supervisee) and the family, then the supervision relationship should consist of a clear boundary between the supervisor and supervisee. Clear boundaries reflect a Euro-American perspective. The appropriateness of theory-based supervision when the therapy on which supervision is based is cultural biased must be questioned.

Despite the shift toward cultural sensitivity and cultural awareness in family therapy practice, confusion and resistance to infusing or integrating various cultural perspectives into training and supervision remain problematic. The belief that current theories are equally appropriate and applicable to all populations regardless of cultural diversity is still very prevalent in our training and supervision practices. "The level of resistance can't be overstated. Among the newly minted psychologists . . . it is painfully clear that the (white) male still firmly controls the standards for defining 'normalcy'" (Bankart, 1997, p. 360).

MAKING THE TRANSITION

To train culturally sensitive family therapists (who can later become culturally sensitive supervisors), supervisors must acknowledge that supervision is as vulnerable to reflecting the dominant culture as other institutions. Ignoring cultural differences between supervisors and supervisees and between supervisees and clients leaves both supervisees and clients unacceptably vulnerable (Bernard & Goodyear, 1998). Supervisors should assist supervisees in identifying and examining their own personal cultural lens, blind spots, and prejudices. Furthermore, supervision should assist the supervisee in minimizing or eradicating the effects that these factors have in her or his interactions with others. In essence, supervision must touch the supervisee on both an intellectual and emotional level.

SUGGESTIONS AND RECOMMENDATIONS

General objectives of infusing cultural thinking into the training and supervision of family therapists are outlined by Falicov (1988):

1. to prevent focusing exclusively on the interior of the family to understand its function and dysfunction. The investigation of the family process should include the larger, sociocultural context.
2. to differentiate among universal, transcultural, culture-specific, and idiosyncratic family behaviors. Universal or transcultural similarities are to be emphasized while recognizing that all families have culture-specific and idiosyncratic behaviors.
3. to discriminate between family situations where cultural issues may be of clinical relevance from those where cultural issues are tangential.
4. to attain a culturally relativistic framework for assessment and intervention and to recognize culturally bound concepts and behaviors that may lead to ethnocentric biases.
5. to avoid the use of negative or positive stereotypes. They may lead to errors of assessment that are often as serious as those that stem from ethnocentric views.
6. to recognize that alternative value systems may be not only possible but also valid, and that each set of cultural values has inherent strengths and weaknesses.
7. to develop an exploratory, sensitive, and respectful attitude toward the family's cultural identity that is integrated with skills in joining, defining a problem, and selecting interventions (pp. 336-337).

A number of accreditation bodies such as the American Association for Marriage and Family Therapy and the Council for the Accreditation of Counseling and Related Programs have mandated that a cultural component be implemented into training programs. As a result, many programs have elected to offer a separate course addressing cultural issues. Although this is a step toward furthering cultural thinking and

awareness in therapy and supervision, it may not be the most effective way of facilitating cultural sensitivity and awareness of family therapists. The literature suggests that after taking a multicultural course, trainees seldom show evidence of having integrated sociocultural factors in the cases that they bring for supervision (Falicov, 1988). Falicov notes that these outcomes may be a result of messages implicit in the act of offering a separate course. It may convey the message that cultural issues are separate from other family issues. It may also designate all other courses offered in the training program as "not cultural," when the goal is to advance the idea that culture appears in various ways in family life and family therapy.

Another possible way to infuse cultural awareness into training practices is through experiential learning such as supervisees interviewing a nonclinical family of a distinct ethnic or socioeconomic group. This method of learning more effectively delivers the message about differentiating functional from dysfunctional behavior (Falicov, 1988). The supervisee learns to rely on her or his own observations about a family's culture. Another example of experiential learning involves requiring trainees to gain field experience working with culturally diverse populations. Depending on geographic location, this method of learning may not always be feasible from a racial perspective. Cultural diversity is not limited to racial differences; therefore, practicum and internship settings representative of different socioeconomic status, sexual orientations, and different worldviews would provide valuable experience and training.

Although practical experience working with culturally diverse populations can encourage supervisees' cultural thinking, Storm, Todd, Sprenkle, and Morgan (2001) suggest more supervisor-specific means of infusing cultural sensitivity and awareness into the training and supervision of family therapists:

(a) sharing and exploration by supervisors and supervisees of their cultural influences within supervision;
(b) regular inquiry by supervisors about cultural influences in all therapy cases; and
(c) supervisors inquiring about how cultural influences are affecting therapy and supervision, which can create a context of permission for those influences (e.g., sexuality) that are less evident to emerge.

CONCLUSION

As the demographics of the United States continue to change, as early as the year 2040, members of nonmajority or subculture groups will become the predominant population group in the United States (Wendel, 1997). Consequently, there is an overwhelming need for family therapy supervisors to break out of the constraints of their traditional monocular vision of families as White, heterosexual, and middle class (McGoldrick, 1998). Successful multicultural supervision can only occur by acquiring a cultural lens that takes into account the diversity of our society and "the ways that societal oppression has silenced the voices and constrained the lives of family members, whole families, and whole communities since this nation was founded" (McGoldrick, 1998, preface). Because family therapy and family therapy supervision are sociopolitical in nature, "the final stage of multicultural supervision must be social action for clients, supervisees, supervisors, and institutions" (Bernard & Goodyear, 1998). Anything less may be oppression rather than family therapy.

REFERENCES

Bankart, C. P. (1997). *Talking cures: A history of Western & Eastern psychotherapies*. Pacific Grove, CA: Brookes/Cole.

Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Brown, M. T., & Landrum-Brown, J. (1995). Counselor supervision: Cross-cultural perspectives. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 263-286). Thousand Oaks, CA: Sage.

Falicov, C. J. (1988). Learning to think culturally. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision* (pp. 335-357). New York: Guilford Press.

Hardy, K. V. (1993). Live supervision in the postmodern era of family therapy: Issues, reflections, and questions. *Contemporary Family Therapy*, *15*, 9-19.

Liddle, H. A, Becker, D., & Diamond, G. M. (1997). Family therapy supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 400-418). New York: John Wiley.

McDaniel, S., Weber, T., & McKeever, J. (1993). Multiple theoretical approaches to supervision: Choices in family therapy training. *Family Process*, *22*, 491-500.

McGoldrick, M. (1998). *Re-visioning family therapy: Race, culture, and gender in clinical practice*. New York: Guilford Press.

McGoldrick, M., Giordano, J., & Pearce, J. K. (1996). Ethnicity and family therapy (2nd ed.). New York: Guilford Press.

Storm, C. L., Todd, T. C., Sprenkle, D. H., & Morgan, M. M. (2001). Gaps between marriage and family therapy supervision assumptions and common practice: Suggested best practices. *Journal of Marriage and Family Therapy*, *27*, 227-239.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477-486.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G., & Vazquez-Nutall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.

Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.

Wendel, P. (1997). Cultural bias among minority counselors. *Counseling Today Online*, *40*, 1-4.

Angela Banks *is a doctoral student at the University of Virginia and a licensed professional counselor. Before beginning her doctoral studies, Angela worked as an elementary school counselor for an at-risk population and as a counselor in a psychiatric group private practice. Angela's research interests include cultural diversity in supervision and family therapy.*

❖**Literature Review—Research**

Attention Deficit Hyperactivity Disorder (ADHD) and Bipolar Disorder in Children and Their Coexisting Comorbidity: A Challenge for Family Counselors

Leslie Barton
Idaho State University

Those affected by mental illness are diagnosed and treated differently depending on the person's particular age and on the particular illness. Adults that have been diagnosed with attention deficit hyperactivity disorder (ADHD)(considered a childhood disorder), are often treated using childhood symptomatology and criteria. Conversely, children diagnosed with bipolar disorder (considered an adult disorder) may experience misdiagnosis and ineffective treatment based on adult criteria. As researchers have found, neither illness is age specific and both children and adults can be affected by either disease. Also found in research is a coexisting comorbidity. Due to the expansiveness of the literature regarding both topics, children are the chosen population of study for this article. The purpose of this study is to examine both ADHD and bipolar disorder particularly in children and their coexisting comorbidity.

Historically, humankind has struggled to deal effectively with mental illness and the problems it causes. Many attempts have been made to diagnose and treat mental illness, but most times to no avail. During the Dark Ages, there were accounts of abuse directed toward the mentally ill, while during Puritan times, there were accounts of the mentally ill being lovingly cared for by family members or hired staff (Eldridge, 1996). As can be seen, the quality of care for those with a mental illness was largely dependent on the attitudes of the times and of the particular caretaker. Throughout time, there have been few standards on how a mental illness would be diagnosed and treated. Diagnosis and treatment were based on the newest popular theories or "en vogue" thoughts of the times (Grob, 1998).

Author's Note: Correspondence regarding this article should be sent to the author at 1316 Woodruff Avenue, Idaho Falls, ID 83404.

With the expansion of medical science, however, mental illness is now being addressed. As in most cases, research regarding mental illness has focused on the adult population except for a few childhood disorders. One such exception is the recognition of attention deficit hyperactivity disorder (ADHD) as a childhood mental and emotional disorder. Children are now diagnosed and treated, whereas their adult counterparts are not accurately assessed and treated due to the lack of research regarding ADHD in adulthood (Barkley, 1997). Conversely, in respect to bipolar disorder, children are not often accurately diagnosed and treated because bipolar disorder is considered an adult mental illness (Geller & Luby, 1997; Kowatch, 1998; St. Dennis & Synoground, 1998). Depending on the specific disorder, both populations are not appropriately diagnosed and treated due to research biases about illness-age-onset specifications.

Researchers have found that neither illness is age specific. At any age, any population can be susceptible to either disease (Barkley, 1997; Geller & Luby, 1997; Kowatch, 1998; Lombardo, 1997; St. Dennis & Synoground, 1998). In this article, each illness will be described separately, as well as the coexisting comorbidity of these illnesses. As the literature on these topics is too expansive to examine accurately both ADHD and bipolar disorder and their comorbidity with all age populations, children will be the chosen population for this article.

ADHD

ADHD is commonly recognized and associated with children. Children with the disorder have sometimes been considered as having an "explosive will" or having "minimal brain damage/dysfunction" (Barkley, 1997; Wolraich & Baumgaertel, 1996). Even in Shakespeare's time ADHD was

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recognized, as mentioned in the play *King Henry VIII*. In the play, one of the characters is unable to stay focused and attentive (Barkley, 1997). Other authors, such as German physician Heinrich Hoffmann, described hyperactivity and inattentiveness in books that he wrote as early as 1848, and in 1902 George Still gave lectures about children who were aggressive and lacked appropriate inhibitions (Wolraich & Baumgaertael, 1996).

As science progressed, the disorder was defined by three specific characteristics: inattentiveness, hyperactivity, and impulsivity. By assessing the preceding characteristics, mental health care professionals would diagnose a child with attention deficit disorder without hyperactivity (ADD), or attention deficit disorder with hyperactivity (Wolraich & Baumgaertael, 1996). As more research was completed in regard to these two different classifications of ADD, it has been found that ADD without hyperactivity may be a separate attention disorder that may be succinctly different from ADD with hyperactivity (Barkley, 1997).

Because hyperactivity and impulsivity are key components in the diagnosis of ADD, in 1987 the disorder was renamed attention deficit hyperactivity disorder in the *Diagnostic and Statistical Manual of Mental Disorders* third edition revised (*DSM-III-R*) (American Psychiatric Association, 1987). The diagnosis of ADD without hyperactivity was then named undifferentiated attention deficit disorder. Changes were made again in the *Diagnostic and Statistical Manual of Mental Disorders* fourth edition (*DSM-IV*). Diagnostic criteria and specific subtypes were determined, and the symptoms of inattention or hyperactivity-impulsivity that do not meet the criteria are now classified under the category of ADHD not otherwise specified (Barkley, 1997; see American Psychiatric Association, 1994, for specific criteria).

The behaviors described in these criteria must be more excessive and severe than presented in other children of the same developmental level and present themselves before the age of 7 years. These behaviors must create impairment in the individual's life in at least two or more settings (i.e., school, work, home, social environments, etc.) (American Psychiatric Association, 1994; National Institute of Mental Health, 1994). Recently, there has been an outcry regarding the age-onset criteria (7 years) of ADHD (Barkley, 1997). Opponents of the age-onset criteria state that depending on the form of the disorder, onset may occur at a later age. As stated by Barkley (1997), for example,

> No such precise age onset criteria are established for other developmental disorders, such as MR (mental retardation), learning disabilities, or language disorders in order for them to be valid disorders, nor should there necessarily be such a criterion for ADHD. (pp. 22)

As can be seen from the *DSM-IV* (American Psychiatric Association, 1994) listing, individuals with ADHD may not have exactly the same symptoms. For those children who qualify for six of the nine items listed under the inattention classification but do not have any of the symptoms under the hyperactivity-impulsivity classification, the diagnosis of ADHD predominantly inattentive type (ADHD-I) is given. Those children who qualify for six out of the nine items listed under the hyperactivity-impulsivity classification but do not have any of the symptoms under the inattention category would be diagnosed with ADHD predominantly hyperactive-impulsive type (ADHD-HI). Children exhibiting symptoms from both classifications would then be diagnosed with ADHD combined type (ADHD-C)(American Psychiatric Association, 1994; Barkley, 1997).

Wolraich and Baumgaertel (1996), when examining the separate ADHD subtypes, concluded that:

1. Girls with ADHD have predominantly inattentive type. It has been proposed that girls exhibit symptoms differently than do boys (e.g., exhibit less hyperactive and impulsive behaviors), and that in the past (without the ADHD predominantly inattentive subtype) girls were being underdiagnosed and not treated. Also, ADHD-I is characterized with few behavioral problems but academic problems seem to prevail.
2. The hyperactive-impulsive subtype of ADHD is characterized with behavioral problems, with few academic problems along with low anxiety and depressive symptoms.
3. ADHD (combined type) seems the most fraught with difficulties. Those individuals that have both hyperactivity-impulsivity symptoms along with inattention symptoms seem to have both behavioral as well as academic problems. This subtype seems to be the most impairing. Also, this subtype is more vulnerable to having other comorbid disorders/illnesses connected with it (pp. 183-184).

Accompanying Comorbid Disorders

As stated formerly, often those with ADHD have other accompanying problems, disorders, and/or mental illnesses. Some of the problems that can accompany ADHD are learning disabilities, Tourette's Syndrome (body and vocal tics), oppositional defiant disorder (ODD), conduct disorder, anxiety, depression, and, as suggested herein, bipolar disorder (National Institute of Mental Health, 1994).

Along with the disorders and illnesses listed above, researchers have also found that other cognitive impairments may exhibit themselves with an ADHD individual (Barkley, 1997). They are as follows (Barkley, 1997):

1. motor coordination and sequencing
2. digit span and mental computation
3. planning and anticipation
4. verbal fluency and confrontational communication
5. effort allocation
6. applying organizational strategies in tasks
7. the internalization of self-directed speech
8. adhering to restrictive instructions
9. self-regulation of emotional arousal
10. may be associated with less mature or diminished moral reasoning (p. 13).

Not all children with ADHD are afflicted with the aforementioned disorders, illnesses, and cognitive impairments, but some do have one or more of these problems. As demonstrated, the symptoms and experiences of those afflicted with ADHD and accompanying comorbid features may vary from person to person and can have devastating effects.

WHAT CAUSES ADHD?

The purported causes of ADHD have ranged from minor head injuries to the use of sugar in the diet. What has been found is that ADHD is not due to too much television, food allergies, excess sugar, poor home life, or poor schools (National Institute of Mental Health, 1994). Research continues regarding the biological etiology of ADHD. Several discoveries have been made regarding the ADHD brain and a "normal" brain. For example, it has been found through the use of positron emission tomography that those individuals with ADHD have less brain activity in the areas of the brain that use glucose to control attention (National Institute of Mental Health, 1994).

Other researchers have found that actual regions of the ADHD brain (e.g., prefrontal cortex, caudate nucleus, and *globus pallidus*) are simply smaller in size than found in the normal brain. Also, the findings show that there is not any asymmetry in size between the left and right frontal regions as opposed to the asymmetry in a normal brain with the right regions being larger than the left (Barkley, 1997). As can be seen, it appears that researchers are getting closer to knowing the biological causes of ADHD, but there is still a good deal of research work to go.

Researchers have also suggested other possible reasons for the presence of ADHD. Possibilities are heavy alcohol and/or drug use during pregnancy, toxins in the environment (i.e. lead, etc.), genetic influences (e.g., if a parent has ADHD, the risk for offspring having it is 57%) (National Institute of Mental Health, 1994; Barkley, 1997, p. 37).

TREATMENT

When diagnosing whether a child has ADHD, the health professional must use a multimethod assessment. For example, behavioral rating scales are helpful, but other assessments such as behavioral observations and clinical judgment should also be used (Reid, 1995, p. 556). After being diagnosed, many ADHD children will then be prescribed a medication (i.e., Ritalin, Cylert, or Dexedrine). These medications assist the child by reducing hyperactivity and increasing the child's ability to focus (National Institute of Mental Health, 1994). When dramatic improvements in behavior, schoolwork, and so forth are noticed, people may think that medication is all that is needed, not realizing that medicine does not cure the disorder, it only alleviates the symptoms. Other forms of treatment are needed in combination with the medication to help the child and his or her support system (e.g., family) learn how to cope and deal with the ongoing effects of the disorder. According to the National Institute of Mental Health (1994) booklet entitled *Attention Deficit Hyperactivity Disorder*, "Many experts believe that the most significant, long-lasting gains appear when medication is combined with behavioral therapy, emotional counseling, and practical support" (p. 23).

As stated, behavioral therapy is one of the therapy components used in the treatment of ADHD, specifically with children. Many times, it is necessary for parents to use behavioral modification with their child on an ongoing basis. Danforth (1998) performed a study in which behavior management techniques were taught to mothers who then employed these behavioral management skills with their noncompliant ADHD as well as ODD children. Behavioral parent training was found to be an effective component of treatment when dealing with noncompliant or disruptive children. As stated, behavioral therapy is just one component in assisting the ADHD child. Along with behavioral therapy and medications, emotional and practical supports should be utilized as well.

Individual counseling as well as social skills training can assist the ADHD child. Being known for having difficulties with peer relations, most ADHD children would benefit from social skills training. By participating in social skills training, the child learns to model appropriate social behaviors (i.e., waiting for a turn, responding to teasing, etc.) (National Institute of Mental Health, 1994). For specific suggestions on how counselors, parents, and others can utilize social skills training, see Landau (1998).

Another option that could be utilized for both the child and family members is attendance at local or national support group meetings. By being able to share with others experiences similar to their own, the child and family members will not feel as isolated or alone (National Institute of Mental Health, 1994).

BIPOLAR DISORDER

Three themes were found on review of the research literature regarding bipolar disorder and children. The most common theme is a correlation and comorbidity between ADHD and early-onset bipolar disorder (Geller & Luby, 1997; Lombardo, 1997; Sachs, Baldassano, Truman, & Guille, 2000; St. Dennis & Synoground, 1998; Taylor). Second, numerous authors (Isaac, 1995; Lombardo, 1997; Sachs et al.; Taylor) discussed the need for more research regarding children with bipolar disorder because frequently symptoms are unrecognized and/or misdiagnosed. Third, childhood early-onset bipolar disorder does not have the same symptomatology as late-onset adult bipolar disorder (Geller & Luby, 1997; Isaac, 1995; Taylor, 1998). Bipolar disorder symptomatology along with the preceding themes will be described more fully.

Bipolar Disorder Symptomatology

No matter the age, there are specific characteristics exhibited by people with bipolar disorder. Bipolar disorder, which used to be called manic-depression, usually involves episodes with severe mood highs and lows. The highs are described as mania whereas the lows are seen as severe depression (National Institute of Mental Health, 1996). Refer to the National Institute of Mental Health (1996) report for a full list of characteristics.

Bipolar disorder has been divided into four different subtypes in the *DSM-IV* (American Psychiatric Association, 1994). The subtype classifications are bipolar I disorder, bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified. By being knowledgeable about the symptoms and subtypes of bipolar disorder, family counselors should more fully understand the differences between early-onset bipolar disorder (in which children are vulnerable) versus the late-onset bipolar disorder that affects adults.

Early-Onset Versus Late-Onset Symptomatology

Characteristics of early-onset bipolar disorder are quite different from their late-onset bipolar disorder counterparts. For example, Geller and Luby (1997) found aggressive hyperactivity, greater familial loading, and lithium resistance more likely to occur with early-onset bipolar disorder. Taylor (1998) describes how children with early-onset bipolar I disorder experience "atypical manic episodes" whereby it is difficult to establish when a manic episode ends or begins. Children with early-onset bipolar I disorder have attention problems and intense fluctuating moods along with aggressive behaviors. These children may be extremely irritable and have unstable and rapidly changing emotional states. As manic episodes are more difficult to identify in children, other factors must be observed and taken into consideration. These factors are poor concentration abilities, impulsivity, hyperactivity, moodiness, and disturbed sleep patterns as well as anger and conduct problems. Compared with adult late-onset bipolar disorder characteristics such as delusional grandiosity, paranoia, and elevated euphoria, the symptoms are extremely different.

According to St. Dennis & Synoground (1998), "mixed states" (episodes of mania and depression that occur simultaneously for at least a week, according to adult symptomatology), are reportedly more common in children and adolescents than their adult counterparts. Many of these children will cycle from mixed state to mixed state, thus making episode determinations more difficult to detect. Also, children and adolescents with early-onset bipolar disorder experience rapid cycling of moods between depression and excitement (within hours or days) versus adults that may experience cycling at a much slower pace (four or more episodes per year) (St. Dennis & Synoground, 1998). Thus, it is more difficult for mental health professionals to determine bipolar disorder using adult criteria when diagnosing younger, early-onset populations.

Again, Geller and Luby (1997) have explained the difficulties involved in trying to fit children and adolescents into adult bipolar disorder symptomatology. They stated,

> If one looks to fit children and adolescents into adult criteria for manic-depressive illness, it will be difficult except for those adolescents who have adult-type onset. . . . A developmental, age-specific viewpoint needs to be considered for pediatric patients who do not have the adult-type onset. (p. 1168)

Even though many practitioners try to diagnose and treat children for bipolar disorder using adult criteria and treatments, their efforts may be in vain due to an ever-increasing knowledge base that is showing that early-onset bipolar disorder is very separate and different from that of adult late-onset.

NEED FOR RESEARCH

Due to lack of knowledge regarding the symptomatology of early-onset bipolar disorder, many mental health professionals either do not recognize or misdiagnose the child's condition. As stated by Geller and Luby (1997), "As yet, no national or international epidemiological study of bipolar disorder . . . during the pediatric years is available" (p. 1169). What Geller and Luby found (through obtaining chart review reports, inpatient service reports, epidemiological information, etc.), is that the prevalence of bipolar disorder in the pediatric and adolescent populations is of the same proportions as in the adult population, and may even be on the rise. Then why, one might ask, has there been so little research completed on these populations in which the prevalence is just as great?

Wick (1993) cited two major reasons why researchers are reluctant to conduct research with younger populations. First, many research studies require large and frequent samplings for research, which are difficult to come by with children; and second, there are many legal and ethical issues involved regarding minors. The above constraints lead to legal restraints regarding the use and testing of medication effects with children as well (Wick, 1993). Thus, a majority of research studies regarding bipolar disorder are conducted with adults. With the aforementioned constraints, adult bipolar disorder is being more deeply understood, whereas childhood early-onset bipolar disorder continues to be only partially, if at all, understood.

Due to health care professionals' lack of knowledge about bipolar disorder in children, "bipolar disorder is very often unrecognized in the most problematic children and adolescents" (Isaac, 1995, p. 273). Isaac conducted a study over a 3-month period at an acute psychiatric unit for children and adolescents. He found that children and adolescents exhibited different bipolar symptoms. Often these children were diag-

nosed with ADHD or with conduct disorder, and so forth, when in reality these children and adolescents had early-onset bipolar disorder.

Out of the 57 patients (age range 7-17 years), 14 patients fully met bipolar disorder criteria, with five of those being prepubertal children. Fifteen patients had histories and features that strongly suggested bipolar disorder, whereas 14 other children needed extended observation time to determine the possibility of bipolar disorder. As can be seen, 43 out of the 57 patients had bipolar disorder and/or its possible related features (Isaac, 1995).

After completion of the research, the psychiatric unit staff was educated about the indicative symptoms of early-onset bipolar disorder. Only five children at the unit had been diagnosed the year prior. Bipolar disorder had gone unrecognized, and until the research study was conducted, patients had been misdiagnosed and classified with disorders such as ADHD or with conduct or adjustment disorders (Isaac, 1995).

A great need exists for research regarding early-onset bipolar disorder. Mental health professionals need to be educated to the differences in the early-onset symptomatology and understand what to assess in order to recognize and make an accurate diagnosis.

CORRELATION AND/OR COMORBIDITY OF ADHD

Many mental health professionals have not been thoroughly informed about childhood early-onset bipolar disorder. With research still underway, and many mental health professionals using adult bipolar disorder symptomatology as the rule when assessing children and adolescents, it is not surprising that many clients with this disorder are misdiagnosed or their illness unrecognized. Those with early-onset bipolar disorder are often diagnosed with ADHD when in actuality it is a comorbid relationship in which the individual has both disorders simultaneously (Biederman, 1998; Geller & Luby, 1997; Lombardo, 1997; Sachs et al., 2000; St. Dennis & Synoground, 1998; Taylor, 1998). As indicated by Sachs et al., 62% of participants with bipolar disorder were also found to have ADHD.

As research studies are beginning to find, there seems to be a high correlation among children that have early-onset bipolar disorder and ADHD. As cited by Sachs et al. (2000), a study by Wozniak et al. found that 94% of children that were referred for treatment at a pediatric psychopharmacology clinic met the criteria for mania as well as for ADHD.

Some researchers (Geller & Luby, 1997) have suggested that ADHD, with its hyperactivity component, may actually be the first indicator of early-onset bipolar disorder. Correlations have been drawn regarding the higher incidence of ADHD in children and adolescents with early-onset bipolar disorder than in those with the later-onset bipolar disorder. Geller & Luby (1997) found that 90% of children with early-onset bipolar disorder also had ADHD, whereas only 30% of adolescents with bipolar disorder had ADHD. It is possible that the aforementioned adolescent population had late-onset adult bipolar disorder. As can be seen, though, out of the group with childhood early-onset bipolar disorder, approximately 90% of them had ADHD as well. This appears to be a noticeable correlation.

In the previously mentioned study by Sachs et al. (2000), no correlation was found between participants with late-onset bipolar disorder and ADHD, whereas a definite correlation was found between participants with early-onset bipolar disorder and ADHD.

As ADHD and early-onset bipolar disorder share common symptomatology (i.e., impulsivity, mood lability, hyperactivity, etc.), some researchers have mentioned the difficulty in differentiating between the two disorders (Biederman, 1998; Isaac, 1995; St. Dennis & Synoground, 1998; Taylor, 1998). As was stated by St. Dennis & Synoground and Sachs et al. (2000), the Mania Rating Scale was able to distinguish children with mania from children with ADHD. St. Dennis and Synoground also mentioned that the Conners Parent and Teacher forms, a commonly used assessment instrument, were unable to differentiate between ADHD characteristics and those of mania. (See St. Dennis & Synoground, for a description of the clinical features that explain the differences between the two disorders.)

Due to possible inaccurate diagnostic measurements, a child or adolescent's illness may progress unrecognized or misdiagnosed. As stated previously, many times the child may be diagnosed with ADHD when he or she is truly experiencing both illnesses simultaneously (Biederman, 1998; Geller & Luby, 1997; Sachs et al., 2000; St. Dennis & Synoground, 1998; Taylor, 1998).

IMPLICATIONS FOR FAMILY COUNSELORS

As seen from the preceding literature on ADHD and bipolar disorder, family counselors will need to have a thorough understanding of both disorders and their comorbidity when working with a child and his or her family.

When working with the ADHD aspect, the family counselor will need to understand the efficacy and possible side effects of the stimulant medications. Also, a thorough understanding of behavioral techniques and social skills training will be a requisite as well (National Institute of Mental Health, 1994).

In regard to bipolar disorder, again, the family counselor will need to be aware of the possible prescribed medications and their effects. Also, individual counseling will need to be employed in order to help clients deal with possible mood lability and so forth that he or she will experience. Individual

and/or family counseling is usually necessary to help the child or adolescent and his or her family learn how to cope with the disorder(s) he or she may have. As Taylor (1998) stated, "Validating the family's pain, underscoring realistic hope, and reframing misinformation or perceptions in a caring manner can become an important professional intervention" (p. 327). Overall, the family counselor will need to assist the client with the pain and grief that he or she and family members are experiencing due to being diagnosed with both disorders.

There are specific topics a family counselor should be aware of when treating children and adolescents with ADHD and bipolar disorder. The family counselor should be cognizant about the different symptoms exhibited with each of the disorders. Also, to more accurately treat the child or adolescent, the counselor will need to have a thorough knowledge about early-onset bipolar disorder and its comorbidity with ADHD. Clearly, the family counselor must stay abreast of the current research to recognize and assist clients with the most up-to-date treatment procedures.

As with any chronic mental illness, if the counselor has an open, communicative relationship with the client's physician, the counselor and physician can work as a team to give the best optimal care for the complex symptomatology that is expressed by these coexisting disorders.

Also, the counselor should assist the child (through individual and family counseling) as well as family members with the anger, despair, sense of hopelessness, sorrow, and blame that frequently occur due to the nature of these chronic problems. Education is necessary when dealing with chronic mental illnesses and disorders such as ADHD and bipolar disorder (Taylor, 1998). By educating extended family members, school personnel, the parent's employers, and so forth, additional "outside" understanding and emotional support can be secured, benefiting the child or adolescent and his or her family. Specifically, through educating these outside individuals, consistent treatment activities and goals can, it is hoped, be met in any situation in which the child or adolescent may be involved (Taylor, 1998).

Regarding treatment for children with the aforementioned disorders, Lombardo (1997) has stated, "The development of effective therapeutic alternatives for these children remains a clinical challenge." As Geller and Luby (1997) have stated, there is still a need for research in order to know how to more effectively treat children and adolescents with comorbid ADHD and bipolar disorder features.

Overall, as more research is conducted regarding children and adolescents, it is hoped that mental health professionals will learn how to diagnose more accurately and effectively treat these illnesses. Family counselors will need to stay abreast of current information and treatments regarding these disorders and their possible comorbidity to effectively recognize and therapeutically treat the affected child or adolescent.

SUMMARY

More research is needed to understand ADHD and bipolar disorder so that those affected are not misdiagnosed or inaccurately and ineffectively treated. As presented, many children and adolescents have not been accurately diagnosed (St. Dennis & Synoground, 1998; Geller & Luby, 1997; Isaac, 1995; Kowatch, 1998; Taylor, 1998). Many have been diagnosed with ADHD but may still not be recognized as having the coexisting bipolar disorder. Family counselors need to become more thoroughly educated in order to detect and treat both comorbid illnesses in children and adolescents and to provide the adequate support needed to their families.

REFERENCES

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: Author.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barkley, R. A. (1997). *ADHD and the nature of self-control*. New York: Guilford Press.

Biederman, J. (1998). Resolved: Mania is mistaken for ADHD in prepubertal children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*(10), 1091-1093.

Danforth, J. S. (1998). The outcome of parent training using the behavior management flow chart with mothers and their children with oppositional defiant disorder and attention-deficit hyperactivity disorder. *Behavior Modification*, *22*(4), 443-473.

Eldridge, L. D. (1996). "Crazy brained": Illness in colonial America. *Bulletin of the History of Medicine*, *70*(3), 361-386.

Geller, B., and Luby, J. (1997). Child and adolescent bipolar disorder: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 1168-1175.

Grob, G. N. (1998). Psychiatry's holy grail. *Bulletin of the History of Medicine*, *72*(2), 189-219.

Isaac, G. (1995). Is bipolar disorder the most common diagnostic entity in hospitalized adolescents and children? *Adolescence*, *30*(117), 273-276.

Kowatch, R. A. (1998). Mania in young children [Letter to the editor]. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*(10),1003.

Landau, S. (1998). Peer relations of children with attention-deficit hyperactivity disorder. *Reading & Writing Quarterly: Overcoming Learning Difficulties*, *14*, 83-105.

Lombardo, G. T. (1997). BPD and ADHD [Letter to the editor]. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(6), 719.

National Institute of Mental Health. (1994). *Attention deficit hyperactivity disorder. Decade of the brain*. Rockville, MD: Author.

National Institute of Mental Health. (1996). *Bipolar disorder. Decade of the brain*. Rockville, MD: Author.

Reid, R. (1995). Assessment of ADHD with culturally different groups: The use of behavioral rating scales. *School Psychology Review*, *24*(4), 537-560.

Sachs, G. S., Baldassano, C. F., Truman, C. J., & Guille, C. (2000). Comorbidity of attention deficit hyperactivity disorder with early- and late-onset bipolar disorder. *The American Journal of Psychiatry*, *157*(3), 466-467.

St. Dennis, C., and Synoground, G. (1998). Medications for early onset bipolar illness: New drug update. *Journal of School Nursing*, *14*(5), 29-43.

Taylor, E. H. (1998). Advances in the diagnosis and treatment of children with serious mental illness. *Journal of the Child Welfare League of America*, *127*(3), 311-329.

Wick, J. (1993). Use of psychoactive medications in children and adolescents. *American Pharmacy*, *NS33*(1), 51-58.

Wolraich, M. L., & Baumgaertel, A. (1996). The prevalence of attention deficit hyperactivity disorder based on the new *DSM-IV* criteria. *Peabody Journal of Education*, *71*(4), 168-186.

***Leslie Barton**, B.A., is completing a master's degree in counseling and will be entering doctoral study at Idaho State University in Pocatello.*

❖**Literature Review—Practice**

Opening Space for Client Reflection: A Postmodern Consideration

John D. West
Kent State University
Richard E. Watts
Baylor University
Heather C. Trepal
Kelly L. Wester
Todd F. Lewis
Kent State University

It is suggested in this article that perhaps during those occasions in which some distance exists between ourselves and our problems in life, we might experience an opportunity for reflective thinking. It is also suggested that opportunities for reflective thinking might be of benefit to clients in counseling. This article reviews selected literature addressing reflective thinking and it reviews selected literature that would seem to provide a perspective on facilitating "space" for reflective thinking during family counseling.

Have you ever been confronted with a decision, then requested the evening to sleep on it and awoke the next morning with a clearer direction? Perhaps you have found yourself with a valued friend whose perspective on life seems to add clarity to your daily puzzling. What of those moments when a partner has just the right idea about stepping out of a conflict with a child and has also suggested a powerful way for reestablishing the parent-child relationship? Or how often, when involved in family counseling, has a supervisory comment or question appeared to open additional possibilities? It is our belief that in part, additive views such as those just mentioned come from one's ability to be in a reflective position, that is, a position outside the immediate puzzling or struggling one may be experiencing. Moreover, it would seem that it is just this ability to enter a reflective position that holds promise for clients in family counseling as they try to create new and preferred meanings that also suggest alternative possibilities.

In commenting on reflection, Andersen (1991a) mentioned that the French "reflexion" is thought to have "the same meaning as the Norwegian 'refleksjon,'" which denotes that "something heard is taken in and thought about before a response is given" (p. 12). For an individual to engage in reflective thinking it may be useful to be outside the immediate situation, and so it may be that sleeping on a decision can open "space" for reflection the next morning. Or it may be that a valued friend's or partner's or supervisor's perspective that comes from outside one's own immediate experience may have been generated in a space that allowed for reflective thinking. It would indeed appear that the counseling process might benefit from considering how to help family members become more reflective, thoughtful, or considered.

Reflective thinking may occur when a family member is encouraged to consider the impact of a problem on one's life; for example, "How has anger made you feel about yourself?" "What has anger required of you?" and "If anger continues to gain control, what might it require of you in the future?" White and Epston (1990) referred to this objectifying and personifying of the problem as externalizing the problem, and White (1993) commented on the idea that as problems become externalized, a taken-for-granted notion that the client is the problem (an angry person) becomes deconstructed. With regard to externalizing the problem, White and Epston mentioned that "neither the person nor the relationship between persons is the problem. Rather, the problem becomes the problem, and then the person's relationship with the problem becomes the problem" (p. 40). It would seem that placing the problem outside the client or outside the family members and placing some distance between them and the problem may allow space for reflective thinking. Zimmerman and Dickerson (1996) noted,

> we see that the dominant culture takes up most of the space and pushes to the edges those experiences that lie outside its normalized standards and values. . . . Is there ever space for

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> people to examine how they have just gone along with the status quo, and whether doing so is even what they want? . . . In therapeutic interactions, we see that one way space can be opened for clients is by creating reflexive practices in the room. (p. 100)

Arranging for space between the family members and the presenting problem may allow for an opportunity to consider the subjugating aspects of taken-for-granted realities, for example, that someone is exclusively characterized as the angry member of the family, the depressed member, the anxious member, and so forth. In this article we review some of the literature that seems to be associated with an understanding of reflective thinking. We also review some of the literature that seems to comment on possibilities for opening space between a family member and the problem in order that reflective thinking might occur, not for the above-mentioned purpose of deconstruction but for the purpose of considering exceptions to old patterns of behavior (de Shazer, 1988) and for the purpose of considering unique outcomes to oppressive stories (White, 1989). Whereas the processes of constructing exceptions and unique outcomes may certainly have a deconstructive effect on an old pattern or story, they are more intentionally aimed at efforts to lift up possibilities for one's future. Both processes (the identification of exceptions and unique outcomes) seem to support the O'Hanlon and Weiner-Davis (1989) comment as well as Haley's (1973) comment on Milton Erickson's work, that meaningful differences can come from small changes. With regard to the current conversation on reflective thinking, it would appear that reflective thinking may help generate exceptions and unique outcomes that facilitate small, yet meaningful differences. There are undoubtedly a number of components to reflective thinking and in the next section we would like to speak of five components interpreted from the literature.

REFLECTIONS ON REFLECTIVE THINKING

Andersen (1995) suggested that reflective thinking can be facilitated in individual counseling as well as family counseling. Whatever the context, there would appear to be a number of thoughts from the literature that are deserving of consideration when contemplating the role of reflective thinking. For example, postmodern literature (Gergen, 1991, 1994, 1999; White & Epston, 1990) has suggested that each of our lives contains multiple realities, narratives, or stories about who we are as we interact with others. For example, an individual may have a story about himself or herself that is descriptive of a responsible adult, and yet at other times the individual may respond from a playful and childlike position. Clients may also have a story that is descriptive of their family relationships, for example, a story about being considerate of one another, about being committed to social justice, about being captured by criticism, or about being plagued by a lack of commitment and limited follow-through. It can certainly occur that one of these realities becomes a dominant reality and that this reality is supported by interactions with others (White & Epston). For instance, in a couple's relationship one may believe that she or he has to be the responsible adult because the other has become the playful partner. From here, a function of reflective thinking can be to help support an expansion of our ideas beyond the dominant story, which White and Epston have noted can at times become problem saturated. Regarding a problem-saturated story, it has been suggested that problems occur for people when the internalized conversations about oneself and one's relationships become restricted or too narrow (Adams-Westcott, Dafforn, & Sterne, 1993; White & Epston), and others have mentioned that these problem-laden stories result in limited perceptions about alternative choices (Tomm, 1989; White & Epston). It has also been indicated that stories or narratives influence our perceptions and directions in life (White & Epston), and although not all stories lead to preferred outcomes, it is indeed fortunate that a multiplicity of realities exist (exceptions and unique outcomes) from which alternative stories can be grounded (Epston, White, & Murray, 1992).

It would also seem important to remember that from the narrative or text metaphor, the meaning of an experience, comment, or question is in part determined by the person experiencing the event, hearing the comment, or receiving the question (White & Epston, 1990). Whether at work or in school, whether with one's family or at church, and so forth, the meaning of a comment or question resides in part within the individual hearing the remark or receiving the inquiry. This is no doubt a valuable point to keep in mind whether one is an administrator, teacher, minister, parent, partner, or counselor. Tomm (1987) noted that with regard to a reflexive process, meanings associated with events are interactively influenced by each other, and we would see the interactive influencing of meanings as characteristic of reflective thinking. Tomm (1987) also noted that "the specific effects of the questions [perhaps asked by a counselor] are determined by the client or family, not by the therapist" (p. 172). This would indicate that although a counselor may help to open some space for reflection, family members certainly need to be honored as the coauthors of reflections.

Zimmerman and Dickerson (1996) spoke of reflexivity as a concept and suggested that this concept is more than reflecting, yet it would seem that their description of reflexivity has captured our understanding of reflective thinking:

> a process in which ideas can bounce off other ideas; aspects of experience can come to the fore, so that persons can begin to notice and examine previously held assumptions. It is an in-between place—between persons, between representations and persons (e.g., letters from others), between experience and persons (e.g., music). (p. 101)

Indeed, reflective thinking would seem to occur within an individual as ideas bounce off other ideas so that a person can consider previously held assumptions. For the family member whose relationships appear to be permeated by a problem, reflective thinking is thought to occur in those moments where the in-between place includes some space between the problem and the person. It is this space that allows for stepping outside of the dominant story, and it is here that thinking and rethinking about one's own thinking takes place. Zimmerman and Dickerson (1996) seemed to describe this thinking about one's own thinking as a part of a reflexive process (or what we are referring to as reflective thinking). Andersen (1993) referred to outer and inner dialogues and indicated that during an outer dialogue the individual is talking with others about concerns and preferred perspectives whereas during an inner dialogue the individual is talking with himself or herself about concerns and perspectives. Shotter (1993) also appeared to be speaking of something similar to reflective thinking when he noted that "people's attempts to realize their thoughts . . . in ways which make those thoughts socially *usable* . . . must be *negotiated* in an inner back-and-forth process, in which they must attempt to understand and challenge their own proposed formulations as the others around them might" (p. 44). For example, when talking with oneself about the desire to step out of conflicts with a family member, one may wonder from the position of a respected friend whether ignoring critical comments is suggestive of a lack of assertiveness or symbolic of a preferred response or alternative narrative. This wondering from another's position may allow for some space or distance from the presenting problem in order that ideas can bounce off each other and in order that previously held assumptions can be examined.

Through reflective thinking new meanings may be created and new behaviors may be identified for the experiences in one's life. This is congruent with the notion that we achieve understandings of ourselves and our relationships through being in conversations with others (Gergen, 1994, 1999) and through being in conversation with others as well as with ourselves (Andersen, 1991a, 1992, 1993, 1995). This is quite different from assuming that meanings reside within events (e.g., marriage or parenting); rather, as Gergen (1994) has suggested, as we engage in conversations with others about events, meanings are created rather than found. White (1993) and Freedman and Combs (1996) referred to Bruner's (1986) concepts of a landscape of consciousness and a landscape of action. Freedman and Combs mentioned that "by 'the landscape of consciousness' we refer to that imaginary territory where people plot the meanings, desires, intentions, beliefs, commitments, motivations, values, and the like that relate to their experience" (p. 98). Likewise, Bruner (1986) noted that with regard to the landscape of action, its "constituents are the arguments of action" (p. 14). Freedman and Combs mentioned, "This is similar to the 'who, what, when, and how' of journalism. In the landscape of action, we plot sequences of events through time" (p. 97). To consider the landscape of action in reflective thinking, a counselor may choose to focus on the future and might, for example, wonder with a client how a valued friend or relative would recommend responding to parental criticisms. Here, the friend or relative's view may come from outside the client's perspective and so may facilitate reflective thinking. It is thought, then, that reflective thinking may have a bearing on the meanings we create for life as well as a bearing on the behaviors we choose in life.

The notion that multiple meanings exist in life and that meanings are associated with the conversations and interpretations of events and experiences does not deny the presence of physical realities. O'Hanlon (1993) stated that

> Radical constructivists and quantum physicists suggest that what we call reality is constructed/fabricated by our beliefs and our neurology. . . . In this view, there is no such thing as reality (or truth either, which is another matter altogether and a compelling reason not to hire a radical constructivist to handle your cash). (pp. 5-6)

It was not too long ago that a friend of one of the authors (C. T. Jackson, personal communication, November 1999) referred to the idea that "it's hard to pick yourself up by your bootstraps if you don't have any boots." From his commentary, and probably from a number of other illustrations, we are perhaps faced with the notion that not all of life can be constructed from our beliefs. Yet, speaking of the social constructionists, O'Hanlon (1993) mentioned, "They . . . hold that there is a physical reality out there but that our social reality, being influenced by language and interaction, is negotiable" (p. 6). It would seem, then, that it is our social realities, the meanings that we provide to events, to physical realities, and to relationships that can be influenced by reflective thinking.

In summary, a few ideas have been reviewed that appear to be associated with reflective thinking. Specifically, (a) the view that alternative realities are present for family members, and reflective thinking may help clients surface these realities; (b) the idea that meanings are determined in part by the individual experiencing an event, hearing a comment, or receiving a question, and so clients become coauthors of their own reflections; (c) the belief that reflective thinking occurs for individuals as ideas "bounce off" other ideas (thinking about thinking) so that a client can consider previously held assumptions; (d) the thought that reflective thinking may help clients consider alternative meanings for their experiences as well as new directions for their behavior; and (e) the realization that physical realities are not to be denied but that social realities are constructed through conversations with others as well as with oneself. Having said this, it would certainly appear that a counselor who is attempting to be thoughtful would want to consider the landscapes of consciousness (beliefs) that are in agreement with one's practice as well as

the landscapes of action (behaviors) that are associated with one's beliefs. It is with the landscapes of action in mind that we now turn our attention to possibilities for opening space for reflective thinking.

OPENING SPACE FOR CLIENT REFLECTION

The question becomes how to help clients move from those patterns of behavior or narratives that are restricting and limiting to a position that offers alternatives and possibilities. A reflecting team may be one vehicle for opening space to facilitate thinking about one's life (Andersen, 1991c) and, as a result, it may offer an opportunity to create new understandings about one's relationships. Reflecting teams have been discussed by Andersen and others (Andersen, 1991c; Friedman, 1995), and in part they can be described as comprising a small group of individuals who function as an audience and listen to a family therapy session. At a certain point, the audience shares their reflections with each other, and by doing so, it is hoped they help to open space for the family and counselor to move to a listening position and to reflect on alternative possibilities for understanding a presenting problem, or perhaps for enriching a new pattern or narrative. In this section we review possibilities from the literature for opening space for reflective thinking as the counselor works with one or more family members without the benefit of a reflecting team. The literature mentioned in this section either directly refers to facilitating reflective thinking without the benefit of a reflecting team or appears to have implications for this practice.

Reducing Pressure to Respond in an Effort to Open Space for Reflection

Zimmerman and Dickerson (1996) noted that at times, discussion of the presenting problem may become so dominant that it interferes with the clinician and clients generating other understandings of the problem and it may even interfere with efforts to consider other possibilities for responding to the problem. They mentioned that when a client is in the position of a respondent,

> there is an overwhelming pull to give some kind of answer or response. This inclination leaves little room for them to reflect or consider the possibilities available. . . . If, however, clients feel no need to respond . . . they may find several more ways to think about their thinking and their lives. (p. 103)

Zimmerman and Dickerson suggested that the counselor may divert his or her eyes from clients by looking to the floor, to the ceiling, or out the window to help them feel less pressure to respond. Wangberg (1991) mentioned the use of such a procedure while working with clients, and as he attempts to become reflective, "I will then lean back to create a bigger distance, I will either look at the ceiling or out the window, and talk *about* them rather than to them" (p. 19). Moreover, Andersen (1991b) noted the appropriateness of being somewhat tentative when one speaks (e.g., "I'm wondering about . . . " or "I'd be curious whether . . . ") as well as viewing situations and concerns from a both-and position rather than an either-or position to encourage reflective thinking. For example, while looking out a window the counselor might wonder, "In addition to experiencing criticalness as not helpful, what might happen if it was viewed as a type of concern, perhaps a parental concern for one's daughter and perhaps a daughter's concern for additional levels of independence?"

Presupposing Change and Avoiding Negative Connotations to Open Space for Reflection

O'Hanlon and Weiner-Davis (1989) suggested that looking for exceptions to problem behaviors can be facilitated with presuppositional questioning: "A basic rule of thumb in constructing presuppositional questions is to keep them open-ended, avoiding questions to which a 'yes' or 'no' response would be possible" (p. 80). A yes or no response to a question might be encouraged as follows: "I can understand your desire to reduce the conflict in your family. In responding to criticisms, have you ever found yourself controlling your anger and sidestepping an argument?" This question can obviously be answered with a yes or no response. A presuppositional question might ask, "In responding to criticisms, when have you noticed yourself making an effort to step out of a conflict?" Here the presupposition is that exceptions to the problem exist (O'Hanlon & Weiner-Davis, 1989), and the open-ended nature of the question will, it is hoped, provide some space for the client to think about or reflect on exceptions to the problem. O'Hanlon and Weiner-Davis (1989) noted, "Reflection upon these questions helps clients to consider their situations from new perspectives" (p. 80).

Many of the examples that follow in the remainder of this article have borrowed from the idea of including a presuppositional quality to the questions asked of clients. Moreover, Andersen (1992) has suggested that the client may find it easier to enter a reflective position if the counselor can refrain from offering a negative connotation to the client's experiences and thoughts. A negative connotation might, for example, be embedded in statements or questions such as, "It's certainly not uncommon to encounter conflict while trying to become more independent. Do you see yourself as having a short fuse?" Instead, and as previously mentioned, the counselor might direct his or her eyes away from a client or a family, perhaps while playing with a piece of lint, and become curious about the situation: "I was struck by your interest in reducing criticism and conflict. When have you noticed yourself making an effort to step out of an argument?" and "What did you find yourself doing at these times?" Questions such as these reflect de Shazer's (1988) desire to locate exceptions to patterns of behavior and White's (1989) interest in considering unique outcomes to oppressive stories, and if they are

offered from a position of curiosity, it is hoped they will be less likely to be heard as embedded with a negative connotation.

Taking a Break to Open Space for Reflection

Zimmerman and Dickerson (1996) also suggested that it may be helpful for the counselor and client to take a break and leave the room when it appears that the discussion of the problem has interfered with what they refer to as reflexivity and what we are calling reflective thinking. A counselor, for example, might ask, "Would it be all right to take a break, where you might stretch and catch a drink of water and I'll also step out of the office for a moment?" and "Could we use this as an opportunity for each of you to be alone and to think about times when you didn't allow criticalness and arguing to completely drag you down; that is, times when you made an effort to not let this pattern be quite so influential?" When the counselor and family members return to the office in about 10 minutes the counselor might ask, "What has occurred to you that's somehow different; that is, when were some times that you remember being less vulnerable to criticism and arguing? And at those moments, what did you find yourself thinking or doing?" From another theoretical context, Minuchin and Fishman (1981) suggested that physical distance might become associated with psychological distance. With their comment in mind, one could wonder whether taking a break might facilitate enough distance from a discussion of the problem that additional perspectives might be considered.

Walter and Peller (2000) suggested asking a family member to move "a little way out of the conversational space" in order to facilitate the individual's ability to reflect on a conversation between the consultant (counselor) and another member of the family (p. 140). As part of this process, the counselor asks the individual to pay attention to how one's thinking changes as a result of being in a listening position. The counselor asks the family member to pull her or his chair back while the counselor and another individual from the family talk about how she or he would like to experience the relationship with the person who is now in the listening position. The individual in the listening position is eventually asked to share reflections on the difference that has occurred in their thinking after hearing another describe the desired relationship as well as the possible insecurities that might accompany movement toward this desired relationship. Again, we might wonder whether pulling a bit out of the conversational space could help to open some psychological distance that in turn might facilitate reflecting on additional perspectives.

Using Indirect Questions to Open Space for Reflection

White (1989) has discussed the use of indirect questions in therapy, and he has provided illustrations of the procedure and mentioned that "these questions encourage family members to speculate on the perceptions of others, including the therapist and colleagues" (p. 41). Walter and Peller (1992) also considered questions that are directed toward another's perceptions. Their comments differed in some ways from White's (1989) remarks, yet they suggested that these questions invite the client to respond from the position of another and encourage her or him to suspend his [the client's] way of thinking for the moment" and for a moment these questions might encourage the client to place himself or herself in the position of the other "or at least think of what she [the other] might say if she were responding to the question" (p. 175). Asking the client to speculate on the perceptions of others may open some distance from the family member's view of the presenting problem and in so doing may allow the client to think about her or his thinking regarding the presenting problem. For example, the counselor might ask, "Who would be someone who would know that there have been times for you when criticalness was less influential?" "When would this person have seen you not letting another's criticalness upset you and what would they have noticed?" and "What would this person suggest as a helpful way to respond to future criticalness in the family?"

Some authors (Andersen, 1991c; Freedman & Combs, 1996; McLean, 1995) have noted the use of teams in counseling. Freedman and Combs suggested that teams may comprise a group of people that are actually not even present during the counseling session but include persons the family member holds in her or his thoughts. These team members may be called on for assistance as a family member considers alternative meanings for experiences or as a member considers alternative ways of responding to a problem. Freedman and Combs provided illustrations of using teams, and they noted that although the team members need not actually attend the counseling session, they may function as a community of significant voices within the client's thoughts, and they may or may not even be people the client knows. For example, they may include a living or deceased grandparent as well as a significant friend, or they may include a noteworthy person in history or a significant figure from current events. To call on the team for assistance, the counselor might ask one or more family members, "Who would you imagine, from your current or past life, supporting this new direction you are taking? Or, is there a famous person who you believe has stood up well in the face of criticism?" After identifying this individual, the counselor might ask, "What would this person have noticed about your efforts to keep criticisms from pulling you into conflict?" and "Who else would have noticed your efforts to not let criticism draw you into conflict?" The counselor might wonder with a family member, "What would any one of these team members suggest as a next step to keep in mind in order to prevent criticisms from pulling you into an argument?" and "What do you think of their suggestions?" As noted in the previous paragraph, the effort to speculate on the perceptions of others may open some distance from the com-

mon view of the problem, and it may be that in this space that the family member can think about his or her thinking. With the assistance of a team, the counselor can ask questions (indirect questions) of a team comprising four, five, or six significant others who are held in the client's thoughts. The team can be referred to again in future sessions as counseling continues.

Stepping Into the Future to Open Space for Reflection

Various authors (de Shazer, 1988; Lipchik, 1988; Lipchik & de Shazer, 1986; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992; Zimmerman & Dickerson, 1996) have written about helping the client consider a problem from a new temporal perspective, that is, a perspective sometime in the future. In talking about therapeutic questions that focus on a future perspective and that might invite client reflection, Lipchik and de Shazer (1986) noted, "These are future oriented questions, worded in a manner which assumes positive change, and phrased as to encourage the client to think of solutions other than those he or she has already tried" (p. 90). Speaking of the procedure referred to as a "miracle question" (de Shazer, 1988), Walter and Peller (1992) noted that

> This was an adaptation of Erickson's crystal ball technique. . . . The idea behind the technique was to have the client create a representation while in a trance of a future with the problem solved or without the problem. The idea was to have the client look backward from the future toward the present and identify how she/he reached a solution. (pp. 77-78)

Similarly, Zimmerman and Dickerson talked of a future-looking-back question that could be asked something like this: "Think about your relationship with your parents 2 years up the road from now when criticisms are less likely to pull you into an argument. Now, looking back over the 2 years, what steps do you see yourself taking to arrive at this new position?" In helping a client consider a problem from a future-oriented perspective, Walter and Peller noted, "This new framing invites them [clients] to suspend their reality of the moment and enter a hypothetical reality" (p. 73). Zimmerman and Dickerson added, "This is a reflexive process, which creates the space for noticing possibilities that have been outside the client's usual view" (p. 103). It would seem that these questions open a possibility for the client to place himself or herself in the future, beyond the present reality, and create some space from the problem in which the client can think about alternative possibilities.

CONCLUSION

Although life would appear to be multistoried, we support the notion that not all of these stories have preferred endings (Epston, et al., 1992) and so, as suggested by Freedman and Combs (1996), we would view counseling as an intentional process where "We hope to engage people in deconstructing problematic stories, identifying preferred directions, and developing alternative stories that support these preferred directions" (p. 118). Realizing that counseling is an intentional effort (e.g., helping the client identify preferred directions in life), and realizing that the client is a coparticipant in making meaning out of the counseling experience suggests a healthy tension that exists within the counseling relationship. That is, although the counselor wants to enter counseling with some ideas about how to be helpful, she or he also needs to remember that the client is actively involved in judging what will be viewed as meaningful. A consideration of the appropriate place for reflective thinking in counseling needs to honor the realization that the client is an interpreter of interactions with the counselor. To paraphrase Littrell (1998) and de Shazer (1985), the client is of course more important than the counseling procedure, and if efforts to be helpful through the use of reflective thinking are not fruitful, listen to the client and consider doing something different.

With the above having been said, the intent of this article was to introduce the idea of participating in reflective thinking during counseling. This limited review of literature has not been an effort to restrict the discussion of reflective thinking, nor has it been an effort to prescribe a list of procedures that leads to reflective thinking. Moreover, we cannot help but wonder if the counselor's ability to open space for another's reflection might not be associated with her or his own willingness to enter reflective moments during a variety of encounters, for example, when interacting with one's own family as well as when responding to opportunities at work. Using reflective thinking as a technique in which one tries to help the client become reflective at a specific moment through the use of a particular procedure would seem less likely to be helpful than viewing it as a common, although not exclusive, part of the counseling and as a regular, although not exclusive, part of the counselor's more private life. One's life can certainly benefit from a multiplicity of responses in addition to reflection, for example, a willingness to receive and provide directives as well as a willingness to function according to routines. Nevertheless, getting outside of one's dominant perspective on a problem to consider alternative positions would seem to have important implications for growth during counseling sessions, learning activities, research endeavors, and life in general. Perhaps it is our willingness to listen to voices that are in addition to the dominant discourse that moves us into the landscape of possibilities. We hope that comments in this article encourage the reader to consider the place of reflective thinking in counseling, education, and research, and to then share his or her own experiences and thoughts with colleagues in order that a discussion of reflective thinking might continue.

REFERENCES

Adams-Westcott, J., Dafforn, T. A., & Sterne, P. (1993) Escaping victim life stories and co-constructing personal agency. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 258-271). New York: Norton.

Andersen, T. (1991a). Basic concepts and practical constructions. In T. Andersen (Ed.), *The reflecting team: Dialogues and dialogues about the dialogues* (pp. 15-41). New York: Norton.

Andersen, T. (1991b). Guidelines for practice. In T. Andersen (Ed.), *The reflecting team: Dialogues and dialogues about the dialogues* (pp. 42-68). New York: Norton.

Andersen, T. (Ed.). (1991c). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: Norton.

Andersen, T. (1992). Reflections on reflecting with families. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 54-68). Newbury Park, CA: Sage.

Andersen, T. (1993). See and hear, and be seen and heard. In S. Friedman (Ed.), *The new language of change: Constructive collaboration in psychotherapy* (pp. 303-322). New York: Guilford Press.

Andersen, T. (1995). Reflecting processes; Acts of informing and forming: You can borrow my eyes, but you must not take them away from me! In S. Friedman (Ed.), *The reflecting team in action: Collaborative practice in family therapy* (pp. 11-37). New York: Guilford Press.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York: Norton.

de Shazer, S. (1988). *Clues:Investigating solutions in brief therapy.* New York: Norton.

Epston, D., White, M., & Murray, K. (1992). A proposal for a re-authoring therapy: Rose's revisioning of her life and a commentary. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 96-115). Newbury Park, CA: Sage.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Friedman, S. (Ed.). (1995). *The reflecting team in action: Collaborative practice in family therapy.* New York: Guilford Press.

Gergen, K. J. (1991). *The saturated self.* New York: Basic Books.

Gergen, K. J. (1994). *Realities and relationships: Soundings in social construction*. Cambridge, MA: Harvard University Press.

Gergen, K. J. (1999). *An invitation to social construction*. Thousand Oaks, CA: Sage.

Haley, J. (1973). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D.* New York: Norton.

Lipchik, E. (1988). Purposeful sequences for beginning the solution-focused interview. In E. Lipchik (Ed.), *Interviewing* (pp. 105-117). Rockville, MD: Aspen.

Lipchik, E., & de Shazer, S. (1986). The purposeful interview. *Journal of Strategic and Systemic Therapies*, *5*, 88-99.

Littrell, J. M. (1998). *Brief counseling in action*. New York: Norton.

McLean, C. (1995). Naming abuse and breaking from its effects. In M. White (Ed.), *Re-authoring lives: Interviews & essays* (pp. 82-111). Adelaide, South Australia: Dulwich Centre Publications.

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

O'Hanlon, W. H. (1993). Possibility therapy: From iatrogenic injury to iatrogenic healing. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 3-17). New York: Norton.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions : A new direction in psychotherapy.* New York: Norton.

Shotter, J. (1993). *Conversational realities: Constructing life through language*. Thousand Oaks, CA: Sage.

Tomm, K. (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, *26*, 167-183.

Tomm, K. (1989). Externalizing the problem and internalizing personal agency. *Journal of Strategic and Systemic Therapies*, *8*, 54-59.

Walter, J. L., & Peller, J. E. (1992). *Becoming solution-focused in brief therapy.* New York: Brunner/Mazel.

Walter, J. L., & Peller, J. E. (2000). *Recreating brief therapy : Preferences and possibilities*. New York: Norton.

Wangberg, F. (1991). Self reflection: Turning the mirror inward. *Journal of Strategic and Systemic Therapies*, *10*, 18-29.

White, M. (1989). The process of questioning: A therapy of literary merit? In M. White (Ed.), *Selected papers* (pp. 37-46). Adelaide, South Australia: Dulwich Centre Publications. (Original work published in 1988, Winter *Dulwich Centre Newsletter*, 8-14)

White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 22-61). New York: Norton. (Original work published in 1991, *Dulwich Centre Newsletter*, *3*, 1-21. Also printed in D. Epston & M. White, 1992, *Experience, contradiction, narrative and imagination* (pp. 109-152). Adelaide, South Australia: Dulwich Centre Publications)

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Zimmerman, J. L., & Dickerson, V. C. (1996). *If problems talked: Narrative therapy in action*. New York: Guilford Press.

John D. West *is a faculty member in the Counseling and Human Development Services Program, College of Education, 310 White Hall, Kent State University, Kent, Ohio 44242.*

Richard E. Watts *is a faculty member in the Department of Educational Psychology at Baylor University, Waco, Texas.*

Heather C. Trepal, ***Kelly L. Wester***, *and* ***Todd F. Lewis*** *are doctoral students in the Counseling and Human Development Services Program at Kent State University.*

Dual Relationships and Professional Integrity: An Ethical Dilemma Case of a Family Counselor as Clergy

June A. Smith
Long Island University
Alanzo H. Smith
Greater New York Conference of Seventh-Day Adventists

Counselors and other related professionals occupy many roles in society in addition to those of their professional responsibilities. Although many of these dual relationships do not raise ethical concerns, by the very nature of their duality, challenging ethical situations may emerge. This article examines one of the categories of dual relationship that has been least explored—counselor and clergy. It provides a vignette that illustrates the double bind of a counselor and clergy concerning a 15-year-old client who was raped, and the request of her parents. It concludes with some basic questions that counselors should consider when faced with ethical dilemmas as well as providing a framework for making ethical decisions.

As clinicians, we are often faced with complex issues in our counseling practice. We are called upon to make ethical decisions that affect the lives of our clients as well as ourselves. Frequently, we make those decisions based on the ethical codes that are standards established by the professional organization. As professionals, we are expected to be aware of the critical effect of ethical behavior at every level of the therapeutic process. We should engage in behaviors that do no harm to our clients, and we are expected to model behavior that reflects ethical conduct.

Stevens (2000) argues that clinicians often face issues in which human cost, risk, social justice, and limited resources are intertwined. As they juggle these aspects of their professional lives, they may choose to make life easier for themselves by ignoring some of the basic ethical guidelines. And because they do not want to view themselves or have others view them as unethical, they may develop multiple rationalizations to justify their behavior.

Pope and Vasquez (1999) discuss some of these rationalizations, for example, "It is not unethical as long as you are an important person," or "It is not unethical as long as you are sure that legal, ethical, and professional standards were made up by people who do not understand the hard realities of psychological practice."

REVIEW OF THE LITERATURE

Ethical guidelines for counseling supervisors were adopted by the Association for Counselor Education and Supervision governing council in March 1993. Schwiebert, Myers, and Dice (2000) provide an overall listing of the helping professions that publish ethical guidelines for its members. These are the American Counseling Association's Code of Ethics and Standards of Practice, the American Medical Association's Principles of Medical Ethics, the American Psychiatric Association's Principles of Medical Ethics, the American Psychological Association's Ethical Principles of Psychologists, the Commission on Rehabilitation Counselor Certification's Code of Ethics, and the National Board of Certified Counselors' Ethical Guidelines for Counselors.

A code of ethics enables an association to clarify to current as well as future members the nature of the ethical responsibilities held in common by its members. This rationale is true for all fields of specialized service. However, despite a code of ethics in most disciplines, the problems with breaches of ethics are on the rise. Owen (1998) highlighted the incident concerning a professor at the University of Wisconsin. Leon Shohet received jail time and a fine for falsifying information on a federal grant application.

Authors' Note: Correspondence regarding this article should be sent to June A. Smith, Ph.D., Long Island University, 720 Northern Boulevard, Brookville, NY 11548.

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The University of Illinois at Chicago found that Restrepo, former research assistant, Department of Psychiatry, engaged in scientific misconduct in clinical research supported by a grant from the National Institute of Mental Health. Restrepo fabricated research data and submitted the data to the director of a project entitled "Prenatal Provider-Patient Encounter." Data were fabricated in the records of 41 patients, including data for which Restrepo claimed to have conducted interviews in certain clinics, consent forms for patients, questionnaires from patients participating in the project, and false information in her study daily logs that recorded each day's events (Dobson, 1999).

Brock and Coufal (1989) did a nationwide study of marriage and family therapists in 1988 that revealed some interesting results. A random sample of 1,000 clinical members of the American Association for Marriage and Family Therapy (AAMFT) was assessed on professional practice behavior related to ethics and the AAMFT code of ethical principles. Respondents were asked about their behaviors pertaining to confidentiality. Sixty one percent of the therapists surveyed were sometimes or more frequently willing to keep one spouse's secret(s) from the other. Twenty percent sometimes or often see a minor client without parental consent, and 73% rarely or never tell parents about a child's disclosure.

Owen (1998) reported that the former chief fundraiser for Salisbury State University in Maryland misused money that he had helped raised. Reported in *The New York Times*, Petersen (1999) refers to the U.S. regulators' January 14, 1999 censure of the accounting firm Price Waterhouse Coopers. There was evidence that the firm's partners, employees, or pension fund had invested in companies that the firm audits.

Birdsall and Hubert (2000) informed us about an Idaho middle school counselor who stated, "My principal was quite offended when I politely explained that I could not divulge what the student had said to me in confidence." One school counselor, said Birdsall and Hubert, when pressed by his building principal to reveal confidential counseling information, placed it in a sealed envelope, then attached a letter stating compliance with reservations that revealing the content would lead to revocation of the counselor's certification and expose the school and principal to legal actions by students and parents for breach of contract.

The debate over what is good and right, said Bruce (1990), has continued for several millennia. Wise philosophical and religious thinkers have advanced various schools of thought on the matter, with die-hard adherents taking one position or another. Ethicists debate whether it is appropriate under some circumstances to withhold or modify the truth if some greater good is accomplished.

According to Brendel (1999) the contextual meanings of secrecy and privacy were explored extensively by Imber-Black (1993), who reported that there are explicit guidelines for therapists and that divulging secrets has the potential for both reconciliation and harm. Whether the secret is related to birth, abortion, incest, addictions, criminal behavior, sexuality, or sexual orientation, when a child and parent share a secret that excludes the other parent, the therapist is compelled to consider the well-being of all family members and yet prevent the family triangle from being destructively replicated in the therapeutic setting.

When considering ethical guidelines, there are six moral principles that are viewed by many: These are autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity (Kitchener, 1984; Meara, Schmidt, & Day, 1996). Autonomy refers to the person's freedom to make choices. Beneficence points to the counselor's responsibility for promoting growth and good for others. Nonmaleficence implies that the professional avoids doing harm, either intentional or unintentional. Justice means fairness or equal treatment of all, and fidelity relates to trust. Professionals are trustworthy and reliable in their word. Veracity is truthfulness (Stevens, 2000).

Counselors need to become sensitized to how these principles are integrated into clinical practice. The sensitivity of whether an action or behavior is ethical or unethical necessitates not only knowledge but an awareness, a sense of intuitive consciousness, of whether the behavior is beneficial to the client (Stevens 2000).

To be ethically alert, counselors need to sharpen and enhance their ethical decision-making skills as well as stay abreast with the overall guiding principles found in ethical codes of the helping professions. At the same time, it is important to realize that no set of ethical standards can cover every situation that may arise. If you are to establish any professional stance, said Birdsall and Hubert (2000), you must be able to integrate and articulate a set of standards that represents the collective knowledge and wisdom available to you as a professional.

Stevens (2000) believes that being willing to value ethical behavior and carry through with behavior that reflects that value requires more than familiarity with these topics. It requires the strength of character to uphold the spirit of the code as well as the set of enforceable standards and procedures. Each time counselors make a decision to overlook the ethical standard of practice, no matter how they rationalize the behavior they are intensely exacerbating the probability of doing harm (Stevens). The message that is being sent is that there are acceptable alternatives to ethical behavior, and that choosing these alternatives does no injury.

Going back to Pope and Vasquez's (1999) list of frequently used rationalizations, we see two of them looming large in this concept of alternatives to ethical behavior; one, it is not unethical as long as you can name at least five other clinicians right off the top of your head who do the same thing, and two, it is not unethical as long as it is more convenient than doing things another way.

However, true ethical dilemmas, said Birdsall and Hubert (2000), are just that—dilemmas. In their complexity, they share the following characteristics:

- There are reasonable choices between two or more courses of action.
- Each choice presents significant potential consequences.
- Each course of action can be supported by ethical principles.
- The selection of either course will compromise an ethical principle.

Dual Relationship

Among the areas of ethical concerns for professional counselors is that of dual relationships. Counselors and other related professionals occupy many roles in society in addition to those of their professional responsibilities. Although many of these dual relationships do not raise ethical concerns, others do, for example, counselor and lover, counselor and relative, counselor and employee, counselor and instructor, or counselor and supervisee. Among the categories of dual relationships that have been least explored is the area of counselor and clergy.

The vignette below illustrates the ethical dilemma of a dual relationship. At the center of this controversy are a clergy who is also a professional counselor, a 15-year-old girl who was raped, and her parents, who do not want to report the incident to the legal authorities.

According to Kaplan (1999), character is most important in ethical decision making. He argues that a thorough knowledge of ethical codes and strong decision-making skills, although necessary, cannot make up for character deficit. Professionals who practice ethical decision making may find themselves disenfranchised from a community that has decided either to ignore unethical behavior or to function at the mandatory level of ethical decision making. The person may find himself or herself cast in the role of agitator (Stevens, 2000).

An Ethical Vignette: The Case of the 15-Year-Old Who Was Raped

Ruth Goulding (fictitious name) is a well developed, mature looking 15-year-old girl from a middle-class family. Her father is an electronics engineer and her mother is a professor in a city college. She is the third child of a family of four. Her parents are ardent Christians, and they take great pride in and painstaking effort to instill good moral values in their children.

Ruth is considered to be energetic and outgoing, with many friends, most of whom are boys. She has a good sense of humor and does average to above average schoolwork. She is involved in many youth activities in her church and is very popular among her peers. Her parents have many close family friends whose children are of Ruth's age. These families have been together for many years and have always shared many of the responsibilities of child care, such as carpooling to take the children to school or church. Their homes have been open and accessible to each other. Both children and adults came and went from one home to another without any questions being asked.

One morning Ruth was home alone when the doorbell rang. The person ringing the bell was not a stranger, he was the father of one of her friends—someone Ruth trusted and in whose car she had traveled many times. There was no obvious reason for the visit; however, they sat on the couch and chatted for some time.

After awhile, the visitor pulled himself closer to her and started touching her in a way that made her uncomfortable. But because of the long-lasting friendship of the families, she tried to be respectful. It did not take long from that point before the visitor raped her.

Before he left, he told her he was sorry for what had happened and begged her not to tell. He even made threats to her and reminded her of his past kindness toward her. Ruth felt confused and dirty. What should she do with herself? Should she tell, and if so, whom? What would her parents think? Would she be the one to break up the happy friendship? Who would believe her story? Would she be blamed for the act? What would her pastor say? Would she still be active in church? What about her friends? What would they think of her? What would they say? Whose fault was it?

She finally went to bed and cried herself to sleep. Later that evening she woke up, still confused and distraught. She decided to keep her story to herself. The perpetrator of the crime still came to her house for family get-togethers and pretended that nothing had happened. This made Ruth all the more miserable, and she began acting out at school, church, and home.

Several months passed after the incident, and Ruth succeeded in masking her feelings and suppressing her emotions. Then it occurred again. This time he was more aggressive and demanding. At the end of Ruth's ordeal, she felt completely violated and abused. The pain, shame, and guilt were more intense than before. She felt that she could not keep her secret hidden any longer.

After several weeks of inner struggle, Ruth told her best friend, who told her next-best friend; eventually, her parents heard. When she was brought in for counseling, Ruth appeared confused, depressed, embarrassed, nervous, and hurt. She cried most of the time. She reported feeling that she had let her family down, and that she could no longer be the person she once was. Her parents cried almost as hard. A person they trusted had raped their daughter.

Ethical Concern: The Problem

During the first session, Ruth's parents made it clear to their clergy/counselor that they did not want to press charges; they wanted to keep the police out of the matter. Several ques-

tions went through the clergy/counselor's mind, questions such as, What were the parents asking of him? Were they asking him to hold a family secret? Would they lose their trust in him if he reported the matter? What would the other members of his congregation think or say about him if he betrayed this trust? Would others fear to confide in him if he reported the matter against the parent's wish? What further impact would there be on his ministry at the church? But most of all, what was his ethical and legal responsibility?

Haas and Malouf (1995) provide us with two major disadvantages of dual relationships: (a) Dual relationships may exploit the client, and (b) dual relationships may affect the therapist's ability to make appropriate clinical decisions. The second disadvantage is more relevant to this study, and that is, did this dual relationship of clergy/counselor affect the counselor's ability to make the appropriate clinical decision?

Haas and Malouf (1995) provide some basic questions that counselors should consider when faced with ethical dilemmas in dual relationships. These are: (a) Will the dual relationship inhibit in any way the client's ability to make autonomous decisions? (b) Can one anticipate ways in which the client will feel that he or she cannot disagree with one because of outside demands of any sort? (c) Will the dual relationship restrict one's response alternative? Can one act the same way and say the same things that one would with any other client? and (d) Where do one's motivations fit in? Is one likely to find oneself playing to an imagined audience rather than doing what is clinically right?

In an effort to resolve the apparent conflict between the clergy/counselor and the parents of the teenager who was raped, the clergy/counselor utilized Forester-Miller and Davis's (1996) *Practitioner's Guide to Ethical Decision Making*. Also utilized were Haas and Malouf's (1995) *Keeping Up the Good Work*, the *American Counseling Association* [ACA] *Standards of Practice and Code of Ethics* (1997), and Stadler (1986). The following steps were taken.

Apply the ACA Code of Ethics

All members of the ACA (1997) are required to adhere to the *Standards of Practice and Code of Ethics*. The standards of practice represent minimal behavioral statements of the code of ethics.

Section B: Confidentiality: (SP-9). Counselors must keep information related to counseling services confidential unless disclosure is in the best interest of clients, is required for the welfare of others, or is required by law. When disclosure is required, only information that is essential is revealed, and the client is informed of such disclosure.

B.1. Right to Privacy.

B.1.a. Respect for Privacy. Counselors respect their clients' right to privacy and avoid illegal and unwarranted disclosures of confidential information.

B.1.f. Minimal Disclosure. When circumstances require the disclosure of confidential information, only essential information is revealed. (See A.3.a and B.6.a.)

Determine the Nature and Dimensions of the Dilemma

According to Haas and Malouf (1995), the practitioner must identify the significant ethical issues. That is, what are the dimensions that make the issue problematic? Is there a conflict between a need to preserve confidentiality and a need to protect the public?

There are three principles at stake in this dilemma. First, there is a legal issue to be resolved; second, there is an ethical issue, that is, to be true to one's client and to live up to their expectations, and third, there is a moral issue, the issue of justice and fidelity. All of these principles apply to this case. To implement one at the expense of the other could be problematic.

As important as the ACA ethics and standards of practice was to the solution, the code of ethics of that particular denomination was also very relevant. Both their *Ministerial Manual* (General Council of Seventh-Day Adventists, 1992) and *Church Manual* (General Council of Seventh-Day Adventists, 1995) address issues surrounding the sexual misconduct of its members. However, neither of them addresses the issue of reporting the rape of a minor.

Generate the Potential Course of Action

Consult an attorney. The clergy/counselor contacted an attorney who is licensed to practice in that state and is very knowledgeable in the area. She provided him with the following information:

> *Social Service Law 413*. Persons and officials required to report cases of suspected child abuse or maltreatment.

The following persons and officials are required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child . . . psychologist, Christian Science practitioner, social worker, mental health professional, substance abuse counselor, and so forth (Gould & Gould, 1995).

He then discussed this information with two of his mentors in the light of the family's concern and the legal implications of the law. Afterwards, he met with the family to discuss with them the legal requirements of the law.

Consider the Potential Consequences of All Options and Determine a Course of Action

The clergy/counselor asked himself several questions prior to meeting with the family, questions such as, What would his church members think of him if he should divulge confidential matters? Would his action cause them or any

other church member to distrust him? Would the family leave the church in disillusionment? Would other family members and close friends leave as well? What would the leaders or members in the congregation say or do when they heard of his action? What about the requirements of the law—should it not take precedent over any other consideration? What would happen if he was to conceal the rape and then later someone else reported it? Could he be charged for negligence; would his license be in jeopardy?

In the light of these questions, he decided to bring the entire family into the counseling session and go over each question with them. He showed tremendous sensitivity toward their concerns and their request for privacy. He discussed with them the double bind he was in. On one hand, if he reported the matter to the law, he stood the risk of loosing them as well as other friends and relatives in the congregation. On the other hand, if he did not report the incident, or caused the incident to be reported, then there would be legal consequences for him.

The family members understood his double bind and were cooperative. They concluded that it was neither right nor necessary for the clergy/counselor to put himself or his license in jeopardy. It was felt that by not reporting the incident, their daughter would become a double victim, once when she was raped and once more by allowing the perpetrator to get away with his crime.

Evaluate the Selected Course of Action

As painful as this was for the family, they were willing to allow themselves the opportunities for growth. During the months that followed, they further concluded that they did the right thing. Stadler (1986) suggested applying three simple tests to the selected course of action to ensure that it is appropriate. (a) The test of justice: The clergy/counselor assessed his sense of fairness and concluded that if given the same set of variables, he would treat any other person the same way he treated this case. (b) The test of publicity: There was no publicity in this case. Both clergy/counselor and family members worked as quietly as they possibly could. Although some parishioners became aware of the incident, the case did not make any headline. (c) The test of universality: Although this study is limited to one state and is not concerned with the laws of all the United States of America or other countries, the recommendation is that the same course of action be taken by any counselor facing a similar situation.

Implementing the Course of Action

After careful consideration and much deliberation, the family decided that they would report the matter to the police. According to Gould, (1995), persons or officials are required to report or cause a report to be made. In this case the clergy/counselor did not make the report but he did cause the report to be made.

CONCLUSION

The family has worked through most of their pain in subsequent counseling sessions. The case went to the courts and the family felt that justice was served. The church and society benefited by protecting other children from the perpetrator, whereas all the legal, ethical, and moral demands of the case were met. Professional counselors, regardless of the counseling setting, carry responsibilities unique to their job roles. With these responsibilities come ethical demands. It is one thing to enjoy the privileges and positions of power, but it is quite another thing for professional counselors to maintain high ethical standards.

As was cited earlier in this article, many mental health professionals have lost not just their licenses but have compromised their professional reputations and personal integrity because they have failed to maintain high ethical standards. The authors' appeal, therefore, is for all counseling and other related professionals to maintain the principles of good practice and ensure high ethical standards.

REFERENCES

American Counseling Association. (1997). *American Counseling Association Code of Ethics and Standards of Practice*. Washington, DC: Author.

Birdsall, B. & Hubert, M. (2000). Ethical issues in school counseling. *Counseling Today*, *43*(4), 30, 36.

Brendel, N. (1999). Family psychotherapy—moral & ethical aspects. *Family Journal*, *7*(2), 112-118.

Brock, G. W., & Coufal, J. C. (1989). Ethical behavior of marriage and family therapists. *Family Therapy Networker*, *13*, 27.

Bruce, C. E. (1990). Personal integrity and career fulfillment. *Black Collegian*, *20*(4), 60-65.

Dobson, A. (1999, January 14). Health and Human Subject Review Committee (HSRC) and academic dishonesty. *University of Sarasota News & Calendar*, 1-2.

Forrester-Miller, H. & Davis, T. (1996). *A practitioner's guide to ethical decision making*. Washington, DC: American Counseling Association.

General Conference of Seventh-Day Adventists. (1992). *Seventh-Day Adventist minister's manual.* Silver Spring, MD: Ministerial Association.

General Conference of Seventh-Day Adventists. (1995). *Seventh-Day Adventist Church manual* Silver Spring, MD.

Gould, J., & Gould, B. (1995). *The family law handbook*. Binghamton, NY: Gould.

Haas, L. J., & Malouf, J. L. (1995). *Keeping up the good work: A practitioner's guide to mental health ethics*. Sarasota, Florida: Professional Resource Press.

Imber-Black, E. (Ed.). (1993). *Secrets in families and family therapy.* New York: Norton.

Kaplan, D. (1999).Models of ethical decision making in marriage and family counseling. In P. Stevens (Ed.), *Ethical casebook for the practice of*

marriage and family counseling (pp.3-17). Alexandria, VA: American Counseling Association.

Kitchener, K. S. (1984). There is more to ethics than principles. *The Counseling Psychologist*, *24*(1), 92-97.

Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist*, *24*(1), 4-7.

Owen, M. (1998). Former fund raiser at Salisbury State comes under fire for use of university funds. *Chronicle of Higher Education*, *15*(3), 45.

Petersen, M. (1999 January, 15). U.S. censures a major firm on its auditing. *The New York Times*, 148 (51403), p. C1.

Pope, K. S., & Vasquez, M.J.T. (1999). On violating the ethical standards. In P. Stevens, "Mental health personnel–professional ethics." *Family Journal*, *8*, (2), 177-178.

Schwiebert, V. L., Myers, J. E., & Dice, C. (2000). Ethical guidelines for counselors working with older adults. *Journal of Counseling & Development*, *8*(2), 123-130.

Stadler, H. A. (1986). Making hard choices: Clarifying controversial ethical issues. *Counseling & Human Development*, *19*, 1-10.

Stevens, P. (2000). Mental health personnel—professional ethics. *Family Journal*, *8*(2), 177-178.

June A. Smith *is an assistant professor in the Department of Counseling and Development, C. W. Post Campus, Long Island University.*

Alanzo H. Smith*, D.Min., Ed.D., is the director of family life for the Greater New York Conference of Seventh-Day Adventists.*

❖Case Consultation

The purpose of this column is to present interesting professional issues and cases. Any issue or case may be submitted for inclusion. Writers may choose to take a position on an issue or present a treatment for the case, or they may present either, without comment, for evaluation by third parties.

edited by Basilia C. Softas-Nall

Introduction

Basilia C. Softas-Nall
University of Northern Colorado

We can keep our hearts together and our approaches separate.

—Vassiliou, a past mentor

As our profession evolves in providing services (*therapy* in ancient Greek means to provide services) for children and their families, each one of us finds different, meaningful ways of contributing to this evolution. During the past 2 years of teaching a contemporary issues in family therapy seminar, our trainees have repeatedly chosen play therapy as a topic. Young children were often left out of family therapy.

The following case by Dr. Schicke Athanasiou uses a consultation model of working with the caretaker as an adjunct to play therapy. In this particular case, the caretaker available to participate is the grandmother. In our psychological services clinic we have seen a significant increase in grandmothers asking for help. Today, more than 3.7 million children live in households headed by a grandparent. This full-time care usually goes on from when the need arises until the children become independent. These grandparents believe that they have done the right thing in accepting responsibility for raising their grandchildren (Williamson & Softas-Nall, 2000). They come to raise their grandchildren for a variety of reasons: substance abuse by a parent (44%); child abuse (28%); teen pregnancy, a mother not being able to care for the child (11%); death of a parent, AIDS, or unemployment of the parents (5%; American Association of Retired Persons, 1994).

The majority of the children have experienced abuse and neglect before moving to their grandparent's care. Estrangement and/or conflict between grandparents and the parents of the grandchildren occurs. The grandparents, in their effort to reparent at this stage in their life and their concern for the child or children who have been traumatized, often seek the help of professionals. The following case integrates play therapy and consultation with the grandmother.

***Basilia C. Softas-Nall**, Ph.D., is a licensed psychologist and professor of counseling psychology in the Division of Professional Psychology at the University of Northern Colorado, Greeley. She teaches marriage and family courses and she coedits the case consultation section of* The Family Journal. *Submissions to this column may also be made via e-mail: softas@unco.edu.*

REFERENCES

American Association of Retired Persons (AARP). (1994). *Data on grandparent-grandchild families*. Washington, DC: AARP Grandparent Information Center.

Williamson, J., & Softas-Nall, B. (2000). Experiences and emotions of grandparents raising grandchildren: Implications for counseling. University of Northern Colorado Research Conference, Greeley, CO.

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Using Consultation With a Grandmother as an Adjunct to Play Therapy

Michelle Schicke Athanasiou
University of Northern Colorado

This article presents a case study illustrating the use of consultation with a grandmother as an adjunct to play therapy. First, a rationale for using consultation is presented, followed by a description of an ecobehavioral model of consultation. Next, a case describing how the consultation model was used with a grandmother whose 4-year-old granddaughter was being seen in play therapy is presented. Finally, advantages of this approach in the context of the case are presented.

Play therapy has a long history as a therapeutic modality for young children with emotional and behavioral problems. Nevertheless, play therapy in isolation can neglect the role of the family system in children's problems, the relative dependence of young children on family members, and their vulnerability to family discord. As a result, many play therapists have advocated for involving parents in the child's treatment by doing collateral work with them (e.g., Landreth, 1991; O'Connor, 1991).

There is a strong rationale for doing collateral work with parents or guardians as part of play therapy. O'Connor (1991) stated that it is important to try to meet the needs of parents who are likely experiencing their own emotional needs at the time they bring their child in for therapy. It is also imperative that parents have information about the work being done with their child, because it is unlikely that parents will provide continued support for a treatment protocol from which they have been excluded. It is therefore necessary to educate parents about the process of play therapy, treatment goals, the general nature of sessions, and treatment progress. O'Connor also discussed the need for problem solving in collateral work with parents or guardians, which generally consists of developing appropriate behavior management strategies. This is important for several reasons:

1. From an ecological perspective, children's problems largely are reciprocally influenced by their interactions with people in various systems in which they function. For young children, the home environment is the most important and influential in their lives. By working with members of the family, the therapist can remain connected to and be helpful to those in important systems.
2. Generalization of progress made in therapy to the home is less problematic, because by having parents implement strategies at home, treatment is being delivered in the generalization setting.
3. Goals of both remediation of current behavior problems and prevention of future problems can occur by helping parents develop problem-solving skills they can use in the future (Gutkin & Curtis, 1999).

Consultation, as described here, is one type of collateral work with parents. Consultation is a therapeutic process that consists of collaborative problem solving between the therapist and parents related to problems that parents are encountering at home. As such, this model avoids some of the pitfalls of some parent training programs. First, some parent training programs provide the same set of specific skills to all parents (e.g., how to praise, give time out, provide choices). The consultation model allows for the development of specific intervention strategies directly tailored to the parents' needs (Sheridan, 1993). These may or may not include the specific skills mentioned above.

Second, parents collaboratively problem solve with therapists in consultation. Rather than the therapist prescribing treatment, mutual problem solving via brainstorming solutions is the basis for interventions. This has the effect of empowering parents to solve their own problems, and it increases the likelihood that intervention plans will be feasible and acceptable to the parents. This is of extreme importance given that it is the parents' responsibility to carry out the intervention plans at home.

It should be mentioned that in consultation, the consultant does not become the parent's therapist. Consultation sessions revolve around caretaking-related issues being experienced by parents. This is to avoid performing dual roles with family members. In many cases, referrals are made to therapists who can provide the parents with individual or couples counseling.

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The specific problem-solving model of consultation used in the following case is behavioral consultation (Bergan & Kratochwill, 1990). This is a stage model consisting of four steps, which are described below. Although this model was originally conceptualized as behavioral in nature, more recent writings have stressed the importance of looking more broadly at children's behavior problems than is possible when using a behavioral model. Gutkin and Curtis (1999) used the term "ecobehavioral" to describe taking into account systemic and ecological variables in the conceptualization of problem behavior while maintaining the methodological rigor and well-documented efficacy of behavioral approaches.

The first step in Bergan and Kratochwill's (1990) is problem identification. This stage involves establishing the objectives for the consultation or determining what will be accomplished in consultation. This includes specifically defining the behaviors the parent wants to change, specifying the desired outcomes in measurable terms, and identifying the circumstances (e.g., when, where, with whom) in which the problem behavior occurs.

Step two, problem analysis, involves helping the parent identify variables that will help resolve the problem (Brown, Pryzwansky, & Schulte, 2001). These variables might include antecedents and setting events that predict problem behavior as well as consequences that follow the behavior. According to Gutkin and Curtis (1999), taking an ecobehavioral perspective involves looking beyond immediate precursors to behavior to more global environmental or ecological factors that might be leading to or maintaining problem behaviors.

Step three is plan implementation. The information gleaned in step two is used as a basis for an intervention plan. At this stage, the consultant makes sure that objectives are established, interventions are selected, barriers to plan implementation are considered, and procedures to measure progress are in place. The parent then carries out the plan in the home, with the consultant monitoring the implementation of the plan and providing support to the parent.

Finally, step four is problem evaluation. During this stage, the consultant and parent determine whether objectives have been met, how effective the plan was, and whether consultation should continue or be terminated. The outcome of consultation typically is determined by comparing assessment information collected prior to plan implementation with information collected after plan implementation. It is also important to consider more subjective perspectives of the consultee regarding plan success.

Although consultation can be used in isolation, this case describes using consultation as an adjunct to play therapy. Specifically, the case illustrates the use of ecobehavioral consultation with the grandmother/guardian of a 4-year-old girl who presented with dysthymic symptoms (e.g., flat affect, clingy behavior) and was brought in for play therapy.

CASE

Brittany, a 4-year-old, was referred for therapy by her maternal grandmother and legal guardian, Marian, aged 48 years. Brittany's biological mother, Ashley, who was a chronic drug addict, had lost custody of Brittany 2 years earlier as a result of abandonment. At the time of the referral, Brittany lived with her maternal grandparents, Marian and Lou, and her younger brother, Jake, aged 2½ years. In an informal agreement between Marian and Ashley, scheduled visits to Marian's house were made on a weekly basis; however, Ashley failed to show up for the visits about 75% of the time. Marian related that Ashley's broken promises hurt Brittany considerably and seriously affected Marian's relationship with her daughter.

Marian reported that she was mostly concerned with Brittany's withdrawal, lack of emotion, and overdependence on her. According to Marian, Brittany's affective responses varied from weepy to flat. Brittany reportedly laughed rarely, showed little interest in eating, and was quiet around others her age. Marian also reported that Brittany was very clingy and dependent. For example, Brittany cried every night because she was frightened of monsters in her room, and she asked for her grandmother to come into her room and sit by her bed. These behaviors, according to Marian, had been occurring for the past 12 months. Marian stated that she was part of the problem in that she wanted to baby her granddaughter and give her all the love Ashley was unable to give her.

Based on information provided by grandmother and observations of Brittany, it was agreed that I would see Brittany for weekly play therapy sessions. In addition, Marian would be seen weekly for parent consultation sessions. Lou's work schedule did not permit his coming to sessions; Marian said she would bring information back to Lou so they could both help Brittany at home. The therapy hour was thus divided into two 25-minute segments. Brittany was seen during the first 25 minutes and grandmother was seen afterwards.

Play Therapy

With regard to my work with Brittany, my initial goal was to build rapport. During initial sessions she separated easily from her grandmother; however, she was extremely quiet. She rarely made eye contact, and she spoke only when I asked her a question. At these times her answers were softly spoken and brief. Her play was exploratory in initial sessions, but she was very tentative in her approach toward new toys, and she looked questioningly at me in an attempt to ask permission to play with each toy she approached. My goals with Brittany were to increase her range of emotional expression and to decrease her dependence.

My therapeutic approach with Brittany involved gently encouraging Brittany to try new ways of behaving and

responding, all in the context of play. For example, when playing with a container of Legos, Brittany took one piece out of the container, set it on the floor, took another piece out of the container, and so forth. This approach seemed to fit with Brittany's careful manner and insecurity. To model a more carefree approach, I got out my own container of Legos, took the lid off, held the container as high over my head as I could, and let the Legos spill out all over the floor. Brittany's initial response was one of shock, but as I modeled exaggerated glee at the freedom of this method, Brittany began laughing. During the next session, Brittany smiled as she turned her container over to dump out her Legos.

Emotional expression was also addressed by encouraging Brittany to move her entire body more. For that reason, after the fourth session, all play therapy sessions were held in a large room typically used by the physical therapist in our center. This room contained ropes, swings, ladders, tricycles, large balls, and seesaws, all of which helped me to get Brittany moving. This had the effect of increasing her emotional range as well as increasing her independence.

Dependence issues were addressed in part by encouraging Brittany to do for herself what was in the realm of her capability. For example, when Brittany climbed on a small slide and asked me to get her down, I guided her through problem solving how to get down rather than physically helping her down.

As the sessions progressed, Brittany laughed often, expressed frustration when she was unable to accomplish something, and infrequently became angry with me for not making decisions for her. She became less dependent in that she accepted my efforts to guide her to do things for herself, and she asked for help less often.

Parent Consultation

Collateral consultation sessions with Brittany's grandmother were conducted weekly at the start of Brittany's treatment. Following an ecobehavioral consultation model, Brittany's problems, as grandmother saw them, were first identified and defined. Marian stated that she was mostly concerned about Brittany's dependence and Brittany's mother missing scheduled visits. In terms of dependence, the two examples Marian gave were Brittany's insistence on sitting on Marian's lap (at which time she would suck her thumb and talk baby talk), and her crying nightly for Marian to come into her bedroom. With regard to Marian's second concern about Ashley failing to show for visits, we talked about how in the context of consultation we would address how grandmother handled visits, given that we could not force Ashley to be more dependable. Next, I asked Marian to pick the problem she believed needed to be worked on first. She stated the dependence behaviors were her biggest concern. We agreed to work on that problem first and address the visitation issue at a later time. As a way to measure whether ideas that were tried at home were successful, I asked Marian to keep track during the week of how often Brittany asked to sit on her lap and how many times Brittany called Marian into her bedroom. In addition, I asked her to pay attention to the circumstances that led to these behaviors, what happened when Brittany did the behaviors, and any circumstances in Brittany's typical settings or systems that might shine light on the behaviors.

During the next visit we talked about what grandmother had noticed at home. During the prior week, Brittany had asked to sit on grandmother's lap an average of three times per day, and she called her into her bedroom one time on all 7 nights. Marian stated that she believed Brittany wanted to sit on her lap because she wanted attention and physical affection from her and that she wanted to be babied. She said Brittany was more likely to want to sit on her lap anytime her younger brother got attention and when she was tired. Grandmother also stated that Brittany wanted to sit on her lap more often on days when her mother missed a visit. This information suggested that Ashley's missing visits was a remote precursor to Brittany's dependence behaviors, and that a systemic issue beyond Brittany's household members figured into her behavior. Granddaughter's calling to Marian in the night happened, according to Marian, as a way to get attention and nurturance. She did not know what led up to Brittany calling her because everyone was sleeping prior to Brittany waking up.

We then set short-term goals for changes in Brittany's behavior. I asked Marian, given that Brittany curled up on her lap three times per day currently, how many times per day might we hope to see the behavior occur in the next 3 weeks. Marian stated that because Brittany was only 4 years old it was okay for her to sometimes want to sit on her lap, but she thought three times per day was excessive for a 4-year-old. Grandmother stated that perhaps once a day would be okay. With regard to calling grandmother into Brittany's bedroom at night, Marian said she believed Brittany could make it through most nights without calling her, and she set a goal of three times per week (in the event of illness or bad dreams).

The next step was to come up with ideas to work on the behaviors. My approach in treatment development was more collaborative than that described by Bergan and Kratochwill (1990). Specifically, rather than giving prescriptions to Marian based on the information gathered about the problem, I chose to brainstorm solutions with Marian in a way that both of us were suggesting ideas (see Gutkin & Curtis, 1999). In this way, grandmother was able to contribute her expertise in parenting Brittany and I was able to contribute my expertise related to child psychology and behavior problems. During this brainstorming procedure, several possible ideas were suggested. From that list, grandmother chose those ideas that she believed would be the most helpful and that were feasible. The final plan, based on Marian's chosen solutions, was as follows:

1. Given that Brittany's overdependence likely was related to her issues of being abandoned by her mother and consistently and continually being disappointed by her, it was stressed that Marian and Lou would attempt to fill the need that Brittany has for security and affection in various ways throughout the day. These overtures on Marian's and Lou's part would be unsolicited by Brittany and would be consistent with attempts to help Brittany be a "big girl." For example, when putting Brittany to bed, Marian would tuck her in, give her kisses and hugs, and tell her that she loves her. Throughout the day, grandmother and grandfather would give Brittany hugs and speak affectionately to her. In addition, her grandparents would look for ways to provide stability and consistency for Brittany as much as possible to help Brittany learn to trust that her needs will be met.
2. Brittany could choose to sit on her grandmother's lap one time per day (for 20 minutes); at other times when Brittany approached grandmother, grandmother would tell Brittany that she is a big girl and that big girls can sit on the couch next to their grandmas. Grandmother would then sit next to Brittany with her arm around her.
3. If Brittany called grandmother into her room in the night, grandmother would stay in her own room but would call to Brittany to tell her that she is right in the next room and that Brittany is safe.

After the plan was devised, Marian agreed to put the plan in place during the week. I told Marian that it was possible we might need to make some changes to the plan in coming weeks but that she should stick with the plan as intended for the next week. Marian also agreed to continue keeping track of how many times Brittany asked to sit on her lap and how many times she called her into her room.

After the plan had been implemented for 1 week, Marian reported that everything was going well. The only issue for her was not going to Brittany's room when she called her. Marian said that when Brittany called her she told Brittany that she was in the next room and that she only really needed her if she was sick. Subsequently, Brittany began calling grandmother in the night saying she had a stomachache. Marian believed that this was an attempt to get Marian to go to her room because she was afraid, rather than a real illness. We decided to deal with the fear issue rather than the stomachache issue. After a discussion of the problem we decided that Marian would give Brittany a flashlight to keep in her room under her pillow. Grandmother would remind Brittany that monsters only come out in the dark. Therefore, when Brittany saw a monster in her room, she was to shine the light on it and it would disappear. Furthermore, Marian was to continue reassuring Brittany that she was in the room next door. She agreed to reassure her once and then ignore further pleas for Marian to come to her room.

Three weeks after the plan started, we looked at progress toward grandmother's goals. Both behaviors had decreased. In the week prior to the visit, Brittany had only asked for her grandmother one time during the night. This was down from 7 nights before the plan and was even two less than the short-term goal. With regard to sitting on her grandmother's lap, Marian reported that Brittany enjoyed the 20 minutes of lap sitting every day. She said they used that time to read books together. Furthermore, Marian reported that Brittany only asked to sit on her lap during her one time per day and that there had been no instances during the previous week of Brittany sucking her thumb or talking babytalk. Marian said she was very pleased with the progress Brittany had made. She said she noticed that overall, Brittany was behaving as independently as a 4-year-old should. Although grandmother said she had a hard time not babying Brittany, she knew it was better for everyone if she encouraged Brittany to be a big girl.

Given the changes in the priority behaviors, we decided to revisit the other issue of concern to grandmother, the fact that Brittany's mom did not show up to visits, thus upsetting Brittany (i.e., she withdrew and became tearful). We talked about the fact that these were appropriate reactions to being disappointed by her mother, so we did not want to try to get Brittany to behave differently when Ashley missed visits. Instead, we decided to work on the circumstances that predicted the behavior. Marian described the events leading up to missed visits. She said that on the morning of scheduled visits, Marian told Brittany her mother was coming to see her. Marian talked with Brittany about the visit throughout the day. When Ashley did not show, Marian stated that she told Brittany it was not her fault and that her mother did love her. She was not sure how much Brittany believed these statements. Several possibilities were discussed. Marian said she did not want to take away Ashley's visits, because despite the fact that Marian would raise Brittany, she did not want Ashley to believe her own mother had given up on her. The agreed-upon plan for this problem was for grandmother not to tell Brittany that her mother was scheduled to visit so there would be no disappointment for Brittany if her mother did not show.

During this discussion, it became apparent that Marian had some personal issues about her parenting of Ashley and her current relationship with her. I thought it was very important that Marian have an opportunity to work through issues related to problems she was having with her daughter, as well as more general issues arising from her decision to parent her grandchildren. However, because my role in this case was Brittany's therapist and consultant to grandmother, it was not appropriate for me to also be her therapist. I therefore made a referral to another therapist who could provide family or individual therapy.

In addition to coming up with ideas on how to help Brittany at home, parent sessions were also used to determine how Brittany's behavior had changed at home as a result of play therapy and to keep grandmother apprised of the global issues being worked on in therapy. One issue that needed to be addressed with grandmother was predicting an increase in Brittany's emotional expressiveness. After 5 weeks of therapy, it was apparent that Brittany was much more expressive

in session. The hope was that this expressiveness would generalize to the home, but it was also important to ensure that grandmother felt comfortable with the expressiveness when it happened. Otherwise, Brittany would likely revert to being withdrawn. Grandmother and I discussed how, when Brittany began expressing more feelings at home, the expression would likely include both positive and negative feelings (e.g., joy as well as anger or sadness). We discussed how it was important for Marian to be accepting of the feelings and not to inadvertently punish Brittany by criticizing her expression of feelings. We also discussed the distinction between appropriate and inappropriate ways of expressing emotion.

CONCLUSION

Incorporating consultation into my therapy with Brittany had multiple benefits over conducting play therapy alone. First, some systemic issues could be identified and addressed. Specifically, by making some changes at various subsystem levels, changes in others were made. For example, Marian reported that because she was trying not to foster Brittany's overdependence on her, Lou was feeling more a part of child rearing and therefore better about their decision to raise the children. Family therapy was still recommended; however, more family-related work was possible using consultation than if I had conducted play therapy alone. Second, using consultation resulted in relatively quick change with Brittany. Changes in Brittany's behavior were seen after only 3 weeks of therapy, and Brittany and her grandmother were seen for a total of eight sessions. Third, my weekly contact with grandmother provided me with a view of what was occurring inside the household, and it provided Marian with information regarding what was occurring in Brittany's therapy. Fourth, having grandmother implement ideas at home programmed generalization of treatment goals. Furthermore, although the general treatment goals were the same in therapy and at home (i.e., decrease dependence), the specifics of how the issues were manifested were accounted for. Treatment at home was specifically tailored to the types of behaviors Brittany displayed at home. Finally, engaging in consultation with grandmother was designed to give her problem-solving skills on which she could draw at later times should the same or similar behaviors become a problem.

REFERENCES

Bergan, J. R., & Kratochwill, T. R. (1990). *Behavioral consultation and therapy*. New York: Plenum Press.

Brown, D., Pryzwansky, W. B., & Schulte, A. C. (2001). *Psychological consultation: Introduction to theory and practice* (5th ed.). Boston: Allyn & Bacon.

Gutkin, T. B., & Curtis, M. J. (1999). School-based consultation theory and practice: The art and science of indirect service delivery. In C. R. Reynolds & T. B. Gutkin (Eds.), *The handbook of school psychology* (3rd ed., pp. 598-637). New York: John Wiley.

Landreth, G. L. (1991). *Play therapy: The art of the relationship*. Bristol, PA: Accelerated Development.

O'Connor, K. J. (1991). *The play therapy primer: An integration of theories and techniques*. New York: John Wiley.

Sheridan, S. M. (1993). Models for working with parents. In J. E. Zins, T. R. Kratochwill, & S. N. Elliott (Eds.), *Handbook of consultation services for children: Applications in educational and clinical settings* (pp. 110-133). San Francisco: Jossey-Bass.

***Michelle Schicke Athanasiou**, Ph.D., is a licensed psychologist and an assistant professor in the Division of Professional Psychology at the University of Northern Colorado. She teaches courses in play therapy and consultation.*

❖Counselor Training

Rolling the Dice: An Experiential Exercise for Enhancing Interventive Questioning Skill

Frank O. Main
Shelly R. Boughner
Grace A. Mims
Janet Logan Schieffer
University of South Dakota

An exercise is presented, Rolling the Dice, that assists students in developing skill and clinical judgment in using interventive questions in counseling and therapy. Steps for using the exercise and different permutations of the exercise are presented, along with examples of its use with counselors in training at various experience levels.

In recent years the use of interventive questions in counseling and therapy has received attention in family therapy and counseling circles. Tomm (1988) defined interventive questions as questions asked by therapists with the primary intent of influencing client processes rather than simply to gain information from clients. Dozier, Hicks, Cornille, & Peterson (1998) presented preliminary evidence suggesting that the style of questioning used by therapists has a significant impact on the alliance between therapist and clients. Furthermore, these authors indicate that "the type of questions one uses in therapy may be the critical factor that determines the level of joining the therapist system is able to make with the patient system" (p. 198).

Several authors, Fleuridas, Nelson, & Rosenthal (1986), Penn (1982, 1985), Tomm (1987), and White (1988) have carefully described and categorized the process of interventive questioning in therapeutic work. These authors have presented examples of various classes of interventive questions: circular, future, reflexive, and relative influence (narrative), along with illustrations of the purpose and use of such questions. For seasoned therapists, the descriptions and examples allow one to fairly quickly assimilate the different types of interventive questions into therapeutic work. Students, however, are often daunted by the abundance of information and struggle to understand and apply it in practice.

In a 1997 article, Jacob Brown presented a model designed to help students develop skill in interventive questioning. Brown's was a three-dimensional model, breaking questions down into their component parts. These parts were titled "format," "orientation," and "subject." Format involves the style of the question and includes open, closed, forced-choice, rating, and ranking options. Orientation considers the person about whom the question is asked. Orientation options include self and other. Subject involves the content of the question and includes behavior, feeling, belief, meaning, and relationship options.

Brown (1997) presented this model graphically as a three-dimensional cube with each axis (height, width, depth) representing one of the three component categories and with each option within the categories represented by a small cube. The resulting figure somewhat resembles a Rubik's cube and assists students to focus on all three question components as they work to develop and enhance their skill in utilizing interventive questions. Brown reported that student learning may be facilitated through attending to question components in a step-by-step fashion, and that learning is easily individualized through identifying the types of questions that a student is already using, and progressively focusing attention on the remaining categories.

Brown (1997) further suggested that clinical judgment is enhanced as students engage in the process of judging the utility of particular categories of questions for the clinical work in which they are engaged. For example, students may gauge the relative impact of asking a question about the client's perspective (self orientation) on a given situation versus asking the client to speculate about someone else's perspective (other orientation).

Following Brown's (1997) model, we have developed an exercise called Rolling the Dice, which has been useful in

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familiarizing students with the types of interventive questions that may be asked in counseling and therapy.

PEDAGOGICAL GOALS

The purpose of the Rolling the Dice exercise is fourfold. First, counselors in training become familiar with the question components. Second, student therapists begin to develop clinical judgment in an enjoyable, nonthreatening environment. Third, students refine questioning skills because they can concretely examine the utility of a particular category of interventive question with particular client situations. Fourth, the supervisor can assess the level at which trainees are failing to develop or utilize certain types of questions and can intervene precisely by modifying the requirements of the exercise. For example, the instructor can arrange the dice to display the types of questions students struggle with the most, or conversely, those with which students have the most success. What student therapists learn via Rolling the Dice in a step-by-step fashion eventually becomes spontaneously integrated into their counseling repertoires. As trainees' clinical judgment increases, they progress from rote responses to thoughtfully executed and orchestrated interventive questions that assist client movement. Therefore, when they encounter clients, student therapists are more likely to generate clinically useful responses.

Rolling the Dice is an action-oriented method that affords trainees the opportunity to develop skill through active participation. The element of chance involved in rolling the dice simulates the spontaneity of the therapeutic encounter, adding further to the utility of the exercise.

MATERIALS

1. Provide a set of dice for each student or group of students. Construction of the dice for use in Rolling the Dice is fairly simple. Square, wooden blocks may be purchased from a local hobby or craft store. The blocks may be unfinished, requiring sanding and staining or painting or may be found already stained or painted. Three blocks are included in each set of dice. Using a word processing program, type the words for each die (see Table 1). Because there are only five types of both format and subject questions and six faces on the die, one face is designated wild on each of these dice and is labeled accordingly. When the wild face surfaces during use of the dice, the students are permitted to choose among the remaining options for that category. For example, they may select from among closed, open, rank, scale, or forced choice in the format category. Because orientation includes only two perspectives, self and other, these options are repeated three times each on the orientation die. The printed words are attached to the block faces using decoupage medium and are coated with two coats of decoupage medium as a sealer.
2. Provide students with copies of the case vignette (see Appendix A) or other case vignettes for use with the exercise.

TABLE 1
Labels for Die Faces

Die 1: Format	Die 2: Subject	Die 3: Orientation
Closed	Beliefs	Self (3×)
Open	Feelings	Other (3×)
Rank	Behaviors	
Scale	Meaning	
Forced choice	Relationships	
Wild	Wild	

3. Provide students with copies of sample questions (see Appendix B) for reference when constructing questions.

PROCEDURE

Distribute and review the case vignette and sample questions, then divide students into small groups of approximately 4 students each. Give each group a set of dice. Invite each group to roll the dice and to construct an interventive question appropriate for use with the clients presented in the vignette using the components that appear on the upper surfaces of the dice. Once students gain familiarity and ease with the process, students may begin constructing questions on their own that the group may then discuss in terms of utility.

VARIATIONS

Several permutations of the exercise may be utilized to meet particular training situations. The instructor may start things off more slowly by introducing one die at a time. Students can then concentrate on a single question component, for example, format, and work up to incorporating additional components into their questions.

Once all students are contributing questions for each roll of the dice, each group may record the questions generated and discuss the merits or clinical utility of these questions. Students should be encouraged to improve each question and to conclude each roll of the dice having developed a range of potentially useful questions falling in the question category displayed on the dice. Trainees may then speculate about the potential impact of the type of question generated on the clients presented in the vignette. Furthermore, trainees may consider the intent of each question and may discuss the benefits and timing of using such questions with clients. Students may be directed to consider various clinical aspects as they evaluate the questions generated by group members. For example, trainees may be asked to discriminate between linear and systemic questions, a problem versus solution focus, or a time frame of past, present, or future.

Finally, trainees may develop clinical hypotheses regarding the vignette and further refine requirements for question generation to enhance meaningful investigation of the

hypothesis. As trainees become more sophisticated in use of the exercise, further permutations may be developed. Once the small groups have considered the clinical utility of questions, each small group can share their best and/or worst questions with the large group, and the instructor may facilitate further discussion.

This exercise provides challenging practice in questioning because students do not know what type of interventive question the roll of the dice will call for. Rolling the Dice may be used in a flexible manner, with permutations allowing for on-the-spot individualized instruction.

LIMITATIONS

We would identify the following as limitations of the Rolling the Dice exercise for training counselors:

1. Students working from certain theoretical orientations (e.g., person centered, rational emotive therapy, etc.) may be uninterested in developing skill in interventive questioning. Student interest in learning such skills is probably necessary for the exercise to be used productively.
2. If this exercise is used only once during the course of training, this exercise may be of most benefit to students with clinical experience and those with strong verbal skills. The benefit to all students will be maximized if the exercise is used repeatedly during training.
3. The exercise requires considerable class time to familiarize students with the question components and the exercise format. Subsequent use of the exercise requires less time, but use of the exercise may consume a significant portion of total class time before students become proficient at question construction.

RECOMMENDATIONS

1. Introduce the exercise early in the semester so students may have as much time as possible to master the material. Utilize the exercise on a periodic basis to maintain interest and maximize learning and application to clinical work.
2. Make the dice available to students during nonclass hours to encourage individual work with the question components.
3. Monitor each student's progress in gaining skill and judgment in the use of interventive questions through clinical supervision, and direct his or her attention to those aspects that require further work.
4. Brush up on your own interventive questioning skills prior to using the exercise in the classroom. Your skill with constructing questions will encourage students to attempt the task.
5. Start out slowly and expect some initial confusion and performance anxiety. Encourage a lighthearted approach, and treat mistakes as part of the work involved in crafting useful questions.

STUDENT EXPERIENCES

Students report diverse reactions to Rolling the Dice depending on their level of counseling experience. Most counselors who have become comfortable utilizing more traditional skills initially experience difficulty in altering their thinking about question generation in counseling. Habitual ways of responding may interfere with question generation. Students' experiences of this nature are reflected in comments such as, "I felt like I was learning to write right-handed when I was naturally left-handed. I understood the questions, but had a hard time constructing them because they were so different from how I usually respond." Such comments are typical of students who have become comfortable using skills characteristic of intrapsychic approaches to change. The use of interventive questioning, in these cases, requires a paradigm shift rather than the simple acquisition of a new set of skills.

Student therapists familiar with systemic approaches to counseling and therapy are often pleasantly surprised by the outcomes of the exercise. Their experiences are reflected in comments such as,

> It forced me to think more concretely about the material that was unfolding in the moment. The Rolling the Dice exercise directly impacted the manner in which I formulated hypotheses about client situations. Also, I became very conscious, perhaps self-conscious, about how the clients experience questions.

Comments such as these suggest that the exercise may dramatically increase the intentionality with which experienced counselors use interventive questions. Similarly, experienced counselors often offer reflections such as

> Responding according to the random throw of the dice not only forced construction of novel questions, it forced reflection upon the utility and purpose of such questions. Frequently, the type of question required by the die faces seemed too obvious or too invasive, or beside the point. This really helped me to think through the types of questions in context and to keep the client in mind when developing questions.

When student therapists are able to develop well-conceptualized questions anchored in the particulars of the client system, they are afforded a dramatic, low-risk glimpse of the potential impact of thoughtful work.

Novice student therapists typically respond to the exercise in yet another way. Their experience is reflected in comments such as

> For me, it was a risk free, yet challenging way to learn how to use questions effectively. I was able to put what I read into action, without the clinical responsibility of working with actual clients. The pace and urgency of the exercise make it feel like actual clinical experience, but I could make mistakes and learn from them, without having clients pay the price.

Novice student therapists are often highly focused on skills, yet they seem able to quickly grasp the contextual issues that emerge during this exercise. This aspect of development is evident in comments such as

> I was struck by the confrontive nature of forced-choice questions. Initially, I thought they were designed to assist the family to become aware of new possibilities, and I was surprised at how they can come across as a judgment about the clients' existing perspectives.

Such comments are typical of new counselors in training. Once they have been provided the opportunity to formulate questions in a simulated context, they gain appreciation for the power and magnitude of the intervention and are, as a result, more cautious and respectful in their use of questions. The Rolling the Dice exercise adds a low-risk route to learning, which is at the same time quite engaging and powerful. The learning experience created through the use of Rolling the Dice may be unique for every participant and may change over time for each participant as well. The remarks above may serve as tentative guidelines to assist instructors in planning their use of the exercise.

CONCLUSION

An exercise was presented that assists student therapists in gaining skill and clinical judgment in using interventive questions. Guidelines are provided for the use of the exercise, and benefits and limitations are discussed. Student comments and reflections about their experiences with the exercise are briefly summarized. Finally, several pedagogical recommendations are provided.

APPENDIX A
Case Vignette

George and Lori Beck complained of the behavior of their 12-year-old daughter, Katherine. They said she lied, stole things, and was often destructive of her things and other items belonging to family members. In general, the parents believed her to be "rebelling," and reported that Katherine frequently had tantrums when they confronted her about her behavior. They had tried many ways of dealing with these problems but had difficulty agreeing on a solution.

George tended to impose severe, prolonged punishment, such as early bedtimes or no telephone privileges for a month, whereas Lori tended to be lenient. Lori often felt that George was overly harsh in his punishments. If she could not persuade him to modify his punishment, she frequently made concessions for Katherine when her husband was not present. For example, once when Katherine took money from the table, George wanted to call the police. Lori talked Katherine into putting the money back and slipped her money on the side after George was convinced to forgo a call to the police. Furthermore, Lori would permit Katherine to talk for hours on the phone even though her father had revoked telephone privileges.

Discussion with the family revealed long-standing marital tensions. George and Lori came from very different families with different cultural and religious backgrounds. Their marriage had been precipitated by George's enlistment in the Navy and shipment overseas. Before that time, Lori had been far from convinced that she wanted to marry George.

Counseling Session: Scene One

Lori, in defense of her concessions with Katherine, says to George, "But I just want Katherine to know that you love her and I am not sure she does." To which George says, "If we allow you and your family's definition of love to run this family, she will marry the first bozo that comes along before she graduates from high school. As Lori and George continue this discussion Katherine is spelling out an expletive on the back of her hand with the end of a paperclip.

APPENDIX B
Sample Questions

Format: Structure of the Question

Open Questions:

- George, how would you describe your relationship with Katherine? (open, relationship, self)
- What do you do that demonstrates love to your daughter? (open, behavior, self)
- What are your ideas about discipline? (open, belief, self)
- How did you feel when Katherine took the money from the table? (open, feelings, self)

Closed Questions:

- Are you still talking a lot about how to parent Katherine? (closed, behavior, self)
- George, are you stern? (closed, behavior, self)
- Lori, are you lenient? (closed, behavior, self)
- Do you think that your daughter ever feels life is not worth living? (closed/feelings/other)

Forced Choice Questions:

- Lori, does your lack of trust make you feel anxious because of the experiences you've had in the past or because of something that's currently happening between you and George? (forced choice/meaning/self)
- George, would you like to stop coming for therapy because you think that things are going better for you or because you feel that this is not the right time for you to be in therapy? (forced choice/beliefs/self)

Ranking Questions:

- In order from most to least pressing, what are your three greatest fears for your daughter if things don't change? (ranking/meaning/self)
- Who would be the most distressed if you decided to leave, George? Who next? (ranking/feelings/self)

Rating (Scaling) Questions:

- How, on a scale of 1 (*no concern whatsoever*) to 10 (*extremely concerned*), would you rate your concern regarding your parenting problem? (rating/feelings/self)
- How, on a scale of 1 to 10 (1 = *totally unsatisfied and wanting to see an attorney* and 10 = *as satisfied as I ever hoped to be as a married person*), would you rate your satisfaction with the marriage since the incident involving Katherine removing the money from the table? (rating/feelings/self)

Subject: These questions can usually be further classified as content or context questions.

Content: Questions about the client situation.

Behaviors:

- George, what did Lori do when she found out that Katherine had been caught stealing? (open/behavior/other)
- Lori, from George's point of view, who do you think he would say was the most upset between the two of you? How does he show it? (ranking/feeling/other)

Feelings:

- When George is upset, is he more likely to speak in an angry manner to you because he thinks that you are the cause of the problem or because he thinks that he is incapable of controlling his own anger under the circumstances? (forced choice/feelings/other)
- Who do you think has the greatest feelings of love right now for you, George? Who next? (ranking/feelings/other).

Beliefs:

- Where do you think George got the idea that men should be disciplinarians? (open/beliefs/other)
- How would you rate Lori's belief in the importance of being in love in order to remain with her on a scale of 1 (*not at all important*) to 10 (*extremely important*)? (rating/beliefs/other)
- What beliefs about remaining with George through thick and thin did you bring with you from your family of origin? (open/beliefs/self)

Context: Questions related to meanings or relationships surrounding client issues.

Meaning Questions:

- When you told Katherine she didn't have to follow her agreement with George, what message were you trying to convey to George? (open/meaning/self)
- Katherine, when your father is upset and makes more rules, what sense do you make of it? (open/meaning/self)
- Katherine, if I asked Lori to tell me why she is sad, what do you think she would say? (open/meaning/other)
- Who do you think most strongly thinks that not celebrating your wedding anniversary last week was because you see your marriage as being on the rocks? (ranking/meaning/self)

Relationship Questions:

- When Katherine misbehaves, do you think that she brings the family closer together because everybody is more concerned about her, or pushes the family farther apart because everybody argues about why she misbehaved? (forced choice/relationship/self)
- Who is most committed to seeing this family stay together? Who next? Who is least committed to this? (ranking/relationship/self)
- How would Lori rate your commitment to the relationship on a scale of 1 (*no commitment*) to 10 (*total commitment*)? (rating/relationship/other)

Orientation: The person inquired about.

Self-Oriented Questions:

- Lori, what did you do when George disciplined Katherine? (open/behavior/self)

Other-Oriented Questions:

- What do you think George was trying to say when he got upset that you told Katherine she could watch TV? (open/meaning/other)

REFERENCES

Brown, J. (1997). The question cube: A model for developing question repertoire in training couple and family therapists. *Journal of Marital and Family Therapy*, *23*(1), 27-40.

Dozier, R., Hicks, M., Cornille, T., & Peterson, G. (1998). The effect of Tomm's therapeutic questioning styles on therapeutic alliance: A clinical analog study. *Family Process*, *37*(2), 189-200.

Flueridas, C., Nelson, T., & Rosenthal, D. (1986). The evolution of circular questions: Training family therapists. *Journal of Marital and Family Therapy*, *12*(2), 113-127.

Penn, P. (1982). Circular questioning. *Family Process*, *21*, 267-280.

Penn, P. (1985). Feed-forward: Future questions, future maps. *Family Process*, *24*, 299-310.

Tomm, K. (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, *26*, 167-183.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions. *Family Process*, *27*, 1-15.

White, M. (1988). The process of questioning: A therapy of literary merit. *Dulwich Centre Publications*, 8-14.

Frank O. Main *is a professor of counseling and serves as chairperson of the Division of Counseling and Psychology in Education at the University of South Dakota.*

Shelly R. Boughner *is an associate professor of counseling and serves as the counseling program coordinator in the Division of Counseling and Psychology in Education at the University of South Dakota.*

Grace A. Mims *is an associate professor of counseling in the Division of Counseling and Psychology in Education at the University of South Dakota.*

Janet Logan Schieffer *is an associate professor of counseling in the Division of Counseling and Psychology in Education at the University of South Dakota.*

❖Techniques to Share

This column provides a forum within which you, the reader, may share with your colleagues some of the creative techniques that you have successfully developed or adapted in your practice with couples and families. Others may be able to adapt your technique for their own use, or they may be stimulated by it to invent related techniques. Please submit your double-spaced manuscript to Robert Sherman, Column Editor, 12 Berkshire Drive, Monroe Township, NJ 08831, or send it to the editor of this journal, indicating that the manuscript is intended for this column.

Exploring Themes of Sibling Experience to Help Resolve Couples Conflict

Arthur G. Mones
St. John's University

This article highlights the important link between sibling experience and couples conflict. Several key themes of marital conflict are discussed: power and hierarchy, complementary role development, proximity-distance, fairness and justice, communication styles and conflict resolution, and friendship, loyalty, and altruism. It is suggested that by exploring these current themes and their historical antecedents, the couples counselor can help to propel partners from a state of disillusionment and conflict to one of acceptance, empathy, and true intimacy. By incorporating the exploration of sibling experience into a therapy process that conveys egalitarianism and warmth, the effectiveness of couples counseling can be greatly enhanced.

Psychological theories and models of psychotherapy have consistently emphasized the importance of parent-child interaction in the understanding of personality development. However, with some rare exceptions (Adler, 1927; Bowen, 1978; Minuchin, 1974), most models have overlooked the tremendous impact of our sibling relationships throughout many phases of the life cycle. Except for time spent together by spouses in long-standing marriages, cumulative time spent with siblings during our formative years far surpasses time in any other relationship during our lifetime. As is the case between parents and children, siblings are permanently bound, by definition, and with no escape, to their familial positions.

It is within our sibling interaction that we learn to deal with differences, fairness, sharing, and conflict. Our sibling experiences are the original "learning laboratory" for self-growth while sharing family resources of love, attention, and discipline. Processes of power, gender identity, competition, cooperation, affection, proximity-distance, communication, and empathy are regularly negotiated between and among brothers and sisters. These same skills and competencies are those that are critical in our marital interactions. The degree to which these processes are successfully negotiated between partners will often determine the fate of a marriage. It is the thesis of this article that couples therapy can be powerfully enhanced by tracing current strengths and difficulties in a marriage to their link with sibling experiences of each partner. It is proposed that by gaining an increased understanding of the key themes in an individual's sibling experience and especially how this knowledge compares with the experience of one's partner, a marital relationship can be propelled from one of disillusionment and conflict to one of acceptance and empathy.

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THE INDIVIDUATIVE PROCESS AND STAGES OF COUPLES DEVELOPMENT

Every human being carries an existential anxiety and incompleteness driven by the frightening awareness of their finite nature and accompanying vulnerability (Becker, 1973). In each person there is a striving for psychological completeness and movement from our limited and flawed nature toward the fulfillment of our full potential and perfection. World religions, philosophy, and psychological theories (Adler, 1927; Bowen, 1978; Robinson, 1997; Schnarch, 1991) attempt to grapple with this dilemma. The psychological process of this lifelong journey of growth and development is called individuation or differentiation (Bowen; Mahler, Pine, & Bergman, 1975). As two adults approach marriage, they seek resolution of this tension by seeking completion and wholeness in the marital bond. Through the process of projective identification, mates find perfection in the other, temporarily suspending the experience of their internal anxiety, during the idealization phase (Mones & Patalano, 2000; Nadelson, Polonsky, & Mathews, 1984; Scarf, 1987). Idealization is a psychological device for coping with our imperfections and does not, in the long run, heal our flawed natures. In short, it is an emotional detour from the central process of individuation. Sooner or later there is a realization, albeit largely unconscious, that the sense of incompleteness cannot be fully erased via the relationship with the other person. This felt sense of internal agitation is externalized and projected onto the partner, who is now blamed for being the source of dissatisfaction. This is the Disillusionment phase (Mones & Patalano, 2000; Nadelson et al., 1984; Scarf, 1987). Troubled marriages become stuck in disillusionment and/or oscillate between cycles of idealization and disillusionment. The successful marriage is able to arrive at Acceptance, an interpersonal state of equality and empathic understanding for the couple (Jacobson & Christensen, 1996). True intimacy flows when two psychologically whole individuals, committed to their respective individuative journeys, make a mature emotional connection. Some can evolve naturally to this state of emotional health; some require assistance through professional guidance and counseling.

The centerpiece of the work in couples therapy is in helping the couple out of their stuck position of disillusionment and pointing each partner toward ownership of the responsibility for self-growth and individuation so that healthy acceptance can develop. It can be very helpful to organize this work around key themes that exist for each partner and to demonstrate how these themes (and underlying emotional needs) lead to obstructions and conflicts within the dyad. The remainder of this article will attempt to illuminate key elements of the partners' sibling experiences that may, in treatment, detoxify these powerful themes. The themes are power and hierarchy, complementary role development, proximity-distance, fairness and justice, communication styles and conflict resolution, and friendship, loyalty, and altruism.

MARITAL THEMES WITH ROOTS IN SIBLING EXPERIENCE

Power and hierarchy. Most marital couples struggle with power and hierarchy and tend to organize themselves in complex one-up/one-down positions. Intrapsychically, the intensity of these battles is related to a protection against vulnerability and powerlessness. This forceful internal experience often interacts with significant emotions related to each partner's sibling experience (Adler, 1927; Sherman and Dinkmeyer, 1987; Toman, 1976, 1988). For instance, Alan may feel that it is his right to make decisions and to have the last say regarding family matters. This may make Alice bristle, as she feels that she is inherently more knowledgeable and competent in many areas of family functioning. Their arguments are quite intense, both engaged in a win-lose stance often escalating from complaint to criticism to contempt, as described by Gottman (1994a, 1994b). In marital treatment, after initially calming down the "angry parts" of the internal emotional systems (Schwartz, 1995) of the partners, the therapist asks each spouse to describe his or her sibling experience with power and hierarchy. Alan is the first born of two brothers born 4 years apart. He describes that within his family of origin it was understood that the older child had the final word in disputes by virtue of being older and stronger. His younger brother would devise passive-aggressive ways in which to challenge his authority but for the most part would retreat and subordinate his needs when conflict arose. Alice describes her experience as the younger sister to a brother 3 years her senior. Her brother would consistently act in irresponsible ways such as failing and cutting classes along with high-risk drug experimentation in adolescence. Alice, in contrast, was a superachiever, extremely conscientious, who took pride in her level of competency and leadership, often assuming a parental-like role with her foundering brother. This exploration helped this couple to contextualize their recursive marital conflict. Each could better understand his or her own emotional contribution to their squabbles and could begin to let go of the need to come out on top. In turn, this greater understanding prodded each partner to take more responsibility for his or her own emotional investment in these battles and to diminish blame of the other.

Complementary role development. Many marriages, even at the dawn of the 21st century, are locked into rigidified roles for each spouse, frequently established within months of exchanging wedding vows and continuing for years on end. This division of labor will often extend to home repair, shopping, cooking, responsibility for the children's scheduling, social planning, keeping in touch with extended family, and the list goes on and on. In addition to the hands-on tasks, there

is the role of executive in the system. The executive not only performs many tasks but has consciousness regarding which tasks are needed (where children need to be on a given day, what items need replenishing in the pantry, birthdays of relatives, etc.). Unfortunately, in our society and in many world cultures, the greatest burden of these tasks as well as most executive functioning for the family continues to fall on women who are often working outside of the home as well. The serious consequences of this type of family structure are to psychologically and physically exhaust many wives while alienating many husbands. Although each spouse becomes a specialist, each misses out on the development of full competency and a true team effort in life. This all-too-common marital role taking will often lead to burnout in midlife.

Whereas role assumption is embedded in our culture, there are key connections to our identity formation within our sibling bonds (Bank & Kahn, 1982). The vast majority of siblings have complementary relationships emanating from a nonshared environment. Dunn and Plomin (1990) make a convincing argument regarding this fact based on sophisticated analyses of behavioral genetics. Like pieces of a puzzle, a brother may be "the athlete" and "the shy one" while his sister is "the scholar" and "the assertive one." Siblings appear to share emotional space, dividing up the psychological territory of who they are and what they believe, much as they share the physical space within their home.

For example, Ben would return home after long hours of work and commuting and proceed to soothe himself by tuning in to any and all sports events on television. Bertha would be enraged, as she expected some closeness and intimate time following her day at her job and returning home to meal preparation and homework help to their young children. Exploration in therapy helped the spouses to see that Ben's work efforts were counterbalanced by a dominant relaxer/unconscious part, whereas Bertha was dominated by a super managerial part of her personality (Schwartz, 1995). It was useful for this couple to trace this conflict to their respective early experience with gender roles: For Ben, the boys in the family could relax, whereas the girls were the servers. For Bertha, the females in her family were expected to maintain the steady family climate or homeostasis, whereas brothers were expected to be high achievers in school and little else. As an outgrowth of this discussion of contrasting sibling experiences, Bertha began to relinquish some of her managerial tendencies and Ben gradually saw that assuming a greater consciousness around the home was an emotional gain that energized him to a far greater degree than *Monday Night Football*!

The complementarity of roles, so ingrained from our sibling experience, will deeply affect our gender definition. What we believe are the basic differences between the sexes, the Mars and Venus syndromes of Gray (1992), can be understood as an outgrowth of our family-of-origin experience as brothers and sisters interwoven with parental and cultural beliefs regarding what constitute male and female "default positions."

It should be further emphasized that most families, peer groups, work relationships, and communities tend to organize their systems into caretaker and care-needer relationships, that is, human systems with varying degrees of responsibility for the efficiency and integrity of the whole. It is proposed that this role differentiation is influenced in a major way by early sibling experience with dominance/subordination, competence/incompetence, maturity/immaturity, and so forth.

Proximity-distance. As mentioned, siblings cannot escape their existence as brothers and sisters in their particular birth order. Human beings do, however, possess the creative power to maintain the closeness and distance in relationships via psychological strategies. As examples, the aggression and control in oppositional behaviors as well as the withdrawal response in depression represent strategies that attempt to balance the forces of enmeshment and disengagement on an interpersonal plane (Mones, 1998). Couples often struggle intensely within this spatial dimension in a choreography of emotional pursuit and distance (Fogarty, 1978). To illustrate, Carla is emotionally comforted by physical closeness and verbal dialogue, whereas Carlos is most able to relax while performing solitary, hands-on tasks. Their competing self-soothing styles result in a constant undercurrent of tension in an otherwise compatible union. Carla, the eldest of two sisters and a youngest brother, was from a family of divorce. Her mother entered the workforce, often leaving Carla in charge of her siblings. To quell her own childhood fears, Carla was constantly organizing activities that would keep the sibling group engaged together at home. Carlos, in contrast, was an only child of two professional parents who would encourage a quiet and self-absorbed family atmosphere. In adulthood, these spouses entered marriage with very different expectations regarding their preferred family climate. Exploring their childhood and sibling histories proved quite helpful in fostering mutual understanding and empathy.

Fairness and justice. Most people carry powerful beliefs regarding fairness and justice. Some individuals carry a sense of entitlement and are comfortable possessing the larger slice of the pie. Their counterparts, however, are satisfied only when they experience equality of possessions, responsibility, and emotional support. Couples often engage in fierce struggles regarding their ability to share in their lives together. This can result in entrenched positions of resentment and withholding that can permanently limit their ability to function as an effective spousal or parental team. When this inequity is experienced as irreparable, separation and divorce often result. Oftentimes this battle continues even when the marriage is dissolved. They fight over monetary support, child custody, visitation, and so forth for extended periods of time, engaging the courts in an attempt to resolve their own failed process of mediation.

This internalized sense of fairness and justice is profoundly influenced by one's sibling experience. Sulloway (1996) posits that much of the history of the world and many great ideas in science and in the arts have been propelled by the younger sibling who is "born to rebel" against the established order tenaciously coveted by the conservative, older sibling. Other students of history have recognized the bifurcation of most societies into camps of those who protect the homeostasis and those less powerful who question authority. Coaching couples with regard to their beliefs in this key area of human interaction can help foster a truly democratic union. As an example, Daria would rail against her husband, Dwayne, for not "caring enough" about their school-age daughters. Daria would react quickly to dissension between the girls and work hard to make sure that fair compromise would be achieved on many contested issues. Dwayne would claim that it is normal for kids to fight and that they would eventually work things out on their own. The therapist, after becoming well acquainted with this couple, helped them to differentiate feelings of caring, which were apparent, from differing beliefs regarding entitlement and fairness. Daria, feeling so sure of her perceptions, challenged this intervention by the therapist, who she felt was unfairly siding with her husband. Not until the couple courageously explored their own sibling interactions and inherent beliefs regarding the importance of fairness and equality was this battle quelled. Daria, a middle child, had spent much of her formative years in the role of mediator between her siblings and, at times, her contentious parents. In addition, she carried a sense of emotional deprivation, feeling that her needs were bypassed in favor of her siblings. Dwayne, an oldest of three siblings and the first grandchild in his extended family system, walked the world of special privilege and came to see that his view of his daughters "working things out" was an extension of his privileged position regarding outcomes eventually favoring his own interests. With much effort, Dwayne was able to see that it was a benefit and not a loss to operate within a system that promoted greater fairness. Daria, after battling the therapist, began to understand that inequities based on differing sibling positions were not signs of lack of caring, and certainly not aimed specifically at her. Armed with this increased understanding, issues that inevitably arise in an intimate union could be viewed and addressed in a constructive manner.

As was the case with Daria and Dwayne, fairness and empathy can be powerfully enhanced by a therapist who can understand each partner's struggles by fostering an understanding of their personality development within their family-of-origin context while prodding each to stretch to a fuller potential of psychological growth. The couples therapist cultivates a process that emphasizes fairness and equality above all else. Couples can effectively learn the importance of acceptance of one another as they come to terms with their own imperfections and vulnerabilities.

Communication styles and conflict resolution. In addition to clashes over power and hierarchy, complementary roles, gender definition and responsibilities, closeness-distance, and fairness and justice, the manner by which couples communicate and resolve their differences looms large as a major area of difficulty. Markman, Stanley, and Blumberg (1994) found that effective problem resolution for couples is the single most powerful predictor of success in marriages.

During the stage of Disillusionment, a husband or wife will typically attempt to change his or her partner so that the marriage can return to the blissful stage of idealization. Pointing out their spouse's faults places the mate in a defensive posture leading to a greater tenacity regarding the traits in question. In turn, the vilified partner will likely hurl back invectives so that the other spouse will become equally defensive. This unproductive marital skirmish can result in further polarization between the partners.

At base, the above sequence is underscored by the natural tendency of people to defend against the exposure of their imperfections. If two intimates disagree, it is assumed that one must be wrong and, to protect against this admission, blame of the other must be proven (Gordon, 1990).

There are many roots of this process that can be traced to our early sibling interaction. Overt aggression and abuse among siblings is not uncommon. Overpowering of one sibling by another via physical or psychological means—teasing, scaring, or other means of humiliation—is a trauma that leaves permanent scars (Wiehe, 1990). These behaviors, an outgrowth of ineffective resolution of intrapsychic struggles with low self-esteem, hurt, fear, and models of parental coercion (Patterson, 1982) have lingering effects in our adult lives. Being immersed in either a bully's role or victim's position as a sibling often carries over and is reenacted during marital conflagrations. Hurt and disappointment will trigger anger. The signal of anger will likely push partners to explode or withdraw (Gottman, 1994; Markman et al., 1994), resulting in shame and/or intimidation and will, on repetition, push a couple toward separation or divorce. In therapy, Ed and Edna would often erupt into scorching battles, with Ed yelling and cursing loudly and Edna at first yelling back and ultimately shutting down in silence. Both came from families with verbally abusive fathers and capitulating mothers. Ed would take out his powerlessness against a younger brother via constant put-downs and pinning him down in fierce wrestling matches. Edna was often gripped with fear during her father's outbursts and became quite protective toward her younger brother, who would flee to her room as a safe haven. These differing adaptations to similar family dynamics and the ensuing drama within their respective sibling interactions helped this couple as they deconstructed moments of severe conflict (Goldner, 1998; Goldner, Penn, Sheinberg, & Walker, 1990; Mones & Panitz, 1994).

As mentioned above in the section on fairness and justice, the modeling of the therapist and the coaching in effective

communication skills (Markman et al., 1994) represents a powerful healing experience for many couples. Communication between intimates can be transformed from bitter win-lose struggles to discussions in which the process of resolution is equally important as the outcomes. As Gandhi taught us, in human interactions as well as on the world stage, the means are as important as the ends (Dalton, 1993; Fischer, 1950).

Friendship, loyalty and altruism. In contradistinction to the above-mentioned themes, so replete with competition and conflict, most siblings also experience moments of transcendence, exemplifying the higher elements of human nature. There are times when siblings share the most private expressions of self-disclosure, providing a refuge from turbulence in the home. In single-parent families or homes where parental emotional resources are limited, it is the sibling subsystem that can provide security and emotional sustenance (Minuchin, 1974). Sibling histories are filled with tales of older siblings protecting younger siblings from neighborhood bullies, teaching them skills in sports, and tutoring them in academic subjects (Bank & Kahn, 1982). The very concepts of friendship, brotherhood, and altruism were explored by early philosophers and lauded as the upper reaches of human potential (Robinson, 1997). When marriages and intimate partnerships support healthy individuation and intimacy and are linked by empathic understanding, often with roots in early sibling interaction, the mates have reached the stage of Acceptance. At this stage, differences do not divide but can actually strengthen the union.

To exemplify, Frank and Francesca truly enjoyed time together. They led very busy lives, involved with their careers, child rearing, and special interests. They relished time together and were quite comfortable spending time apart. Conflicts, of course, would arise, and arguments would ensue, but this couple had a way of putting their contentiousness in perspective, as they respected each other deeply. Each partner could cite a secure sibling bond as contributory to their comfort in their marriage. Both had older siblings who did their share of teasing and competing, distasteful episodes that were overpowered by a definite sense of protection and pride in their being a sibling team. This couple took great pride in establishing and shaping a truly equal partnership.

CONCLUSION

This article has attempted to illustrate the usefulness of exploring the sibling experience of partners within couples treatment, a topic sorely lacking in many theories and treatment applications. Several key themes of marital conflict have been discussed and the importance of their linkage to early sibling interaction explored. These themes are power and hierarchy, complementary role development, proximity-distance, fairness and justice, communication styles and conflict resolution, and friendship, loyalty, and altruism. It is suggested that by exploring these current themes and their historical antecedents, the couples therapist can help to propel partners from a stage of disillusionment and dissension to acceptance and empathy. In addition to the discussion and understanding of this content, the therapeutic process of this exploration can be a very powerful healing path. By modeling respect and caring for the emotional burdens that partners bring to the marriage and by differentiating these trigger points from the loving potential of the relationship, the therapist can help point the mates toward greater responsibility for their own self-growth while diminishing negativity and blame. As they stay steady on their own respective paths of individuation, there will be more room for resonance and acceptance. By staying mindful of the points of tension and points of transcendence carried from our powerful sibling influence, therapists can guide couples toward their full emotional potential.

REFERENCES

Adler, A. (1927). *The practice and theory of individual psychology.* New York: Harcourt, Brace & World.

Bank, S., & Kahn, M. (1982). *The sibling bond*. New York: Basic Books.

Becker, E. (1973). *The denial of death*. New York: Free Press.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Dalton, D. (1993). *Mahatma Gandhi: Nonviolent power in action*. New York: Columbia University Press.

Dunn, J., & Plomin, R. (1990). *Separate lives: Why siblings are so different*. New York: Basic Books.

Fischer, L. (1950). *The life of Mahatma Gandhi*. New York: Harper & Brothers.

Fogarty, T. (1978). The distancer and the pursuer. *Compendium II: The best of the family, 1978-1983*. Rye, NY: Center for Family Learning.

Goldner, V. (1998). The treatment of violence and victimization in intimate relationships. *Family Process*, *37*, 263-286.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Gender paradoxes in volatile attachments. *Family Process*, *29*, 343-364.

Gordon, L. (1990). *Love knots*.New York: Dell.

Gottman, J. (1994a). *What predicts divorce?* Hillsdale, NJ: Lawrence Erlbaum.

Gottman, J. (1994b). *Why marriages succeed or fail*. New York: Simon & Schuster.

Gray, J. (1992). *Men are from Mars, women are from Venus*. New York: Harper/Collins.

Jacobson, N., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: Norton.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant: Symbiosis and individuation*. New York: Basic Books.

Markman, H., Stanley, S., & Blumberg, S. (1994). *Fighting for your marriage*. San Francisco: Jossey-Bass.

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

Mones, A. (1998). Oppositional children and their families: An adaptational dance in space and time. *American Journal of Orthopsychiatry*, *68*(1), 147-153.

Mones, A., & Panitz, P. (1994). Marital violence: An integrated systems approach. *Journal of Social Stress and the Homeless*, *7*(2), 39-51.

Mones, A., & Patalano, F. (2000). From projective identification to empathic connection: The transformation of a marriage from the inside out. *Journal of Couples Therapy*, *9*(1/2), 56-66.

Nadelson, C., Polonsky, D., & Mathews, M. (1984). Marriage as a developmental process. In C. Nadelson & D. Polonsky (Eds.), *Marriage and divorce: A contemporary perspective* (pp. 127-141). New York: Guilford Press.

Patterson, G. (1982). *Coercive family process*. Eugene, OR: Castalia.

Robinson, D. (1997). *The great ideas of philosophy* [Audiotape course]. Springfield, VA: Teaching Company.

Scarf, M. (1987). *Intimate partners: Patterns in love and marriage*. New York: Ballantine.

Schnarch, D. (1991). *Constructing the sexual crucible: An integration of sexual and marital therapy*. New York: Norton.

Schwartz, R. (1995). *Internal family systems therapy*. New York: Guilford Press.

Sherman, R., & Dinkmeyer, D. (1987). *Systems of family therapy: An Adlerian integration*. New York: Brunner/Mazel.

Sulloway, F. (1996). *Born to rebel*. New York: Pantheon.

Toman, W. (1976). *Family constellation (3rd ed.). New York: Springer.*

Toman, W. (1988). *Family therapy and sibling position*. Northvale, NJ: Jason Aronson.

Wiehe, V. (1990). *Sibling abuse: Hidden physical, emotional, and sexual trauma*. Lexington, MA: Lexington Books.

***Arthur G. Mones**, Ph.D., is a diplomate in clinical psychology. He is coordinator of the marital and family psychology specialization within the doctoral program in clinical psychology at St. John's University, Queens, New York. Dr. Mones is an approved supervisor of The American Association of Marriage and Family Therapy. He is engaged in private clinical practice in Hewlett, Long Island, New York.*

❖Family Stories

Please send a family story that might be of interest to your colleagues. Larry Golden, University of Texas at San Antonio, Downtown Campus, COEHD, 501 W. Durango Blvd., San Antonio, TX 78207; e-mail: lgolden@.utsa.edu.

A Story About Private Practice

Larry Golden
University of Texas at San Antonio

Private practice isn't called *private* for nothing. You close the door and it's just you and your client. Of course, there is that uninvited guest, managed care. And it isn't called *practice* for nothing. I'm still practicing after 25 years. When does mastery come? This is a short story that takes you behind the door. Alex, the client, suffers suicidal depression, the effects of recent loss and an earlier attachment injury he inflicted on his former wife, Elena. An attachment injury occurs when the partner you depend on fails you during a critical time of need (Johnson, Makinen, & Millikin, 2001). Sam, our fictional therapist, makes little progress until he brings to bear the religiosity the client seems to deny. This story ends well. It is fiction, after all, so I made sure of that. I wish for happy endings for all of Sam's clients and yours, too.

A STORY ABOUT PRIVATE PRACTICE

Session 2. Alex was referred to Sam by a physician who was treating him with Prozac. The medicine hadn't done enough. Alex was 43, Anglo, suicidal, owned a gun, drove recklessly even when sober. Creative, literate, ran a successful advertising agency. Alex's infant son, Francisco, had died of burns; subsequently, he and Elena were divorced. Sam insisted that Alex dispose of his gun as a condition for continuing counseling.

Sam hadn't received authorization from HealthCorp for the additional sessions he requested. He might be treating this difficult client for the $10.00 copay. Thank God, Sam liked brief therapy. His Jungian colleagues felt as if they had sold their souls.

Sam: What about Elena?

Alex: I met Elena in Mexico City. I was there studying Spanish. It was so romantic. She was so beautiful. Elena was on her knees praying to the Virgin of Guadalupe when I first saw her. She was very superstitious, a fanatic Catholic. She was from a little town and she had walked 30 miles over mountain trails to this shrine in Mexico City. I must have wanted that kind of devotion for myself. I brought her to San Antonio and we married in the Catholic Church. She couldn't speak much English. She depended on me for everything. She was mine.

Sam: So what happened?

Alex: She got pregnant. She supposedly forgot to take her birth control pills. I pushed her into getting an abortion. I was still in college and we didn't have any money. We just weren't ready for a baby. She went along with me but she never forgave me or herself.

Five years later my business was doing okay and Elena was working at Aero Mexico as a reservations clerk. We decided that it was the right time. We had a wonderful baby boy, Francisco. We had him with us for only 6 months.

I was giving Francisco a bath. The phone rang and I ran to get it. I thought it would be all right because there was just an inch of water in the tub. It was Elena. She was working a late shift. We talked for a few minutes. While I was gone, somehow, Francisco turned on the hot water faucet. It was scalding. He died a few days later. Elena said, "God has taught us the meaning of a child's life. She actually believed that God had paid us back for the abortion. As if God gives a damn one way or the other. We stopped talking. The marriage died.

Sam admitted to feeling overwhelmed by Alex' tragedy.

Alex: All I want is someone to hold my hand while I figure out this suicide thing. I don't want to make a mess of it.

Sam: I'm sorry, Alex. I want no part of that.

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Alex: That's fine. You don't have to worry. If I decide to do it, I'll put some distance between us first. I wouldn't want to disturb your nice little practice.

They discovered a common interest in classical music and spent the remainder of the session listening to Igor Stravinsky's *Firebird*.

Session 10. Alex was allergic to mountain cedar, a little tree with pretty blue berries that grows all over the hills north of San Antonio.

Alex: Texas is a poisonous place. I wonder if I snorted the pollen directly up my nose if it would kill me.
Sam: What about the gun? Did you get rid of it?
Alex: Sure. But I've got redundant systems. I'm a vodka enthusiast. I'm cooking my liver over a slow flame. Sam, you're my last hope, my guru, my Jesus, my bulletproof vest, my savior. Give me a reason to live.
Sam: If you're alive, there are possibilities.
Alex: Doctor, vat is dis terapy already? How vil you mek me a heppy human bink? This was Alex's version of Freud's German accent.
Sam: Isn't it enough to be a funny human bink?
Alex: Everyday I wake up and I eat and excrete. What's the point?
Sam: Aren't you a Catholic?
Alex: Lapsed.
Sam: I'm thinking about what Elena said about losing Francisco, 'God has taught us the meaning of a child's life.' What if she's right?
Alex: That's why I'm lapsed. Just that kind of bullshit. She was the one who forgot to take her birth control pills. Francisco's death was an accident, not an act of God. Everyone—family, friends, even casual acquaintances, tells me to stop blaming myself.
Sam: Have you confessed to a priest?
Alex: What the hell for? I didn't do anything wrong.
Sam: Then why are you suicidal?
Alex: Can a priest bring Francisco back?
Sam: If he were a good priest, he would tell you the truth.
Alex: And what might that be, Rabbi Freud?
Sam: You should have taken better care of Elena. She depended on you. You forced her to commit what for her was a murder. You should have taken better care of Francisco. He was God's gift to you.
Alex: Where do you come off judging me? Are you implying that I murdered my son?
Sam: You didn't mean any harm but his death was your fault, nonetheless.
Alex: I know.
Sam: I think that a priest might tell you how to get rid of sin.
Alex: How so?
Sam: You're the Catholic, how does it work?
Alex: Confession and penitence.
Sam: You've already confessed to me and anyone else on the planet who will listen. Next comes the penitence.
Alex: And what might that be?
Sam: I don't know.

The session was over and Alex said that he would call to reschedule. He did not call and, as was good practice with these kinds of patients, Sam took the initiative. Alex answered the phone. He maintained that counseling had done him about as much good as he had expected and he wasn't planning to come anymore. To Sam, Alex sounded as if he was finally at peace with himself. Anyone who knows about the secret lives of suicides would find this kind of peace less than reassuring. Of course, Sam documented the call.

A chance encounter. Alex and his misery were replaced in Sam's practice by multitudes of new clients and their miseries. Years later, Sam and Alex ran into each other at an American Counseling Association conference in Dallas. Alex had gotten a master's degree in counseling. He was employed as a counselor at an addictions clinic run by the Archdiocese of Dallas.

Alex: Your counseling must have helped. I'm still alive.
Sam: I'm sure glad to hear that, Alex. What do you hear from Elena?
Alex: She's back in Mexico City, still working for Aero Mexico. She calls me once a year, on the anniversary of Francisco's death. We're the only ones who can really know what it was like.
Sam: What kinds of clients are you seeing?
Alex: Kids hooked on one substance or another. I work hard to save them. I'm beginning to understand the meaning of a child's life.

REFERENCE

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital & Family Therapy*, *27*, 145-155.

***Larry Golden**, Ph.D., is associate professor and chairs the Department of Counseling, Educational Psychology, and Adult and Higher Education at The University of Texas at San Antonio.*

Counseling Is the Answer . . . Counseling Is the Answer . . . But What Is the Question? 25 Questions for Couples and Families

Daniel Eckstein
Ottawa University, Phoenix

The title for this article was inspired by a Charles Schultz *Peanuts* comic strip. For three frames, Charlie Brown waves a placard proclaiming, "Christ is the answer, Christ is the answer, Christ is the answer." The final frame shows Snoopy's replying placard, "But what is the question?"

A premise of this column is that families and couples can often obtain insights simply through the process of self-assessment or interviewing and then by relating to one's partner's responses to a series of personal and relationship-oriented questions. Part 1 provides 25 such questions. After discussing Part 1 answers, the couple and family members then are invited to do Part 2 together. Couples and families can answer the questions and discuss the responses together. (Later, if desired, the issues can be discussed with a counselor.)

Part 1

Answer the questions from the perspective of either (a) your partner, (b) another family member, and/or (c) yourself. The suggested sequence is similar to the process used in couples renewal seminars called marriage encounter.

Here are the questions—feel free to pass on any item if so desired. First, answer the questions alone. Then share your responses with your partner or family member(s), with one person going through his or her responses to all the questions. The roles should then be reversed, with the other person(s) sharing responses to all the questions.

A second option is to give the answers to each separate question, each person alternating going first or second in the order of sharing. Whichever method is used, the third step suggested is that a time of discussion follow the responses. Surprises, new learnings, reminders of previous learnings, and last, the implications for you personally, then your relationship and/or family relationship, can be identified and discussed.

The maximum benefit will be gained by answering the questions specifically about your partner or one other family member. You can, of course, complete several versions of the questionnaire for each family member.

Procedure

An American Indian koan that can be viewed as one way of describing empathy is, "If you want to understand my world, walk a mile in my moccasins."

What follows is a series of 25 questions that the author has used personally, based on his own counseling with couples and families. Also included are questions from the writings in various marriage and family therapy books and journals. Particular contributions are noted from solution-focused therapy (O'Hanlon, 2000; Berg & Dolan, 2000).

25 Relationship Questions

1. On a scale of 1 to 10, rate your current level of satisfaction with your relationship. Elaborate on the specific reason(s) for giving this numeric value.
2. What are some activities in which you currently experience joy, fun, and/or happiness between you and _____?
3. What (if anything) do you do primarily with or for yourself *alone* that brings you happiness?
4. What was the high of the last year for you personally? And now for you as a couple or family?
5. Can you remember a time recently when you pleasantly surprised yourself or did something out of character that pleased you?
6. How about the same question for you as a couple? (Or family?)
7. Can you recall a time when you thought you had a problem in your relationship but you did not? What changed it from being a problem to not being a problem?

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8. What amount of the time do you feel you are aligned or in harmony in your relationship? Cite specific examples of how you feel both aligned and unaligned with your partner.
9. How do you think your friends would describe your relationship between you and _____?
10. Cite some examples of how your partner (family member[s]) has encouraged you in the past month.
11. Cite some examples of how your partner (family member[s]) has discouraged you in the past month.
12. What do you think your responses to 9, 10, and 11 say about *your* wants, needs, motivators, and values?
13. When you and your partner are (a) happy together, contrasted with being (b) in conflict with each other, what would actually be seen and/or heard if it had been videotaped on those times?
14. What do you have a right to expect from your partner (family member)?
15. What does your partner (family member) have a right to expect from you?
16. Consider the following three different ways of describing the attachment between you and your partner. In what ways would you describe your relationship as:
    a. Secure (cite examples) _____
    _____
    _____
    b. Anxious or ambivalent (cite examples) _____
    _____
    _____
    c. Avoidant (cite examples) _____
    _____
    _____
17. What specifically would it (a) look like, (b) feel like, (c) sound like, and/or even (d) smell like when you and your partner are really connected with each other?
18. Contrast the above concrete ways of describing your relationship when you are feeling alienated and/or distant from your partner.
19. Using the analogy of flags used at a race track, what would you define as (a) green flags—indicators that say "go forward," positive indictors in your relationship? (b) yellow flags—what are the "caution" signals in your relationship that have or may be slowing down the "relationship race"? (c) red flags—what has stopped the race in past relationships or what could end it in the future?
20. When you and your partner (family member) have challenges, how do you typically resolve them?
21. Give (an) example(s) of when your problems in the relationship are not occurring.
22. How do you prevent the problem from getting worse?
23. If you were to wake up tomorrow and a miracle had occurred in your relationship resulting in all the challenges between you and your partner and/or family being resolved, how would your life be different? Assume that the miracle occurred during the night when you were asleep; what small differences would you be able to identify the next morning that would indicate that indeed a miracle had occurred?
24. What needs to be different in your relationship to make your life more happy?
25. How would others around you be able to know your relationship had changed in a positive manner?

Part 2

Complete your answers to the following questions, as well as the suggested activities, together as a couple or as a family.

1. Consider a challenging situation in your relationship.
   a. If you were to have a dream or symbolic form for you and your partner, what would it be?
   b. How would these two symbolic forms relate to each other?
   c. Where would this take place?
   d. What if it never changed, if it went on forever, how would that be for you?
   e. Now together actually act it out—*be* your story.
2. Process your experience.
   a. Were either of you surprised by each other's story?
   b. What characters, values, or beliefs of your two stories were in conflict?
   c. What part(s) of your story was (were) in harmony?
3. Now create a *new story* that combines your two individual stories. What alternative attitudes and/or behaviors would be necessary to creatively combine these separate stories into one complementary "Once upon a time . . . ?"
4. Discussion:
   a. What parallels can you draw between your stories and your actual relationship?
   b. Cite examples of complementary and conflicting challenges in your relationship.
   c. What problem-solving strategies did you utilize in creating your new combined couples story?
5. Implications/applications:
   a. How can you apply any of the insights from this activity for improved personal strategies to your relationship?
   b. What would be some suggested problem-solving strategies you might utilize to make the stories better?
   c. How can you plan to have more fun in the future, both for yourself personally as well as for your partnership and/or family unit?

REVIEW OF LITERATURE

In solution-focused brief therapy (SFBT), Insoo Kim Berg (Berg & Dolan, 2000) believes that instead of trying to get rid of the problem, a better focus for couples is to identify and strengthen the already existing solution. It is an optimistic premise that the solution exists and is merely waiting to be remembered or rediscovered. The key ingredient is to listen to one's partner and not pay too much attention to the problem that you two may describe. Two primary techniques are asking the "miracle" question (no. 23), and by using scaling techniques (nos. 1 and 8).

Pat Love (1994) believes the following phases are characteristic of primary love relationships. Love postulates that attraction is the first stage of the primary love relationship. Stages of primary love relationship are as follows:

1. **Attraction stage**: She believes we are more attracted to some individuals and not to others because humans exude a chemical called pheromones. Thus, it is often our chemicals and our hormones that are leading us. We are often attracted to people who represent unfinished business and who can complete our lives. Nature has two drives, those being procreation, to keep our species alive, and diversity—the more diverse we are, the better we are able to survive. The attraction stage is about getting together, not necessary about staying together. She says attraction is a purely chemical response to nature's attempt to procreate the species. Because attraction decreases the more often it is experienced, many individuals participate in dangerous, risk-taking behaviors to get the euphoria of the chemical high of attraction by choosing a partner who is dangerous, unavailable, or with whom a relationship must be secretive.
2. **Infatuation stage** (limerance): This is an altered state of consciousness that makes us feel euphoric. It leaves us longing for more, as if we are walking 3 feet off the ground; limerance is chemically induced. We are also under the influence of dopamine and norepinephrine. By using the provocative phrase "hot monogamy," she contends that staying with one partner is a choice; it is about our intentions. Our partner thus becomes the catalyst of this euphoric feeling—we feel open, zestful, we feel and show love, and we are undefended, too. We believe we are falling in love, and in our culture we too often equate infatuation with love. Much of our music reinforces this notion. Danger, fear, and risk all enhance the limerance experience. When the amphetamine high starts to wane, couples will up the ante by engaging in behaviors of which their family and friends would not approve, such as having a secret relationship with someone that is not approved of by family and friends. Love contends that because amphetamines are activated by the presence of the partner, sexual energy has more to do with biology than the relationship itself. For example, a high-testosterone (T) person falls for a low-T person. The low-T person's sexual energy spikes. The high-T person feels as if they have died and gone to heaven because they believe they have found someone who will fulfill them sexually. Three to 6 months later, the body develops a tolerance and the amphetamine high begins to wane—it is a time-limited experience. Other cultures recognize limerance but do not value it as our culture does. It is usually not a rationale for a long-term relationship in other cultures. In the limerance phase the intensity of desire is misinterpreted during attraction and infatuation as depth of emotion. In reality it is time limited, usually decreasing in 3 to 6 months.
3. **Attachment stage**: In this phase partners value each other, and they practice caring behaviors. They are under the influence of endorphins, resulting in feelings of peace, calm, and safety. Love reports that many people lack the ability to attach because we only know what we were taught in childhood. She believes the ultimate leap is to realize that couples can be in a relationship while still being who they are without being abandoned or being swallowed up by the other person. She stresses that it is not the level of desire that makes hot monogamy; rather, it is the profoundness of connectedness between the individuals. Love has developed the following equation to define love: nature + choice + history + psychodynamics = love.

Other Attachment Theories

Other attachment theories are presented below:

- The ways in which adults' behavior in romantic relationships reflects the attachment relationships identified in early caregiver relationships. Hazan & Shaver (1987, 1990) used a three-category measure of adult attachment based on Ainsworth, Blehar, Walters, and Wall's (1978) typology and discovered that adults could be classified the same way—secure, anxious/ambivalent, and avoidant—in their romantic relationships. Secure lovers show high levels of relationship trust, commitment, acceptance, and relationship longevity. Anxious/ambivalent lovers demonstrate more jealousy and obsession about their lovers than secure lovers do. Avoidant lovers fear intimacy and commitment.
- Young and Acitelli (1998) explored the relationship between attachment style, the degree of public commitment to the relationship, and the perception of a partner. They found that securely attached individuals' perceptions of their partners were not affected by their marital status, indicating that securely attached people do not need overt indicators of commitment to feel positively about their partners. For insecurely attached individuals, the researchers found that perception of one's partner was heavily influenced by overt displays of commitment between the partners.

  Individuals who describe their attachment style as anxious/ambivalent often view marriage as an indicator that they are worthy of love; conversely, for avoidant individuals, marriage may indicate to them that their partners are not committed and thus are not be trusted.

  Marital status has also been found to be important to anxious/ambivalently attached individuals. Married men with this particular attachment style have significantly less positive perceptions of their partners than married men with other attachment styles or unmarried men with the same attachment style. Of the three attachment types, anxious/ambivalent individuals are more likely to view their partners as worthy and able although doubting their own worth and ability.
- Differing attachment styles affect how a person reacts emotionally to the termination of a romantic relationship. How a person reacts emotionally to the termination of a romantic relationship is strongly related to their attachment style. For example, avoidant individuals have demonstrated the least amount of emotional distress, whereas anxious/ambivalent individuals exhibited the most emotional distress. After the relationship has been terminated, anxious/ambivalent individuals are the most likely to report that they are still in love. Insecure attachment (more specially, avoidant attachment) predates relationship instability (Feeney 1999).

Boundary Issues

Attachment disorders are evident in Pia Melody's (1992) addictive cycle in codependent, addicted relationships, more commonly referred to as the love addict/love avoidant cycle.

She says that for a love addict, the greatest fear is that of abandonment with an underlying fear of intimacy. Other characteristics include:

- Being responsive to the avoidant's seductiveness and entering the relationship in a haze of fantasy.
- Getting high from the fantasy.
- Denying how walled in the avoidant really is.
- Experiencing an event that shatters the denial.
- Experiencing intense emotional withdrawal following the denial.
- Obsessive planning then occurs, often leading to addictions (food, drugs, alcohol, sex, nicotine, love).
- The person then returns to the fantasy or moves on to a new relationship.

Conversely, for what Melody defines as a love avoidant, the greatest fear is that of intimacy with an underlying fear of abandonment. Here are some of the characteristic phases:

- The person enters the relationship because he or she cannot say no.
- There is a wall of seduction that impedes intimacy; the person goes behind a wall of seduction, making the love addict feel special.
- It is a wall of anger that justifies abandonment by becoming overwhelmed by enmeshment and/or neediness of the love addict and by protecting oneself by being critical of the love addict.
- The person then abandons relationship in some way.
- This usually cycles into an addiction process; (i.e., sex, love, alcohol, drugs, work, gambling, etc.).
- The person may return to the relationship out of guilt or of fears of abandonment, or he or she moves on to connect with another partner.

Encouragement

As Watts and Pietrzak (2000) observe, Adlerian psychology stresses that encouragement skills include demonstrating concern for each other through active listening and empathy, communicating respect for and confidence in one's partner, focusing on each other's strengths, assets, and resources, and seeing the humor in life experiences. SFBT stresses that couples are not sick and thus are not identified or labeled by their diagnosis. Goals of SFBT are to help couples change their behaviors and attitudes from a problem and failure focus to a focus on solutions and successes and to discover and develop latent assets, resources, and strengths that may have been overlooked as a couple focuses primarily on problems and limitations.

William O'Hanlon (2000) has identified the following 10 types of questions and statements in solution-based therapy.

1. Scaling questions are designed to get continual assessment and feedback from the person or family and get them to realize changes or gray areas in the problem situation.
2. Difference questions are designed to highlight differences and get the person to compare and contrast things about the problem, exceptions, or solutions.
3. Accomplishment questions attempt to get the person or family to recognize that something positive happened as a result of their efforts.
4. Goal questions assist the person or the family to identify what they are interested in accomplishing or setting the end point for therapy or problem resolution.
5. Compliments and praise encourage the acknowledgment of accomplishments, good intentions, or level of functioning.
6. Atypical experiences in regard to the problem (exceptions) help to elicit descriptions of times when things went differently from the usual problem situation.
7. Description questions ask the person or the family to describe the problem or solution situation in observable terms.
8. Smaller step questions and/or comments are designed to get couples to scale back grand ideas about their goals or progress toward achievable ends or progress.
9. Highlighting change and new stories help couples notice or acknowledge changes or differences in their perceptions of themselves or other people's views of them.
10. Motivation questions explore the motivation to change and to determine whether you have a "customer" for change.

Part 3—Summary

Having answered the questions, completed the exercise together, and read the material, answer some concluding questions, such as:

1. What are some of your major learnings or relearnings about yourself?
2. What are some major learnings or relearnings about your partner (family member[s])?
3. What would be some suggested problem-solving strategies that could help bring you closer together as a couple or a family?

REFERENCES

Ainsworth, M.D.S., Blehar, M., Walters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.

Berg, I. K., & Dolan, Y. (2000). *Tales of solutions: A collection of hope inspiring stories*. New York: Norton.

Feeney, J. A. (1999). Adult attachment, emotional control and marital satisfaction. *Personal Relationships*, *6*, 169-185.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*(3), 511-524.

Hazan, C., & Shaver, P. (1990). Love and work: An attachment theoretical perspective. *Journal of Personality and Social Psychology, 59*, 270-280.

Love, P. (1994). *Hot monogamy* [Audiotape]. New York: Sounds True.

Melody, P. (1992). *Facing love addiction*. San Francisco: Harper.

O'Hanlon, W. (2000). *Do one thing right: Ten simple ways to change your life*. New York: Quill.

Watts, R. E., & Pietrzak, D. (2000). Adlerian "encouragement" and the therapeutic process of solution-focused brief therapy. *Journal of Counseling & Development*, *78*(3), 442-445.

Young, A. M., & Acitelli, L. K. (1998). The role of attachment style and relationship status of the perceiver in the perceptions of the romantic partner. *Journal of Social and Personal Relationships*, *15*(2), 161-173.

***Daniel Eckstein**, Ph.D., ABPP, is currently an adjunct or visiting professor for the following universities: Capella University, Minneapolis; Ottawa University, Scottsdale; Northern Arizona University, Phoenix; and the Adler School of Professional psychology, Toronto. Dr. Eckstein is the author or coauthor of 11 books, including* Raising Respectful Kids in a Rude World*, A Life-Style Primer, and* Relationship Repair: "Fix It" Strategies for Couples and Families. *He has diplomates in counseling psychology from the American Board of Professional Psychology and in Adlerian psychology from the North American Society for Adlerian Psychology. E-mail: deckstein@juno.com. His Web page, www.encouragingleadership.com, contains other relationship articles that can be downloaded at no charge.*

Gender Differences in Sexuality: Perceptions, Myths, and Realities

Michael W. Wiederman
Columbia College

Couples and family counselors may be faced with cases of sexual and relationship difficulties that are caused, or at least exacerbated, by client perceptions and beliefs as to how men and women differ with regard to sexuality. Some such perceptions and beliefs may be consistent with findings from empirical research, whereas others may be based on cultural myths. This article briefly addresses one of the most prevalent and potentially harmful such myths in our culture: Men and women differ in their respective sexual peaks. The article concludes by describing a way clients might be presented with data on gender differences in sexuality that leads to a greater appreciation for the diversity within each gender as well as between the genders.

Certainly there are some marked male-female differences with regard to sexuality, and everyone seems to know that. Simply ask people how men and women differ when it comes to sex and folks readily provide their assessment. Clients in therapy also hold beliefs regarding how men and women differ sexually, and examining those beliefs can be an important part of therapy when the problem under consideration is sexual. Why? Because what we believe about males and females influences what we expect of ourselves and our partners. To the extent that those perceptions and beliefs do not match reality, there is the risk of disappointment, hurt, and conflict.

Suppose the members of a male-female couple expect that men desire sex more than do women (a common belief in our culture). How might each member of the couple react to the realization that in their case the male is less interested in sex than is the female? Of course, the answer to that question depends on a variety of factors, including whether it has always been that way within their relationship. However, underlying beliefs about male-female differences in sexuality may lead to a conclusion that something is wrong with the male (too little interest in sex), the female (too much interest in sex), or the couple (he no longer finds her attractive or is cheating on her).

Examining couples' perceptions and beliefs about male-female differences in sexuality may be fruitful for understanding their current sexual difficulties. However, examination of such beliefs begs the question as to whether particular beliefs are myths or are based in reality. Also, for those client perceptions and beliefs that are congruent with findings from sound empirical research, there is the potential problem of clients having an exaggerated view of how different men and women are (we might refer to this as the "men are from Mars, women are from Venus" myth). This article briefly discusses one of the most common myths we hold in our culture regarding male-female differences in sexuality. The article concludes by discussing a way that male-female differences in sexuality might be presented so as to keep such differences in context.

THE MYTH OF SEXUAL PEAKS

It seems that everyone has heard the following truism: Men reach their sexual peak in their late teens (roughly age 18?) whereas women reach their sexual peak in their 30s (or older?). I have witnessed this knowledge claim being hauled out to explain everything from a particular woman's sexual interest in a younger man to women's general sexual dissatisfaction within marriage to parents' concern over the teenage boy their daughter is dating. This knowledge claim implies some inherent or biological difference between the sexes such that men's libido, or sex drive, has cooled by the time their female peers' libido is revving up and reaching its highest point. In reality, however, there is no evidence for such a biological sex difference (Baldwin & Baldwin, 1997).

So, how did this myth get started? The notion of men's and women's sexual peaks derives from data Alfred Kinsey and his colleagues (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) collected a half century ago. These researchers tabulated the total number of self-reported "sexual outlets" for each respondent per year—that is, the total number of orgasms or ejaculations each individual

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experienced through any means (e.g., masturbation, oral stimulation, vaginal or anal intercourse, erotic dreams). When these researchers graphed the total number of sexual outlets as a function of the age of the respondent, the line on the graph peaked (was highest) for men among those respondents who were in their late teens. For women, the graph peaked among those who were in their 30s.

It appears that the best explanation for this apparent sex difference has much more to do with what it meant to be a male or female raised in the United States during the early part of the 20th century than it does any physiological, hormonal, or anatomical sex difference. That is, the apparent difference in men's versus women's timing of the frequency of sexual outlets was probably the result of greater social prohibitions placed on women compared with men with regard to being a "sexual" person, stimulating one's own genitals, and having sexual relationships other than within marriage (Baldwin & Baldwin, 1997). Much more recent data indicate that the frequency of sexual activity declines over the life span for both men and women, and men and women report very similar levels of sexual activity within each age group (Jasso, 1985; Laumann, Gagnon, Michael, & Michaels, 1994). Also, note that the original graphs on which the knowledge claim was based were constructed to summarize data on a large group of people surveyed at one point in time; they did not represent the life course or changes over time for any particular research participant. So the data peaks did not necessarily correspond to peaks in sexual interest within any individual's life.

Why is perpetuation of this myth harmful? It implies that through a cruel twist of biology, men and women are destined to be sexually frustrated, as each gender is sexually primed at different points in the life cycle. When any individual couple experiences such a discrepancy in sex drive, the myth of gender differences in sexual peaks could be hauled out to explain it, thereby curtailing further consideration of the dynamics within that particular relationship. Taken to an extreme, belief in the myth could be used to justify sexual coercion among young men and extramarital affairs among 30-something or 40-something women.

Myths are most likely to be perpetuated when they seem to fit with experience, which may explain the persistence of this myth. Why does the myth of gender differences in sexual peaks seem to fit reality in so many cases? The answer may have to do with another, more realistic set of gender differences. First, parents, educators, and others are frequently more concerned about controlling the sexuality of teenage girls than they are of stifling the sexuality of teenage boys. Indeed, the traditional double standard is reflective of the greater attempted control of female sexuality compared with male sexuality. Perhaps it is not surprising that teen boys are more desirous of sexual activity, especially casual sexual activity with a variety of partners, than are teen girls (Chara & Kuennen, 1994; Taris & Semin, 1997). Then there is the scarcity principle (Cialdini, 1993). This robust psychological principle states that when our access to something is limited, that thing becomes even more attractive to us. For teen boys, the relative scarcity of willing sexual partners makes sexual activity even more enticing.

Why would the tables turn by the time couples are in their 30s and 40s? Again there may be another gender difference at work. It appears that compared with women, men are more likely to objectify sexual partners, focusing on the partner's physical appearance as a sexual object (Fredrickson & Roberts, 1997). It is probably this dynamic that explains why women's weight gain in marriage results in decreased sexual interest on the part of her husband, whereas men's weight gain appears unrelated to women's sexual interest in their husbands (Margolin & White, 1987). Also, men seem to be more sexually stimulated by variety with regard to different sexual partners, whereas women seem to be more aroused by variety with regard to different experiences with their steady sexual partner (Kelley & Musialowski, 1986). Add to this the phenomenon of some men viewing their partners as less "sexy" after motherhood, a phenomenon women apparently do not experience with regard to their mate's new fatherhood.

What all of this means is that by the time a couple has been married for several years, the male may be much less interested in his partner sexually compared with the early days of the marriage. In contrast, the woman's sexual interest may not have waned to the same extent, and she may even be more comfortable with her body image compared to young adulthood (Heatherton, Mahamedi, Striepe, Field, & Keel, 1997). She may be ready to seek new sexual adventures with her steady mate at a time when his sexual interest in her is at an all-time low (for the reasons described above). To the extent that these phenomena coalesce during the woman's 30s or 40s, we have apparent support for the myth of the gender difference in sexual peaks. It is important to note, however, that such a gender difference in biological sexual peaks (if it existed) cannot be rectified, but all of the other phenomena described here are open to intervention.

THE RESEARCH SAYS . . .

There is, of course, a body of empirical research on gender differences in sexuality, including such topics as sexual experience (Lauman et al., 1994; Oliver & Hyde, 1993), characteristics in an ideal sexual partner (McGuirl & Wiederman, 2000), and beliefs about the causes of male and female sexual desire (Regan & Berscheid, 1995). In several instances, researchers have found inaccuracies or distortions in men's and women's perceptions of the sexuality of the other gender. For example, McGuirl and Wiederman found that college women tended to underestimate college men's desire for a sexual partner who is open to discussing sex and clearly communicating desires. College women overestimated the extent to which college men desired partners who paid compliments

during sex, were easily sexually aroused, and viewed sexually explicit media. In contrast, college men overestimated the extent to which college women desired a sexual partner who was physically attractive and could delay ejaculation.

Clients may encounter research findings on sexuality and gender, typically as covered in popular media such as magazines, and incorporate these findings into their perceptions and beliefs about gender differences in sexuality. A potential problem is that people tend to hear statements such as "Men were more this way and women were more this way" as indicating that all men, most men, or the typical man is a certain way whereas all women, most women, or the typical woman is a certain other way. Of course, the gender differences reported were based on statistically significant differences between men and women, which does not tell us anything about the size or magnitude of those differences (Wiederman, 2001). A statistically significant difference simply indicates that it is unlikely (although not impossible) that given the difference the researcher found in this particular sample, in reality there is absolutely no difference between men and women in the larger population. However, the words *statistically significant* rarely, if ever, appear in popular media presentations of research findings, and I suspect that the public would interpret those words as indicating a large or important difference even if such a phrase was included.

Another common misinterpretation of findings is that the average reported by men and women represents what the average, or typical, man or woman experiences. Averages, however, are based on addition and division with data for the entire sample, so it is quite possible that no individual in the entire sample experienced what turned out to be the average for the group. So is there something that can be done to avoid potential misunderstandings regarding research findings on gender differences in sexuality?

One potential solution is to educate clients for whom these perceptions and beliefs are problematic and to do so by presenting research findings in a way that makes more intuitive sense. For example, some researchers have called for use of a "common language effect size statistic" (McGraw & Wong, 1992). Through a few computations, research findings on gender differences in sexuality can be expressed as the likelihood that a man in any given male-female pairing would hold the greater level of experience or attitude or whatever. In other words, the question is: If a male and female were randomly and repeatedly selected from the population, in what proportion of these pairings would the man (or the woman) hold the greater "score" or level of experience? For example, consider experience with masturbation, which is the one aspect of sexual behavior that appears to display the largest gender difference (Oliver & Hyde, 1993). In 75% of these theoretical pairings, the male would indicate having had greater experience compared with the female (based on calculations from data supplied by Oliver & Hyde).

TABLE 1

Patterns of Male and Female Preferences for Certain Sexual Activities

Sexual Activity	Man Yes, Woman No (%)	Woman Yes, Man No (%)	Both No (%)	Both Yes (%)
Vaginal intercourse	19	12	4	64
Giving oral sex	28	11	56	6
Receiving oral sex	32	16	39	13
Watching partner undress	35	14	38	13

NOTE: Data are based on results from the nationally representative sample of adults reported on by Lauman, Gagnon, Michael, & Michaels (1994). The percentages represent respondents who reported finding that particular sexual activity "very appealing," and the degree of match or mismatch is based on the assumption of random pairings of males and females. Percentages within each row may not sum to 100 because of rounding.

Along these same lines, it is possible to compute the proportion of times males and females would agree on some sexual experience, attitude, or preference, assuming they were randomly paired. For example, based on nationally representative data from Laumann et al. (1994), in 37% of male-female pairings the man masturbated during the previous year whereas the woman did not. In 15% of pairings the woman masturbated whereas the man did not. In 21% of pairings neither person masturbated, and in the remaining 27% of pairings both the man and woman masturbated. Table 1 shows the pattern of preferences for certain sexual activities as a function of gender and the degree of expected agreement and disagreement if men and women were randomly paired.

Note that in the majority of cases there would be agreement, but when there is not, it is more likely that the male would prefer the activity whereas the female would not. However, it is clear that there would also be some instances in which the woman would prefer the activity whereas the man would not. Of course, men and women are not randomly paired to form lasting relationships, and there is likely to be greater similarity among actual couples because they select partners who are more likely to share sexual values and preferences. Still, sharing information such as Table 1 with particular clients may help them understand the degree of variation that exists within as well as between the genders, thereby dissuading them of the belief that men are a certain way whereas women are a different way.

CONCLUSION

Client perceptions and beliefs about gender differences in sexuality are but one potential aspect of sexual and relationship difficulties that may need to be addressed. Still, it may be an important aspect in certain cases, whereby a therapist needs to confront harmful myths, educate as to potentially

accurate gender differences, and provide a context in which clients can appreciate that there is a great deal of diversity within each gender as well as between the genders. In an era in which clients are bombarded with media messages and men are frequently seen as "from Mars" and women "from Venus," tackling overly simplistic generalizations regarding male-female differences in sexuality may be more relevant than ever.

REFERENCES

Baldwin, J. D., & Baldwin, J. I. (1997). Gender differences in sexual interest. *Archives of Sexual Behavior*, *26*, 181-210.

Chara, P. J., & Kuennen, L. M. (1994). Diverging gender attitudes regarding casual sex: A cross-sectional study. *Psychological Reports*, *74*, 57-58.

Cialdini, R. B. (1993). *Influence*. New York: William Morrow.

Fredrickson, B. L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, *21*, 173-206.

Heatherton, T. F., Mahamedi, F., Striepe, M., Field, A. E., & Keel, P. (1997). A 10-year longitudinal study of body weight, dieting, and eating disorder symptoms. *Journal of Abnormal Psychology*, *106*, 117-125.

Jasso, G. (1985). Marital coital frequency and the passage of time: Estimating the separate effects of spouses' ages and marital duration, birth and marriage cohorts, and period influences. *American Sociological Review*, *50*, 224-241.

Kelley, K., & Musialowski, D. (1986). Repeated exposure to sexually explicit stimuli: Novelty, sex, and sexual attitudes. *Archives of Sexual Behavior*, *15*, 487-498.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Philadelphia: W. B. Saunders.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press.

Margolin, L., & White, L. (1987). The continuing role of physical attractiveness in marriage. *Journal of Marriage and the Family*, *49*, 21-27.

McGraw, K. O., & Wong, S. P. (1992). A common language effect size statistic. *Psychological Bulletin*, *111*, 361-365.

McGuirl, K. E., & Wiederman, M. W. (2000). Characteristics of the ideal sex partner: Gender differences and perceptions of the other gender. *Journal of Sex & Marital Therapy*, *26*, 153-159.

Oliver, M. B., & Hyde, J. S. (1993). Gender differences in sexuality: A meta-analysis. *Psychological Bulletin*, *114*, 29-51.

Regan, P. C., & Berscheid, E. (1995). Gender differences in beliefs about the causes of male and female sexual desire. *Personal Relationships*, *2*, 345-358.

Taris, T. W., & Semin, G. R. (1997). Gender as a moderator of the effects of the love motive and relational context on sexual experience. *Archives of Sexual Behavior*, *26*, 159-180.

Wiederman, M. W. (2001). *Understanding sexuality research*. Belmont, CA: Wadsworth.

***Michael Wiederman**, Ph.D., is an associate professor in the Department of Human Relations at Columbia College. He has been an active member of the Society for the Scientific Study of Sexuality and is currently the book review editor for* The Journal of Sex Research. *His recent publications include* Understanding Sexuality Research *(2001, Wadsworth),* The Complete Guide to Graduate School Admission *(2nd ed., 2000, Erlbaum), and* The Handbook for Conducting Research on Human Sexuality *(2001, Erlbaum). He may be reached by e-mail at mwiederman@colacoll.edu.*

❖Interview

Integrating Cognitive and Systemic Perspectives: An Interview With Frank M. Dattilio

Richard E. Watts
Baylor University

Frank M. Dattilio is a major influence in the increasing integration of cognitive and systemic perspectives in couple and family therapy. He is on the faculty of psychiatry at Harvard Medical School and the University of Pennsylvania School of Medicine, a clinical psychologist in private practice, and clinical director of the Center for Integrative Psychotherapy in Allentown, Pennsylvania. Dattilio is a diplomate in behavioral and clinical psychology with the American Board of Professional Psychology and a clinical member and approved supervisor of the American Association for Marriage and Family Therapy. His most recent publications include *Case Studies in Couple and Family Therapy: Systemic & Cognitive Perspectives* (Dattilio, 1998) and *Comparative Treatments of Couples Problems* (Dattilio & Bevilacqua, 2000).

TRAINING AND DEVELOPMENT OF INTEREST IN INTEGRATION

Watts: I appreciate your willingness to take the time for this interview. To begin, why don't you talk a bit about your background and training.

Dattilio: I haven't always been the luckiest person in the world, but on a few occasions I have managed to be in the right place at the right time. On one of those luckier occasions I had the rare opportunity, in the late 1970s, early '80s, to study with the late Joseph Wolpe, M.D., who is regarded as the father of behavior therapy. I met Dr. Wolpe in the late 1970s when I attended a brief lecture that he presented on behavior therapy and had the opportunity to speak with him in person. As a result of our chat, he invited me to one of his seminars at his institute in Philadelphia, and subsequently, I was invited to study with him for several years while I completed my Ph.D. at Temple University in Philadelphia.

Several years later, I applied for a postdoctoral fellowship in the Department of Psychiatry at the University of Pennsylvania School of Medicine, where Aaron T. Beck had been pioneering his early work in cognitive therapy. My training and experience with Wolpe was attractive to Beck, and he consequently offered me a 2-year postdoctoral fellowship.

The majority of my marriage and family therapy training was gained at Temple University. This was during the years that the systems and structural approach was rapidly gaining in popularity. Consequently, there wasn't very much interest in the behavioral approach to couples and families, since it was greatly overshadowed by the more popular theories. Nonetheless, my interest seemed to head in the direction that applied cognitive-behavioral strategies to couples and families. I always respected the systems approach and felt that somewhere there was fertile ground for an integration of the two modalities.

I didn't actually start doing heavy work with couples and families until after my tenure with Aaron Beck. I assisted him while he was composing his popular book, *Love is Never Enough* [1988], and found the work to be quite fascinating. It was at that point that I began to investigate more into the application of cognitive-behavior therapy with couples and families and, in 1990, coauthored a book with Christine Padesky titled *Cognitive Therapy with Couples*. This book did extremely well and has been translated into one-half dozen languages.

Watts: How did you come to be interested in the integration of cognitive and systemic therapeutic perspectives?

Dattilio: I have always been practical minded, which is one of the reasons I was so attracted to the cognitive-behavioral approach. At the same time, theories that were grounded in empirical validation were also very

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important to me. I was troubled, however, when it came to working with couples and families because the dynamics were different than working with individuals, and the cognitive-behavioral approach seemed to be lacking in some ways. It was at that point that I began to read more of the work of Bertalanffy [1968] on his general systems theory, as well as the work of Murray Bowen [1978]. I also stumbled upon some early articles published by Birchler and Spinks [1980] that addressed integrating behavioral systems and marital and family therapy. I was encouraged by what could possibly be a melding of systems theories and cognitive-behavioral therapy. I was also a firm believer in the fact that couples and families constitute a complex set of dynamics that are directly or indirectly related in a causal network. Consequently, when one individual was seen within a group and needed to be viewed with respect to the function of the emergent relational qualities among family members, it was essential that a systems approach be incorporated.

I have always respected the theory of circularity and the multidirectional flow of influence between family members. I believe that it is virtually impossible to address cognitive-behavioral issues with couples or families without respecting the connections or relations among family members and the overall organization of the system. To attempt to understand an individual family member's behavior outside of the familiar context in which it occurs, in my opinion, misses the forest for the trees. One [the therapist] must direct his or her focus on the pattern of interaction within the family unit. It is in the sense that the function of the family member or member of a couple is determined, in part, by the individual's position in the relationship or the family. In addition, it was always my feeling that the systems approach fell short of addressing specific thoughts and behaviors that were addressed effectively by the cognitive-behavioral model. Hence, the need for integration seemed essential.

Watts: Then would you agree with Probst's [1988] contention that all therapeutic techniques, regardless of theoretical orientation, essentially place cognition at the center of therapeutic work?

Dattilio: That is indisputable as far as I am concerned. It has always been my feeling that in the general sense, because most psychotherapies involve human communications, the majority of therapies may be said to be cognitive. For similar reasons, most therapies can be considered behavioral as well, because communication is behavior and all behavior is communicative. And because the human condition involves emotions, most psychotherapy addresses emotion to a significant degree. Consequently, any particular therapy can be viewed through a variety of lenses as cognitive, behavioral, emotional, and so on.

However, because of the aspects of communication and cognitive processing, even therapies that function on the most visceral level still involve some aspects of cognition. Whether or not such therapies choose to address cognition as their primary agent of change varies. Suffice it to say that to avoid cognition in any therapeutic modality is to avoid much of what constitutes the human condition.

AREAS OF COMMON GROUND

Watts: What areas of common ground do you see between cognitive therapy and the systemic therapies?

Dattilio: This question needs to be answered in two parts—theoretical compatibility and therapeutic commonality. The systems perspective on family functioning requires that the family must be considered as an entity composed of interacting parts. Consequently, to understand any behavior in a couple or family relationship, one must look at the relationship qualities and the interactions among the members as well as the characteristics of the family as a unit. Similarly, a cognitive-behavioral perspective focuses on the interaction among family members with a particular emphasis on the interrelated nature of family members' expectancies, beliefs, and attributions. In this sense, then, both models share an emphasis on multidirectional, reciprocal influence and the necessity of looking at behaviors in that particular context.

The therapeutic commonality lies in the goal that involves some type of perceptual and/or behavioral change and how they address the primary issue of change. For example, some systems theories maintain that problems in families are often exacerbated by the way in which a family attempts to deal with specific issues. The goal of the therapy in these cases, then, is not merely to solve the problem for the family but to alter the family's approach in order to change the problem-solving mechanism. Cognitive-behavior therapists look at this in the same manner, focusing on the locus of the impediment to change, either through individual beliefs of family members or their individual or corporate lack of skills necessary to change. In this respect, both therapeutic approaches would address the impediment so that the family can begin to take the needed action to implement the specific change. This may equate to spending time on communication skills training, or examining the couple or family members' beliefs about disagreements in relationships, or on observational skills, etc.

Watts: What does cognitive-behavior therapy have to offer systemic-oriented therapists?

Dattilio: This is a very interesting question. I think the answer is that cognitive-behavior therapy can offer at least as much as the systemic therapies have to offer cognitive-behavior therapy.

While I have always maintained great respect for systemic-oriented therapies, it is my contention that they fail to place enough emphasis on the aspects of cognitive restructuring [Dattilio, 1998]. I find somewhat of a contradiction in much of the literature in the

sense that systemic therapies tend to, in one sense, shy away from the direct manipulation of cognitions and behaviors yet often, in another vein, talk about how important it is to address them.

I think, in essence, that cognitive-behavior therapy has a great deal to offer systemic-oriented therapists in that it draws attention to helping to take a step further in dealing with distorted beliefs which, in many cases, may be one of the keys in changing couple and family dynamics. Cognitive-behavior therapists are more concerned than system therapists with identifying family members' dysfunctional cognitions and behaviors. This focus may be helpful for systemic therapists in that it acknowledges important dynamics that may be blocking the couple or family's ability to change. Thus, offering a new perspective to system theorists may suffice if it enables the couple or family to deal effectively with the problem. Systemic therapists may utilize more structured examination of beliefs and expectations if "reframing" does not permit the family to change. In the same respect, the cognitive-behavioral therapist might offer alternative cognitions and schemas to the family if attempts at more structured examinations have failed.

To quote Leslie

> A cognitive-behavioral approach also offers systemic therapists a valuable reminder of the importance of individual properties, as well as offering therapeutic strategies for addressing these properties. Most notable, perhaps, is the fact that individuals are active information processors. Individual belief systems not only interact with family properties but can limit the change that the family and therapist seek to make. Systems therapists may further their understanding of family functioning by focusing on the cognitive schemata that each person brings to therapy as well as on systemic variables (e.g., boundaries). Such an addition both broadens the therapist's avenues for intervention and provides the therapist with a truly "systemic" picture of the multiple levels of influence and causation in the family. (p. 81)

Watts: You anticipated my next question at the beginning of your previous response. What aspects of systemic therapies would be useful for cognitive therapists?

Dattilio: Because systems theorists do not believe that intellectual understanding is important, they are more interested in changing the interactional sequences among family members than in furthering the family's understanding. This is somewhat contrary to what the cognitive-behaviorists believe: the importance of gaining insight into how cognitions influence the problem. In this respect, cognitive-behavioral therapists take responsibility for seeing that each member understands how this develops within the family unit. This may be, at times, too intrusive and, in some cases, could actually inhibit the process of change. Thus, I believe that systems theory offers cognitive therapists somewhat of a mode of temperance that may allow them to be more reflective in how their role as a therapist could actually inhibit change. Minuchin and Nichols [1998] underscore this aspect very clearly in a recent chapter.

Furthermore, the systemic model of therapy may help cognitive-behavior therapists to be more aware of attending to family goals and more focused on altering interactional patterns within the family unit. A fine example is of this is in an article by Gayla Margolin [1981]. Margolin incorporated the systemic ideas found in social learning concepts of interdependency of family members and mutual and reciprocal causation with the behavioral notion of operant conditioning. Margolin offered a model of circular influence and regulation similar to the feedback cycles described in systems theory.

Watts: What aspects of systemic perspectives do you think will be the least attractive to cognitive therapists?

Dattilio: Probably the less directive posture of the therapist in treatment. Many proponents of systems theory tend to view the therapist as a reflective instrument of change as opposed to the more direct style of the cognitive-behaviorist. So, many systems therapists would tend to view some of what cognitive-behaviorists do as being almost intrusive.

Watts: What aspects of cognitive therapy do you think will be the least attractive to systemic-oriented therapists?

Dattilio: I think that if cognitive-behavior therapy is used in too rigid of a fashion, it could come off too intrusive, which would be incompatible to a systems approach. I think that much of this has to do with the therapist's posture and artistic style.

THOUGHTS ABOUT THE FUTURE

Watts: Now I want you to pull out your crystal ball. What do you see for the future of cognitive-systemic integration regarding both theory and practice?

Dattilio: I see the future of the integration of cognitive-systemic therapies to be very promising. In my opinion, the entire field of psychotherapy has been gravitating toward a more integrative approach over the last 10 to 15 years. In regard to couple and family therapy, I think more and more individuals are moving toward an integrative approach. There are many different modalities that have good things to offer, and so, professionals are motivated to use the best of each to form an approach that works and is effective. I also believe that cognitive-systemic integration will become increasingly popular, particularly since both the cognitive-behavioral and systemic modalities have so much to offer and the combination is very comprehensive. This union also opens the door for many other types of techniques and strategies that are so versatile in dealing with contemporary issues among couples and families. I firmly believe that we still have a great deal more work to do with regard to ironing out the theoretical differences, however. Individuals have, however, already cited initial successes in the practice aspect and hopefully, this will aid in the

development of a more comprehensive theoretical orientation in the future.

Watts: What readings do you recommend for persons interested in learning more about integrating cognitive and systemic perspectives?

Dattilio: First of all, I would strongly recommend that readers familiarize themselves with the classic works in both the systems theory and cognitive-behavior therapy. These would include the early works of Stuart [1980], Baucom and Epstein [1990], and Dattilio and Padesky [1990], as well as the early writings of Bertalanffy [1968], Bowen [1978], and other systems theorists.

There are a number of excellent works currently in print that would be a good start for addressing the integration of these two approaches. Certainly the early work of Birchler and Spinks [1980] suggests the groundwork for integration, along with that of Margolin [1981] as well as Epstein, Schlesinger, and Dryden [1988] and Kirschner and Kirschner [1993].

One of the best chapters addressing this issue is by Leslie [1988]. One of my most recent works [Dattilio, 1998] presents a broad spectrum of 16 different modalities of couples and family therapy and how they may integrate with cognitive-behavior therapy. This is done through detailed case studies that contain dialogue between myself and sundry authors. Also, a comparative book just released on couples therapy looks at a single case study from 16 different perspectives of treatment and discusses the similarities and dissimilarities of each [Dattilio & Bevilacqua, 2000].

Watts: Are you or is anyone you know doing training and supervision in cognitive-systemic integration?

Dattilio: I conduct training and supervision through the Department of Psychiatry at both Harvard Medical School and the University of Pennsylvania School of Medicine for the past 11 years. My supervision, as of this interview, is very limited since I have been focusing my efforts more on lecturing and writing. I do know, however, that there are a number of other individuals throughout the world that offer training and supervision. A list of individuals can be obtained from The International Association of Cognitive Psychotherapy.

Watts: What is involved in training and supervising counselors in cognitive-systemic integration?

Dattilio: What is usually involved is basic didactic instruction in the systemic theories as well as cognitive-behavior therapy of couples and families. The integrational aspect of the training occurs, in my opinion, more through the actual hands-on experience with cases, either through videotape observation or cotherapy.

Watts: What current and near future projects are you working on?

Dattilio: I just finished a coedited book titled *Comparative Treatments of Couples Problems* [Dattilio & Bevilacqua, 2000]. This book presents a full-length case of a distressed couple, along with 10 questions that are posed to some of the most prominent theorists/therapists in the world representing 16 different modalities of therapy. The questions range from the therapists' conceptualization of the couple's problems and their assessment on the couple's amenability to treatment, to actual treatment strategies, techniques, follow-up, and termination. The book closes with an epilogue that compares and contrasts all of the theories in search of a mode of integration.

I am also currently at work on a solo-authored text invloving *Cognitive-Behavioral Strategies With Families*. This book is designed to address the theory and application of cognitive-behavior therapy with different modalities of treatment and how they can best be combined in an integrative fashion. This text will also offer several detailed case illustrations of working with families in conflict and address in detail the need for cognitive-behavior therapy to be conducted against the backdrop of a systems perspective.

Watts: Any final comments before we end the interview?

Dattilio: Only that one of my favorite quotes comes from the late, great Virginia Satir, for whom I hold great respect. In one of her later works she wrote, "It behooves us all to continue being students. My recommendation is that we free ourselves to look anywhere to what seems to fit. This makes each of us continually growing entities" [Satir & Baldwin, 1983, p. ix]. I think Satir's statement says it all.

REFERENCES

Baucom, D. H., & Epstein, N. (1990). *Cognitive-behavioral marital therapy.* New York: Brunner/Mazel.

Beck, A. T. (1988). *Love is never enough*. New York: Harper Collins.

Bertalanffy, L. von. (1968). *General systems theory.* New York: Braziller.

Birchler, G. R., & Spinks, S. H. (1980). Behavioral-systems marital and family therapy: Integration and clinical application. *American Journal of Family Therapy*, *8*, 6-28.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Dattilio, F. M. (Ed.). (1998). *Case studies in couples and family therapy: Systemic and cognitive perspectives*. New York: Guilford Press.

Dattilio, F. M., & Bevilacqua, L. J. (Eds.). (2000). *Comparative treatments of couples problems*. New York: Springer.

Dattilio, F. M., & Padesky, C. A. (1990). *Cognitive therapy with couples*. Sarasota, FL: Professional Resource Exchange.

Epstein, N., Schlesinger, S. E., & Dryden, W. (Eds.). (1988). *Cognitive-behavioral therapy with families*. New York: Brunner/Mazel.

Kirschner, S., & Kirschner, D. A. (1993). Couples and families. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 401-412). New York: Plenum Press.

Leslie, L. (1988). Cognitive-behavioral and systems models of family therapy: How compatible are they? In N. B. Epstein, S. E. Schlesinger, & W. Dryden (Eds.), *Cognitive-behavior therapy with families* (pp. 49-83). New York: Brunner/Mazel.

Margolin, G. (1981). A behavioral systems approach to the treatment of marital jealousy. *Clinical Psychology Review, 1*, 469-487.

Minuchin, S., & Nichols, M. P. (1998). Structural family therapy. In F. M. Dattilio (Ed.), *Case studies in couple and family therapy: Systemic and cognitive perspectives* (pp. 108-131). New York: Guilford Press.

Probst, L. R. (1988). *Psychotherapy in a religious framework: Spirituality in the emotional healing process*. New York: Human Services Press.

Satir, V., & Baldwin, M. (1983). *Satir step by step: A guide to creating change in families*. Palo Alto, CA: Science & Behavior Books.

Stuart, R. B. (1980). *Helping couples change: A social learning approach to marital therapy.* New York: Guilford Press.

***Richard E. Watts** is associate professor of counseling in the Department of Educational Psychology at Baylor University, Waco, Texas.*

❖ Book Reviews

This column provides brief reviews of books and other materials that may be useful to counselors both in their work with couples and families and in their personal growth and development. If you wish to have materials reviewed in this column, please write to Mary Katherine Nieponski, 16443 South Park Rd., Lockport, IL 60441-9748 or e-mail: krystal807@aol.com.

edited by Mary Katherine Nieponski

Family Counseling and Therapy (3rd ed.) (2000). Arthur M. Horne (Ed.), Itasca, IL: Peacock Publishers, 615 pages, $47.00. Reviewed by Mark D. Register

The third edition of *Family Counseling and Therapy* represents a continued effort to offer insightful, current, and balanced discussion on the many theoretical approaches to family counseling and therapy. From the first edition of this text, published in 1982, attempts have been consistently made to shed the cookie-cutter theoretical formulation of the 1950s and 1960s, which used White, middle-class families as the norm for all others to model. In this edition, Horne calls on the submissions of his contemporaries, who have each devoted years and decades to practice, to elucidate on their own theoretical orientations and those to whom they ascribe. For ease in comparing the framework of each chapter, authors were instructed to follow a common outline. A table is provided at the beginning of the book to further illustrate that objective.

Strengths of this book are its attention to balance and to the comfort of its readership. The 19 chapters are broken generally into three sections. The first three chapters address the book's arrangement. Chapter 1 is an introduction that explains how each chapter is organized and what the reader should expect to find within that organization. Chapter 2 traces a chronology of family therapy from its theoretical origins to more contemporary issues such as considerations for "remarried families" and the importance of practicing within an operational-multicultural and empathetic-political framework in order to be efficacious. A basic idea put forth in this chapter is that every family is unique in how it is affected by large internal and external forces, and it is the shortsighted therapist or counselor (terms that the book uses interchangeably) who attempts to push the family into a monochromatic framework. Finally, chapter 3 identifies central commonalties among the theories described throughout the book.

Chapters 4 through 18 address a homeostatic representation of various theoretical perspectives. Each attends to a format that focuses on definition, historical development, tenets of the model, application, case example, and evaluation. Because a major tenet of family therapy is that families exist in a larger environment and are ever changed by experience, it is appropriate that some biography of the founding theorist is provided in each chapter. This helps show the progression of theory. Drawing from chapter 15, there are three primary forces in psychology: First force is psychoanalytic and psychodynamic therapy, second force is behavioral, and third force is humanistic. It is important to note that there was no value placed on these and each was equally represented in the text. Chapter 19, the final chapter and section, offers a critical and timely discussion about ethics in family therapy.

Although the book is an extraordinarily well-written and thoughtful display of application, two minor concerns are expressed here. What seemed perplexing at first was the difference between chapters 9 ("Brief Family Therapy") and 15 ("Behavioral Approaches to Couple and Family Therapy"). The major difference here is the latter chapter's focus on social learning theory. Although they stem from the same school of thought, social learning theory investigates problems of living within the family over the behavior affecting the system. Still, it seems that these two chapters could have been combined. The other concern is not based in content but in design. Although each author was to follow a prescribed format, that format tends to vary from chapter to chapter. Specifically, that some chapters had summaries and some did not somewhat diminished the overall power of *Family Counseling and Therapy.* Those chapters with summaries offered closure, whereas those without seemed to close abruptly.

The book's greatest practical strength lies in chapters 9, 15, and 16. In this age of managed health care, efficacious and time-efficient therapy is king. These three chapters all deal with behaviorally focused therapy. As a result, each has extensive empirical research supporting its effectiveness in identifying and resolving interpersonal problems. Other chapters, too, offer great value to theoretical discussion and

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application. For example, chapter 13, "Adlerian Family Therapy," points to Adler's interest in providing uncommon attention to children. A related quote is provided that justifies this interest: "It's not terribly difficult to tame a lion, but is there anyone who has learned to make a lamb roar?" The meaning here is that although therapists help families achieve healthy homeostasis, they need to attend to the needs of every member. Chapter 17 echoes that question and stretches therapists to attend to their own biases as well. According to Kathryn Norsworthy as she writes on "Feminist Family Therapy," too many therapists are guilty of deliberately or inadvertently reinforcing traditional gender roles, placing the yoke of oppression around the neck of women and girls. This book presents feminist therapy as more a philosophical necessity of ethical practice than a theory with clear techniques to be applied.

Family Counseling and Therapy offers a comprehensive discussion of those approaches most widely used today. At the same time, it leaves the reader with a sense of what this all means in terms of real-world implications. The chapter on ethics helps the reader conceptualize how to apply therapy most responsibly. The current edition is an excellent resource for any family therapist, student, researcher, or instructor of family therapy.

Mark D. Register *is a counseling psychology Ph.D. student at the University of Georgia.*

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101 Interventions in Family Therapy (1993). Thorana Nelson and Terry Trepper (Eds.), New York: Haworth Press, 428 pages, $49.95. Reviewed by Bill C. Greenwalt

I must admit that I had seen Nelson and Trepper's book numerous times in the past. My immediate reaction was to discard the book as another "easy" approach to doing therapy: Just learn a few easy techniques and you, too, can be a master therapist. Often, new therapists want a quick answer to difficult cases. My thought was that this book was reaching out to that group of people in an effort to make a quick buck. Imagine my surprise when I opened the package and found this book to review. I prepared myself to write a stinging review emphasizing that therapy is more than a collection of techniques. I may write such a review, but not for this book.

Looking at the table of contents, one is struck by the quality of the contributors; people considered leaders in the field and highly respected authors and presenters joined in a project to provide therapists with what the contributors considered one of their favorite techniques. Some wrote alone whereas others wrote with a group of colleagues on some technique they had developed collectively. Although the editors provided guidelines for writing about the technique, not all of the contributors followed those guidelines, choosing instead to present the intervention in their own way. Fortunately for the editors, this results in a book more easily read because of the varied presentations.

In the Foreword, Kenneth Hardy refers to the book as a "smorgasbord of therapeutic techniques and interventions." This is a very fitting description of the collection of interventions. One can find a wide variety of techniques to use in routine and unusual cases. This is not a collection of gimmicks or quick fixes but a presentation of reasoned client interventions. Most contributors placed the intervention within a theoretical framework, explaining why the technique led to change in the client. The manner in which this is done can be beneficial in teaching beginning therapists the role that theory plays in the selection or framing of interventions. Therapists can then reframe the technique to fit their own working theory and client situation.

The book clearly reflects the varied approaches used within the mental health field. Some interventions are more appropriate for particular therapeutic theories and would not be selected for use by therapists working out of a different theory. In other words, one can expect to pick and choose without having to agree with all contributors to find the book extremely valuable. The richness of the variety results in something for everyone. How many of the interventions would be used by an individual therapist would vary considerably. One has to decide how a particular technique would fit with one's own approach to therapy. The information is made available, but it is up to the clinician to integrate it into his or her own work. Some may have more difficulty doing this than others, because the book does not address this particular issue. Perhaps the editors in another edition of the book should consider a couple of chapters on integrating interventions into different theoretical approaches.

No attempt was made to classify the interventions into categories. This may be a shortcoming. The reader must read through all of the techniques in order to find anything. This is not a book to pull off of the shelf to look for something to resolve a particular problem with a client. Instead, therapists add to their total collection of knowledge and can then return to the book for a refresher on the basic concepts or pull it out of their mental data bank of possible choices when faced with the client. In either case, the book will probably be read and reread a number of times.

The book is a very useful addition to any clinical library to be used by practicing clinicians or to be used by students learning the art of therapy. The book is well worth the time to read. In fact, if one enjoys reading short stories, it is an exceptionally easy book to read, and the knowledge gained can be very worthwhile.

Bill C. Greenwalt*, Ed.D. is an assistant professor at Western Kentucky University, teaching Marriage and Family Therapy courses in the Department of Counseling Programs.*

Treating Nonoffending Parents in Child Sexual Abuse Cases (with *Connections Workbook*) (2001). Jill S. Levenson and John S. Morin, Thousand Oaks, CA: Sage Publications, $37.95 (paperback). Reviewed by Karen C. Billette

Authors Jill S. Levenson and John S. Morin have chosen to address a subject that many people would rather not think about. In their book, *Treating Nonoffending Parents in Sexual Abuse Cases (Connections for Family Safety)* and accompanying workbook, the authors attempt to deal with the reality of child sexual abuse in society. As pointed out in the book, child sexual offenders often become a part of relationships in which children are involved. The books both deal very concisely and realistically with this scenario. What do adults have to know and do to keep children safe from a child sex offender who has served his or her prison sentence?

A real strength of this book and workbook are the practical applications. There are many checklists, specific instructions, charts, and graphs to give information to the family dealing with these issues. The book is presented with many cautions for the family as well. For example, one section is devoted to whether reunification can even be attempted. This also applies to new relationships in which the adults are considering being together and there are children involved. The authors state numerous times that the offender must pass a lie detector test and the family must go through the stages of therapy for even a chance of success in this situation.

Although the book is very well written and the guidelines are very clear, one concern is that the workbook is not very family-friendly. The workbook is actually what the nonoffending parent will be working through, and it contains much jargon. This is a problem because the workbook is intended for use by average people. For example, one page states, "In *Connections*, you will learn to identify the behavioral, physical, and emotional indicators of sexual abuse in children." This phrasing would have to be explained to many people who might not be familiar with psychological terms. Much of the workbook is written in this type of language. The exercises, checklists, and information are excellent, but need to be communicated to the general population much more effectively.

Overall, the book and the workbook fill a very realistic need in the therapeutic community. Many people would prefer to ignore this issue. However, this position could produce even more child abuse victims. Any attempt to prevent child abuse through therapy and support for the families is admirable. The book and accompanying workbook are a positive and informative addition for therapists working with child abuse victims and their families.

Karen Billette *is a licensed school counselor and teacher currently working with English as a Second Language students in the Portland, Oregon area.*

Basic concepts in family therapy: An introductory text (2nd ed.). (2000). Linda Berg-Cross (Ed.), New York: Haworth Press. Reviewed by Bob Bertolino, Ph.D.

In the update to her original edition of *Basic Concepts in Family Therapy: An Introductory Text*, Linda Berg-Cross has strengthened an already well-written book. Whereas most texts on family therapy provide overviews of traditional theoretical perspectives, Berg-Cross has focused on specific concepts and how they interrelate with "relevant ideas of individual theorists." In sum, this book is chock-full of important and useful concepts for understanding families.

The 600-plus page text is divided into six units. Each unit addresses an important area of study in family therapy. Unit One is "Getting Acquainted With the Family." In this section the family structure is explored. Unit Two, "Family Concepts—A Systems Perspective," delves into topics such as individuation, separation, cutoffs, triangles, rituals, and secrets. "Family Concepts—Ecological Stressors" follows. In this unit, family resiliency and poverty, chronic illness in children, and adoption and infertility are addressed. Unit Four is "Family Concepts—A Cognitive Perspective." Topics covered in this section include communication styles, problem solving, and family productivity. "Family Concepts—A Sibling Perspective" is the fifth unit. In this section birth order and sibling relationships are explored. The final unit is "Family Concepts—A Social Psychological Perspective." Attribution, equity theory, reactance, and cultural influences are just some of the concepts explored in this closing unit.

Each unit and chapter is clearly written in a smooth, conversational style. In addition, there are numerous case examples that are referred to as diaries. These diaries serve as illustrations that help to clarify the concepts discussed. Another wonderful aspect of this text is the inclusion of a bibliography at the end. This thorough resource offers suggestions for further reading and even has some film recommendations.

This is an excellent book for instructors, professionals, and students. As a graduate text, it would fit nicely as an adjunct to other texts that give overviews but discuss few concepts in depth or at length. It could also be used as a primary text for family studies–type courses. The possibilities for this book are numerous. But perhaps the best compliment this reviewer has to offer is that Berg-Cross has embedded her words in human experience. She engages readers at an experiential level, allowing the concepts to come alive. In essence, this book is more than just a regurgitation of previously written-about ideas and concepts.

Bob Bertolino*, Ph.D., is the assistant director of early childhood programs at Youth In Need, Inc., in St. Charles, Missouri. He is also founder of Therapeutic Collaborations Consultation and Training and an assistant adjunct professor at several St. Louis–area universities. Dr. Bertolino has*

authored or coauthored seven books, including Therapy with Troubled Teenagers: Rewriting Young Lives in Progress and the forthcoming Collaborative, Competency-Based Counseling and Therapy. He teaches workshops nationally and internationally on collaborative, competency-based approaches to psychotherapy and clinical hypnosis.

Stepfamily Realities: How to Overcome Difficulties and Have a Happy Family (1994). Margaret Newman, Oakland, CA: New Harbinger Publications, 257 pages, $16.95. Reviewed by Donald A. Strano

Margaret Newman draws upon her experience as a clinician in an attempt to present information that will help stepfamilies understand what lies behind many common difficulties. Her stated intention is to provide some practical solutions to the challenges faced by members of stepfamilies. The Introduction indicates that this book is written for people contemplating leaving a first marriage or in second marriages (or beyond) as well as children and extended family members. It is suggested that the book presents explanations (realities) of life in a stepfamily as well as the skills necessary to learn to deal with those realities.

The chapters in this book can be divided into two broad sections. The first deals with issues related to understanding family life (e.g., individual differences in families, separateness in families, boundaries, habits, attitudes and rituals, emotions, family rules, jealousy, and birth order). The second broad area addresses ways to deal with various family issues (e.g., discipline, balancing roles and maintaining a homeostasis within the family, incorporating new children, sexuality, money, and communication).

The subject matter is important—additional resources are always needed by clinicians. Drawing on her practical experience, the author presents information that she has been sharing with clients through her practice. A strength of this work is the use of client stories to illustrate various points. Chapter titles are also engaging, posed as client statements (e.g., "This Isn't What I Expected," and "Mom, Can't You Leave Him Alone?") and dealing with important topics such as discipline and family rules. In several cases, the author touches on extremely important issues for stepparents such as not having the opportunity to develop cooperative parenting styles over time. However, in this case as in much of the book, the author leaves much territory unexplored.

Starting with the title, this book seems to suggest a singular reality and operates from a stance that suggests that problems are the norm. There is a frequent focus on what does not work, spending a lot of time on what not to do. The reader gets what Insoo Kim Berg (DeJong & Berg, 1998) refers to as a problem-saturated story. Although the last chapter does deal with a story of successful family life, it is only seven pages out of the entire book. The author also indicates that she draws on 40 years of research. However, there is no reference to any research or any summary of findings in the text. Although this is clearly a book written for a broad audience and not a scholarly summary of research, substantiating assertions would lend credibility to the work.

Theorists such as Adler, Bowen, and Leary are acknowledged as sources of information for this work. However, there is no consistent theoretical foundation for the book. Although there is a very brief discussion of genograms and a short chapter on birth order, most of the text seems to ignore theoretical considerations, presenting no consistent theme. Even the focus on stepfamilies does not seem to hold the chapters together, with much of the information being applicable to family life in general. Specifically, the chapter on discipline appears to be contradictory to Adler's theory—at least as interpreted by Dreikurs (Dreikurs & Soltz, 1964). Also, the accuracy of some assertions should be questioned (e.g., describing punishment as negative reinforcement), again pointing to the lack of a clear theoretical foundation.

One value of this kind of book is for a practitioner to extend his or her work beyond the office. This book does not appear to contribute much in this manner. Readers with no experience in counseling may benefit from the information presented. The later chapters present general parenting and communication skills that could be useful. However, it is a concern that the chapter addressing discipline is titled "You're Not My Father." Although the content of the chapter does not appear to, this title seems to support gender stereotypes of family roles.

REFERENCES

DeJong, P., & Berg, I. K. (1998). *Interviewing for solutions*. Pacific Grove, CA: Brooks/Cole.

Dreikurs, R., & Soltz, V. (1964). *Children: The challenge*. New York: Hawthorn Books.

***Donald A. Strano**, Ed.D., NCC, is an assistant professor and graduate coordinator in the Department of Counseling and Educational Psychology at Slippery Rock University. He has also worked in a number of clinical settings as a counselor and psychologist.*

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