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**New Zealand and Australian Marriage and  
Family Therapy Practitioners: Paradigm  
Adherence, Practitioner Profiles and  
Clinical Practice**

A thesis presented in partial fulfillment of the requirements for the degree  
of Master of Arts in Psychology at Massey University

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## ABSTRACT

A partial replication of a study conducted in the United States (Booth, 1996) on the theoretical perspectives of marriage and family practitioners using the Paradigm Adherence Scale (PAS), and a survey on demographic characteristics and clinical practice were conducted with New Zealand and Australian marriage and family therapy practitioners. The PAS measures adherence to the three main paradigms associated with marriage and family therapy (psychological, systems and social constructionist). The Australasian marriage and family therapy practitioners in the sample (N=88) were slightly more females than males, mainly middle-aged (48.6 years), and engaged equally in both private and public practices. Participants came from a diversity of mental health disciplines including social work, psychology, counselling and psychotherapy. They had been practising marriage and family therapy for 11.69 years on average, conducting short-term therapy (an average of 9.45 sessions) and treating a wide range of serious problems. Results from the PAS indicated that the largest proportions of participants adhered primarily to a combination of the three paradigms (43.2%) or to a social constructionist paradigm (39.8%). It was found that both the post-graduate and current or most recent supervisors' preferred paradigm predict participants' strength of adherence to a particular paradigm. Some methodological limitations were discussed. The study provided interesting insights into the training and practice of New Zealand and Australian practitioners and provides a baseline for future research, making it possible to describe the developments of marriage and family therapy in Australasia.

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## CHAPTER 1

### Introduction

Family therapy in Australia and New Zealand is rich and diverse. As Michael Durrant (1994) mentions, family therapy in Australia and New Zealand has developed over a period of 20 years in a variety of locations and with a variety of influences. Amongst these influences were international movements in child welfare, the emergence of humanistic psychology, the therapeutic community movement and the growth of marriage guidance agencies. Clearly, no single person introduced family therapy to Australasia. Many schools of thought particularly in the United States of America (USA), Canada, Britain and Italy influenced it, and it was shaped by the distinctive and diverse social and cultural context of both Australia and New Zealand. Thus, it is fair to state that the emergence of this field has been carefully scrutinised by an environment of self-awareness in which consideration of socio-political factors such as gender, violence, politics, and culture have proven paramount.

This phenomenon is best explained by Stagoll (1982, cited in Durrant, p. 15) "... family therapy in Australia must look carefully at where it fits into Australian society. A therapy which does not deeply explore and confront its relationships with its culture will inevitably become, at best, ineffective and at worst, oppressive and a part of the very problem it seeks to overcome".

In addition, Charles Waldegrave (1998) founder of the Family Centre in Lower Hutt New Zealand postulates, “ Cultures are all about the meanings people give events. They raise issues that are critical for psychologists, such as identity and belonging. Our experience at the Family Centre- an organisation that is structured along cultural lines, in the fields of family therapy, community development, social policy research, and education- has led to much new learning. We do our work within three cultural sections, Maori, Pacific Island, and Pakeha (European); each section is staffed primarily by workers from a particular culture” (p. 400).

With these antecedents it is no surprise that there is no single approach to practising, as a marriage and family therapist (MFT), in New Zealand and Australia. Professionals practising within this field come from a wide variety of academic backgrounds and use a broad range of theories and intervention techniques. Throughout the past 50 years, MFT worldwide has taken many twists and turns and has developed into a broad range of methods for working with families with various biopsychosocial difficulties. Within family therapy there is a extensive variety of views concerning what issues are appropriately addressed by family therapy; who defines these problems; what constitutes family therapy practice; what type of theoretical rationale informs these practices and what type of research supports the validity of these practices (Carr, 2000).

Several studies conducted by Bor, Mallandian and Vetere (1998), Doherty and Simmons (1996), Simmons and Doherty (1995, 1998) and Nelson and Palmer (2001) on the clinical



practice patterns of marriage and family therapists (MFTs) in the USA and the United Kingdom have begun to construct a professional practice profile. In each study clinical members of the American Association of Marriage and Family Therapy (AAMFT) or the United Kingdom Association of Family Therapists (AFT) were surveyed regarding demographic characteristics, educational background and practice related characteristics. In 1996 Booth (Booth & Cottone, 2000) took a different approach and assessed the theoretical perspectives of marriage and family therapists by devising a scale (Paradigm Adherence Scale) which measures practitioners' adherence to a specific paradigm associated with family therapy.

However, no studies in Australia or New Zealand have documented the professional practice of marriage and family therapists (MFTs). A partial replication of Booth's (1996) study conducted in the USA and a comparison between the present study and the aforementioned studies has been conducted as means of verifying similarities and unique aspects of MFTs and their practice in Australasia. Therefore the current study focuses on achieving an understanding of the idiosyncrasies of MFT practice and the major theoretical frameworks informing clinical practice within Australia and New Zealand. This study also reviews the research literature on paradigm adherence by MFTs and highlights the trajectory of theoretical perspectives which have informed clinical practice to the present.

Two surveys of MFT, conducted in the mid 1970s in the USA by Everett (1980) and Sprenkle, Keeney and Sutton (1982), found that members of the AAMFT reported being more influenced and oriented to individual and psychodynamic approaches in their practice, than by systems approaches. On the other hand, similar studies conducted in the mid 1980's (Nichols, Nichols & Hardy, 1990; Wetchler, 1988) found that more therapists reported their primary clinical orientation as one of systems, rather than psychodynamic theories. Simmons and Doherty's (1995) Minnesota study of MFTs found that therapists who received academic training in a marriage and family therapy program had a more systemic orientation. This was evidenced by a tendency to conceptualise problems at the family and larger systems level rather than at an individual level.

Similarly, the survey of clinical members of the AAMFT conducted by Booth in 1996 reported that a majority of therapists were primarily adhering to the systems paradigm (43.6%) or practising from a combination of paradigms (42.2%). However, the newer social constructionist approaches were being used by a smaller but significant percentage of therapists (13.7%). Furthermore, nearly half of the therapists in the paradigm combination group chose responses indicating adherence to both systems and social constructionist philosophies.

These findings coincide with the rapid growth of post-modernism, specifically social constructionist approaches, and changes in the field during the 1990s. Social constructionist theories emerged out of criticisms of traditional family systems paradigms (Hoffman, 1988). The tenets of this newer approach reflect a new epistemology for

mental health and marriage and family therapy professionals. These include ideas about reality as socially constructed, the central role of language and meanings in therapy, the socio-political and cultural context of problems, and the importance of collaborative and consensus-building processes in therapy (McGoldrick, 1998; McNamee & Gergen, 1992; White & Epston, 1992; Waldegrave & Tamasese, 1993).

Therapies reflective of social constructionist thought are usually discussed within the metaphors of conversation, dialogue, narrative, consensus, and meaning. The client may be an individual, a whole family, or varying groups of family members and other significant persons. The focus of therapy is placed on client's strengths and new ways of interpreting their life. Some proponents of this approach are Anderson and Goolishian (1988; 1990), Cecchin (1992), de Shazer (1991), Hoffman (1988; 1990; 1991), O'Hanlon (1992), and White and Epston (1990).

Of particular interest to this research is the important contribution of Michael White and David Epston's Narrative therapy to Australia and New Zealand practice (1990; 1992). Payne (1999) described Narrative therapy as built around two organizing metaphors, personal narratives and social constructions. Narrative therapy emphasizes the detachment from unhelpful stories by externalizing problems. By challenging fixed and pessimistic versions of experiences, therapists make room for flexibility and hope. Uncovering unique outcomes provides an opening through which new and more optimistic stories can be envisioned.

Clearly, this approach has generated a great deal of awareness of family therapy as a beneficial treatment modality. The large numbers of publications in reputable journals and newsletters are evidences of its acceptance locally, as well as internationally. For example, the *Australian and New Zealand Journal of Family Therapy* (Flaskas, 1995, 1999), *The Dulwich Centre Newsletter* (Adelaide, 2000; White, 2001), *Family Process* (Strand, 1997) and the *Journal of Marital and Family Therapy* (Minuchin, 1998; Sulzki, 1998), to name a few have recently published articles on Narrative therapy and have ongoing debates about its implications to practice. In addition, the Dulwich Centre is currently advertising workshops and training opportunities, and has issued the inaugural edition of *The International Journal of Narrative Therapy and Community Work* (Dulwich Center, 2002) with contributions by Monica McGoldrick, Charles Waldegrave, and Karl Tomm, among others. This approach will be addressed further in the following section.

Now that social constructionist therapies are taking centre stage in the family therapy literature, it seems timely to examine to what extent New Zealanders and Australians are using this approach in their practice. It is also necessary to explore how practice under this new paradigm compares to the more traditional psychological and systemic paradigms. In other words, this study takes up the task of organising and clarifying the assumptions outlining MFT practice in Australasia.

Considering that practice must be informed by research in order to provide the most effective and efficient services, it is essential to differentiate between various theories and therapies available today (Bergin & Garfield 1994; Piercy & Sprenkle, 1990). Evolving paradigms must, therefore, be examined for their usefulness and validity in particular areas. Also, to gain a better understanding of current trends, information about the prevalence of a particular paradigm employed by practitioners, as well as its core characteristics, is necessary. For informed choices to be made, it is paramount to demonstrating the viability of various treatment modalities to health care professionals, consumers and trainees, as well as the options available to them.

Most research examining the clinical practice of MFTs and comparing therapists across disciplines has focused on the outcome of therapy (Dunn & Schwebel, 1995; Pinsof & Wynne, 1995; Pinsof, Wynne & Hambright, 1996; Shadish, Ragsdale, Glaser & Montgomery, 1996). Only recently, has the process of what actually takes place during the course of family therapy been addressed (Alexander, Holtzworth-Munroe & Jameson, 1994; Piercy & Sprenkle, 1990). Research which disseminates clear ideas regarding who clinicians are and what happens in the “real world” of clinical practice, is still scarce.

In contrast, the focus of this study is not directed at client satisfaction but relies instead on practitioner’s accounts of their own practice, training and supervisory experiences. Aspects of studies conducted by Booth & Cottone (2000) Doherty and Simmons (1996), Nelson & Palmer, (2001) and Simmons and Doherty, (1995, 1998), have served as

guidelines for the current study. Questions on demographic information have been extracted from these studies and adapted to the Australasian population. As well, Booth's Paradigm Adherence Scale (PAS) has been used to gain specific information on techniques and interventions employed in clinical practice.

The present study's significance lies in the fact that different academic and clinical training requirements (e.g., course work, theoretical orientation, supervisory requirements and internship requirements), evident throughout diverse training institutes in Australasia (Australian and New Zealand Journal of Family Therapy, 2000; Cantwell & Holmes, 1994), may be associated with different approaches in areas of clinical practice. These include the manner in which presenting problems are conceptualised, diagnostic practices or a philosophy of non-diagnosis, length of treatment, as well as primary mode of practice, to name a few. In other words, when comparing Australasian professionals with their counterparts in USA and the United Kingdom, it is useful to note clinical practice differences and similarities, as well as to link these findings with previous research.

### **Research Aims**

Due to lack of published information about what characteristics influence the actual practice of therapists in New Zealand and Australia, the first part of this study was descriptive. It aimed at understanding the characteristics and clinical practice of MFT in

Australasia and at comparing them to North American and British practice. In order to address these issues the following research questions have been formulated:

Who are Australian and New Zealand MFT practitioners?

What level of training have they received?

What professions comprise MFT practitioners?

In which setting are they primarily employed?

How long have MFTs been in clinical practice and how long have they been working in MFT?

How long do they engage in treatment?

How much weekly contact do they have with clients and what is their active caseload?

What are the presenting problems most frequently seen?

What are the most frequent disorders treated?

What client populations do they feel confident treating?

What training experience do practitioners have and what MFT approach did supervisors prefer?

The second part of this research was aimed at determining which paradigm professionals currently practising MFT favour. It also explored the relationship between paradigm preference and supervisory experiences.

## CHAPTER 2

This chapter highlights main events that took part in the development of marriage and family therapy to date. A historical review of the evolution of family therapy will be outlined, leading into the major paradigms in family therapy.

### Historical Overview

Family therapy first emerged in the 1950s in a number of different countries, and within the contexts of a variety of different movements, disciplines, research and therapeutic traditions. Some of the pivotal events that shifted the view of life problems from an individual to a systemic perspective, include the child guidance movements and the marriage counselling movement; social work; psychiatry and clinical psychology practices; the studies of small group dynamics; the etiology of schizophrenia; the general systems theories and cybernetics (Broderick & Schraeder, 1991; Nichols, 1992).

The earliest approaches to psychotherapy prevalent in the 20<sup>th</sup> century focused on individual therapy and the patient-therapist relationship as the best way to treat psychological problems. Human problems were intrapersonal; therefore patients were separated from their families for treatment based on their individual symptomatic behaviours. Family therapy emerged as an alternative to the more traditional (individual based), limited ways of thinking about and treating specific syndromes, specially the



treatment of children and adolescents (Alexander & Parson, 1982; Haley, 1973; Minuchin, 1974). This new contextual perspective proposed that psychological problems were developed and maintained within the social context of the family. As a result the focus of treatment was redirected from the internal world of the individual patient to the entire family system.

In the 1950s and 1960s, psychodynamic, client-centered and biomedical individually focused interventions dominated mainstream mental-health practice. These models advocated a causal, linear model of understanding human illness that emphasised internal dysfunction, but failed to recognise the reciprocal nature of interpersonal relations (Nichols & Schwartz, 2001). In opposition, family therapy proposed that psychological problems were best explained by circular, recursive events which focused on the mutually influential and interpersonal context in which they developed (Bateson, 1972).

Family therapy evolved within the child guidance clinics when experimental conjoint interviews, involving parents and children, began to be held. Through similar experiments John Bowlby in London and John Bell in the USA, determined that a child's symptoms were usually a function of emotional distress within the family (Kaslow, 1984). Marriage counselling also contributed to the development of family therapy, when in the 1930's psychoanalysts (e.g., Oberndorf) recognised the advantages of treating married couples in conjoint sessions. Later, Nathaniel Ackerman agreed that the

simultaneous treatment of married couples was a good idea and suggested that mothers and children could benefit from being treated together (Ackerman, 1966; Kaslow, 1984).

Social work, psychiatry and clinical psychology independently made significant contributions to family therapy. Social workers often visited families in their homes and were trained to interview each family member to gain understanding of the family's problems. Many prominent family therapists were initially trained in social work, and their family oriented background contributed generously to the development of marriage and family therapy. These include Virginia Satir, Lynn Hoffman and Monica McGoldrick in the USA; and Michael White in Australia. Within psychiatry, Alfred Adler and Harry Stack Sullivan's work emphasised the importance of fragmented family relationships in the development and maintenance of symptomatic behaviours. Whereas in clinical psychology the involvement of parents in behaviour therapy programmes with their children and the application of the principles of social learning theory, laid the foundations for the development of family therapy (Broderick & Schraeder, 1991).

Group dynamics have also been relevant to family therapy because group life is a complex blend of individual personalities and the underlying properties of the group. During the 1920s, social psychologists studied small group dynamics in order to understand political problems, group structure and group boundaries. Empirical research conducted by Kurt Lewin in the 1950s led to the conceptualisation that a group is more than the sum of its parts. He suggested that group discussions are superior to individual

instructions or lecturing, for changing ideas and behaviour. This finding emphasised that conjoint family meetings might be more effective than separate meetings with individuals (Nichols & Schwartz, 2001).

Two important concepts of small group dynamics are the distinction between process and content of group discussions, and role theory. Therapists needed to understand not only what was said (content), but also how these ideas were communicated (process). It was believed that by focusing on the process of interrelating, therapists could help families improve the way they related and thus enhance their own capacity to deal with the content of their problems (Carr, 2000). Virginia Satir (1972) expanded on the concept of how individuals behave and communicate in groups by describing several family roles, which served to stabilise expected characteristic behaviour patterns in a family. Other forms of group dynamics that also contributed to family therapy include psychodrama and gestalt therapy. In Moreno's (1945) psychodrama clients are encouraged to act out their conflicts instead of discussing them. Whereas Perls' (1961) gestalt therapy allows clients to address two sides of a dilemma or deal with unfinished emotional business in instances where the other party is unavailable or deceased.

By highlighting the role of family dynamics in the aetiology and maintenance of abnormal behaviour, scientific research into the familial origins of schizophrenia also contributed to the emergence of family therapy. In the 1940s and 1950s Bateson in Palo Alto, Lidz at Yale, and Bowen at the National Institute of Mental Health conducted

research on families with schizophrenic members. Their studies provided insights into family dynamics and communication processes.

Gregory Bateson (1972) along with Jay Haley, John Weakland, John Fry and Don Jackson developed the schizophrenia project in Palo Alto, and made significant contributions to the development of family therapy (Bateson, Jackson, Haley & Weakland, 1956). These contributions consisted of the double-bind theory of schizophrenia and the conceptualisation of communication as a multilevel process. In addition, their conceptualization of general systems theory and cybernetics served as a guideline for understanding family organisation and processes (e.g., Bateson, 1978; Haley, 1973; Jackson, 1967).

The double-bind theory was particularly significant because it offered a complex yet logical explanation of the links between family process and abnormal behaviour, highlighting the occurrences of simultaneous communications at multiple levels. Although many of the assumptions about the family's role in schizophrenia later proved to be incorrect, these researches resulted in some of the earliest observations of communication and organisation of families (Nichols and Schwartz, 2001).

Another assumption of the Palo Alto group was that general systems theory, along with cybernetics, could offer a framework within which to conceptualise family organisation and process, thus offering an explanation for abnormal behaviour (Gurman & Kniskern,

1991; Nichols & Schwartz, 2001). General systems theory addresses Lewin's idea and questions "How is it that the whole is more than the sum of its parts?" while Cybernetics attends to the question: "How do systems use feedback to remain stable or to adapt to new circumstances?" (Carr, 2000, p.60). These theories, when applied to family therapy, suggested that the family is a system with semi-permeable boundaries that is organised into subsystems capable of using negative and positive feedback to promote stability and change.

Along with the aforementioned theories, psychodynamic theories, experiential theories, cognitive/behavioural theories, communication models, intergenerational models, feminist contributions and postmodern approaches, are amongst the most influential theories or "schools of thought" in the development of family therapy to date. In the following chapter some of these theories will be discussed within the three main paradigms associated with marriage and family therapy.

## CHAPTER 3

### Major Paradigms in Family Therapy

As discussed previously, marriage and family therapy developed from many schools and traditions, and uses a wide range of intervention techniques. Different authors have classified these “schools” to create a better understanding of the circumstances of their development and to help identify the similarities and differences among them (e.g., Booth & Cottone, 2000; Cottone, 1989, 1992; Goldenberg & Goldenberg, 2000; Madanes & Haley, 1977; Nichols & Schwartz, 2001). Booth and Cottone (2000; Cottone, 1992) proposed the classification of marriage and family therapy into three main paradigms. These include the psychological, the systems and the social constructionist paradigms and will be addressed below with respect to their theoretical frameworks and their therapeutic practices. The three paradigms will underpin core literature considered for the current study.

Booth and Cottone (2000) identify the characteristics of these three paradigms as follows: Firstly the " psychological paradigm focuses on the individual and intrapersonal dynamics; historical perspectives used to assess and assign diagnosis; and insight (cognitive or affective) viewed as precursors to change". Secondly the "systems paradigm focuses on the family's interpersonal interaction; encourages a present and future-oriented

focus; attempts to resolve relationship problems; avoids psychiatric diagnostic labels; and views symptoms presented as indicating dysfunction in the family". Finally the "Social constructionist paradigm focuses on conversation, dialogue, narrative, consensus, and meaning; on the awareness of social and cultural processes in defining problems; emphasises the importance of a collaborative process in therapy, on relying on the family's strengths" (p. 330).

### **Psychological Paradigm**

Cottone (1992) postulates that psychological thinking reflects a cause and effect perspective in which personal problems are assumed to result from specific antecedent characteristics in the environment of the person seeking treatment. He states that the main theoretical assumptions underlying the psychological paradigm include placing the main focus of attention on the individual and intrapersonal dynamics, as well as assessing and diagnosing individuals in order to find the cause of the problem. Thereafter, problems can be identified, studied and modified directly. In other words, therapeutic change is seen to occur through some modification of a client's thoughts, feelings or behaviours. As Booth (1996) mentions, therapeutic strategies under this paradigm are directed toward internal or external processes affecting the individual.

For example, behavioural models of family therapy attempt to bring scientific methods into practice by developing regularly monitored, data-based intervention procedures.

Personal functioning is viewed as the result of continuous, reciprocal interaction between behaviour and its controlling social conditions. Therefore, cognitive-behavioural therapists attempt to increase positive interactions between family members, alter the environmental conditions that oppose such interactions, and train people to maintain their newly acquired positive behavioural changes (Baucom & Epstein, 1990). Some specific therapies that derive from cognitive-behavioural theories include behavioural couple therapy, behavioural parent training, functional family therapy, and the conjoint treatment of sexual dysfunction. Proper assessment plays a key role in all of these efforts inclusive of identifying the problem, measuring progress and validating change (Alexander & Parsons, 1982; Dattilio, 1998).

Therapists adopting a psychological approach may see clients in individual therapy or marriage and family therapy. Thus, a therapist meeting with a couple or family may be employing psychological or individually oriented assumptions and techniques in therapy. These approaches may then arrive at a singular family diagnosis, sustained by a DSM-IV like procedures, which is linked to a curative mode of treatment. The practice of which is based on empirical research (Denton, Patterson & Van Meir, 1997; Tomm & Sanders, 1983).

Some other specific models of therapy reflective of the psychological paradigm are rational-emotive, client-centred, Gestalt, and psychodynamic. Authors pertaining to these tenets include but are not limited to Ackerman (1966), Boszormenyi-Nagy and Spark



(1973) Framo (1976; 1992), Rogers (1980) object relations proponent Fairburn (1954) and psychoanalyst Meissner (1981).

### **Systems Paradigm**

Systems theories began to blossom in the 1960s and flourished in the 1970s changing the focus from the individual and individual problems to the family system. As a direct challenge to the medical and psychological treatment philosophies, the systems paradigm practitioners focus on relationships issues (Cottone, 1992). Some of the characteristics of the systems paradigm include change occurring through social relationships in specific contexts. The causes of clients' problems are seen as being non-linear and reciprocal.

Some specific models of therapy reflective of the systems paradigm include: strategic family therapy, Mental Research Institute's (MRI) brief therapy, structural family therapy and systemic family therapy. The systems paradigm's main focus lies in identifying problem-maintaining behavioural patterns, and believes that if the family context changes so will the individual's behaviours.

### **Strategic**

Strategic Family therapy has its roots in the Palo Alto research group led by Bateson. Key figures of the strategic approach include Jay Haley and Cloe Madanes, who believe that a

faulty hierarchy within the family maintains problems (Haley, 1987; Madanes & Haley, 1977). Strategic interventions are generally characterized by the use of specific strategies for addressing family problems and interventions are directly geared toward changing the presenting complaint. Therapy is change-oriented and the therapist is responsible for successful therapeutic outcomes, which are accomplished by the therapist first assessing the cycle of paradoxical directives (Haley, 1987). Strategic therapists focus on present interactions, they do not interpret family member's behaviour or explore the past. Thus, therapy is terminated when presenting problems have ceased (Fish & Piercy, 1987).

### **Mental Research Institute (MRI)**

The principal figures in the MRI tradition include John Weakland, Paul Watzlawick, Robert Fisch and Lynn Segal. The MRI brief approach to family therapy is an integration of Bateson's (1972) ideas on cybernetics and systems theories, Erickson's approach to hypnotherapy and von Foerster's (1981) constructivism (Fisch, Weakland & Segal, 1982).

The main concept of the MRI approach is focused on problem maintaining sequences within an individual. Proponents postulate that ineffective attempts to solve problems eventually come to maintain these problems. Assessment therefore focuses on tracking repetitive behaviour patterns involving problems and ineffective attempted solutions. Tracking is achieved by asking questions in the session and then disrupting problem-maintaining behaviour patterns by assigning homework paradoxically designed to break

up the existing sequence of behaviour. Treatment goals do not involve changing the family, nor do therapists take place much importance on hierarchy. Treatment is limited to an average of 10 sessions (Weakland et al., 1974).

## **Structural**

Structural Family Therapy emerged in the early 1970s and was seen as the most influential model in the MFT field. Salvador Minuchin (1974), the primary advocate of this approach, described families as having an underlying organisation in terms that provide clear guidelines for diagnosis and treatment. The most important tenet of his theory suggests that every family has a structure that is revealed only when the family is in action. Structural therapy is characterised by its emphasis on organisational issues and the main goals of therapy include correcting dysfunctional hierarchies by clearing boundaries between parent and child (Colapinto, 1991). Structural therapy involves promoting a healthy structure by modifying the way people relate to one another and it is finalised once the family structure is altered in a way it can maintain itself without the use of the presenting problem (Fish & Piercy, 1987).

## **Milan Systemic**

The original Milan team comprised Selvini Palazzoli, Boscolo, Cecchin and Prata (1978). Milan systemic family therapy is similar to the strategic and MRI approaches, as the

works of Bateson also influenced it. The Milan team presented a model in which problems were viewed as being maintained by interactional patterns, and individual symptoms were seen as maintained by family homeostasis. To counteract this resistance to change, the team relied on paradoxical interventions. They identified three fundamental interviewing guidelines for therapy, hypothesising, circularity, and neutrality, which are used to shape the structure of the therapeutic process (Selvini Palazzoli et al., 1980). These include the intake procedure, the number and frequency of sessions, the nature of between-session contacts, and responses to a lack of therapeutic progress (Tomm, 1984).

### **Summary**

The approaches to therapy addressed above are reflective of Cottone's (1992) systemic-relational paradigm. In these approaches a reciprocal causality prevails a linear one. The focus is placed on the interpersonal and contextual influences of people's actions, and on identifying and disrupting problem-maintaining interaction patterns. Treatment is brief, and the main treatment goal is the resolution of the presenting problem.

### **Social Constructionist Paradigm**

The 1980s and 1990s saw family therapy undergo a gradual but dramatic transformation. Family therapy literature was influenced by philosophy, biology, psychology, linguistics and feminist studies which challenged the main tenets of the traditional systems model, resulting in a paradigmatic shift (Hoffman, 2002). This newer movement defined as postmodernism is not interested in psychodiagnostic labels nor does it preoccupy itself with intrapsychic issues. Instead the 'new epistemology' of the marriage and family therapy paradigm is concerned with issues of knowledge, power, control, and objectivity (Hoffman, 1985).

Many references in recent family therapy literature allude to the paradigmatic shift from a modernist model to post-modern metaphors (Wieling & Negretti, Strokes, Kimball, et al., 2001; Doherty, 1991). Modernism is the idea that autonomous subjects, through reason and science, attain objective knowledge of a reality and discover lasting truths about the world. In family therapy this translates into the search for an essential theory of family functioning, such as the cybernetic-systems model (Hoffman, 1985).

Post-modernism responds to the questions of ontology and epistemology by denying that a real world can be known through an objective lens. This theory also denies that the world can be understood outside texts, language and social discourse about it (Docherty, 1993). Post-modern thinkers employ the construct of constructivism to emphasise the

subjective construction of reality. They also believe that people's knowledge of the world derives from their own creating, ordering, constructing, and giving meaning to what people experience. The main focuses are placed on multiple perspectives and realities, the social, political, and historical forces shaping people's conceptions of reality, and the constantly changing nature of human beings (Doherty, 1991).

With the post-modern assumption "there are no realities only points of view", came an interest in how narratives organising people's lives are generated. Family therapists in the post-modern tradition are constructivists who view therapy as a collaborative process between the therapist and the client. Therapists concern themselves with how people make meaning of their lives and how they construct reality. They participate with the client in deconstructing the universal truth in the story clients bring to therapy and collaborates in constructing a new story which solves problems the dominant story does not (Doherty, 1991).

Post modernism was also greatly influenced by the feminist critique which challenged family therapy tenets such as neutrality, circularity, and the emphasis on family systems at the expense of the individual (Avis, 1985). Feminism has also provoked and supported significant shifts in the therapist/client relationship advocating instead a more equal, collaborative and empathic partnership (Sprinkle & Bischof, 1994). Feminism is also significant because it is one of the few movements within family therapy that has critically examined the values of the society to which family therapists are helping people

to adjust. It has a clear vision of the threats to family life including patriarchy and its consequential oppression that denies women, children, and even men dignity, free choice, and a sense of equality (Avis, 1992, 1996; Hare-Mustin, 1980, 1987)

Post- modern theories have at times been called constructivist, contextual, narrative, reflexive, and second order cybernetics. Although different theoretical ideas are associated with these terms, social construction may be a theoretically more precise term which reflects the idea of this paradigmatic shift (Hoffman, 1990; Sprenkle and Bischof, 1994). In social constructionist theory, problems are conceptualised as stories that people agree to tell themselves and others. White and Epston suggest ‘ what a therapist and client do during the interview is akin to co-authoring and reading a book’ (1991, p 68). This is a revolutionary break from the idea that “... symptoms are the result of some underlying problem, a psychic or structural problem such as incongruent hierarchies, covert parental conflicts, low self esteem, deviant communications, repressed feelings, or “dirt games”...” (de Shazer, 1991; p. 31).

Social Constructionist family therapies are based on the writings of Bateson (1972, 1979), Derrida (1982), Foucault, (1965,1980), Gergen (1985), Maturana and Varela (1980, 1987), Piaget (1952), von Foerster, (1981), von Glaserfeld (1984), Hare-Mustin (1987) and others. As Hoffman states (1990) social constructionism differs from the more biologically oriented term “constructivism”, in that it places more emphasis on social interpretation and the intersubjective influence of language and culture.

## **Constructivism**

Post-modern psychology is interested in how people make meaning in their lives and how they construct reality. Knowledge, its nature and how people come to know, are essential considerations for constructivists. According to von Glasersfeld (1988 p. 86) constructivists view knowledge as actively constructed by people through their interactions with their environment, and although it does not deny the existence of an ontological reality, it denies the human observer the possibility of acquiring a true representation of reality.

Neimeyer & Mahoney, (1993, 1995) describe constructivism as an epistemological perspective that emphasises on the assertion that humans are proactive participants in their own experience. They view human life as an organising processes operating at implicit levels of awareness, and human experience as reflecting the dynamics of individualised, self-organising processes. Therefore, constructivism focuses on the self-organising and proactive features of human knowing and their implication for human change.

In 1984 von Glasersfeld introduced the term “radical constructivism” to the family therapy field sustaining the view that reality results from the relatively durable perceptual and cognitive structures of the knower. The two basic principles of this approach are that



knowledge is actively constructed by the individual and not passively received, and that the function of cognition organises the experiential world rather than seeking to discover ontological reality. The focus on radical constructivism resides on how individuals' "dynamic" cognitions are structurally determined by the nervous system and are continuously producing one's adaptation to the environment (von Glasersfeld, 1988).

Paul Watzlawick, Paul Dell and Lynn Hoffman imported the implication constructivism has into the role of the family therapist. Hoffman (1990,) and explained the role of the therapist as having no presuppositions or set ideas about pathology, dysfunctional structures, and what should be changed. Instead constructivist family therapists have shifted their attention to the process by which families negotiate a common reality.

Constructivist therapists seek to discover what is problematic for each client they serve, problems are viewed in the context in which they are embedded and interpretations of experiences depend on the language used and the meanings attached to them by the client (Efran, Lukens & Lukens, 1988). The interventions that result from this interaction help the client explore possible avenues for movement while respecting the core organising principles on which his or her view of life are constructed. Thus, psychotherapy can be viewed as collaboration in the construction and reconstruction of meaning.

## Social Constructionism

Social constructionist theory and constructivism are comparative in some ways. The idea of an objective truth or knowledge is also challenged and the social or interactional (and thus language-dependent) aspect of self-knowledge and knowledge of the world is emphasized. Social constructionism focuses on the notion of that the individual's realities are multiple and that reality is socially constructed (Anderson & Goolishian, 1990; Gergen, 1985; McNamee & Gergen, 1992). However, Hoffman (1990) suggested that social constructionist theory, as opposed to constructivism, "places far more emphasis on social interpretation and the intersubjective influence of language, family, and culture, and much less on the operations of the nervous system (p. 2). In addition to this, evolving, fluid, and socially-influenced processes of creating meanings are emphasised rather than a fixed model of biologically based cognition" (p. 3).

Social constructionist theories emerged out of criticisms to the traditional family systems paradigm. The tenets of social constructionism reflect a new epistemology for mental health and marriage and family therapy professionals. These include ideas about: reality as socially constructed, the central role of language and meanings in therapy, the socio-political and cultural context of problems, and the importance of collaborative and consensus-building processes in therapy. These tenets imply that therapists grounded in a social constructionist approach, work from a collaborative non-expert stance in which therapy is co-constructed. The therapist focuses on assisting clients understand the

cultural roots of their beliefs and facilitates the exploration of new meaning, thus achieving better outcomes for new solutions (Andersen, 1991; Andersen & Goolishian, 1990; White, 1995; Epston & White, 1992).

Some specific social constructionist therapeutic approaches in which language and meaning take precedence over behavioural sequences or family interactional patterns are: narrative therapy (White & Epston, 1990), the reflecting team approach (Andersen, 1991), solution-oriented therapy (O'Hanlon & Weiner-Davis, 1989), cognitive-consensual therapy (Cottone, 1992), solution-focused therapy (de Shazer, 1991; de Shazer & Berg, 1992), the reflexive stance (Hoffman, 1990, 1991), and the collaborative language systems approach (Anderson, 1994; Anderson & Goolishian, 1988, 1990). Of particular relevance to this study are narrative therapy and the "Just Therapy" approach as well as solution focused brief therapy.

### **Narrative Therapy**

The contributions of Michael White and David Epston's Narrative therapy have had many implications for current practice in the Australasian family therapy field. Narrative therapy is based on the postmodern narrative approach of viewing human interactions from a storied and moral universe. White, Epston and the whole narrative movement have been influenced by Michel Foucault's ideas. White (1991) following Foucault's ideas, stated that " meaning structures and practices are inseparable and related to power"

(p.122). Therefore culture's dominant stories can disempower and objectify individuals in their actions and meanings. Language and telling of relational stories are embedded within a cultural and social context.

Just as the dominant discourses within a culture suppress marginalized voices, the same process occurs within individuals whose self-conception differs from cultural norms (Freedman & Combs, 1996, McGoldrick, 1998). White (1997) challenges therapists to be transparent, to fully own their ideas as perspectives which may be biased by their own race, gender and class, rather than putting them forth as the truth. Narrative therapists try not to make assumptions about people in order to honor each client's unique story and cultural heritage. Therapists are interested in co-authoring with clients new stories about them, emphasizing their preferred ways of relating to themselves and to others. Narrative therapy is a commitment to helping people rewrite the stories of their lives re-envisioning their pasts and rewriting their futures.

In contrast to the more traditional approaches, Narrative therapy encourages therapists to take a collaborative empathetic position and to search for a time in the client's history when he or she was strong or resourceful. This is achieved by using questions, directed at externalizing peoples' problem, and by taking a non-imposing, respectful approach. Spaces are opened for the re authoring of alternative life stories (White, 1989; Zimmerman & Dickerson, 1996).

Among the main contributions of White and Epston's (1994) work in Australia and New Zealand are the "externalization of problems", and the use of therapeutic letters. These are used as mechanisms for assisting families to separate "problem saturated" aspects of their lives and relationships and to address the future and predict continued success in the search for new possibilities. Epston also developed "leagues", or groups of people battling with the same problem as part of a supporting community (Epston et al., 1994; Epston & White, 1992).

In addition to the specific contributions of Narrative therapy, and as a response to post-modern challenges along with an apparent western philosophy based dominant mental health field, Australian and New Zealand therapists have committed to place therapy within a larger sociopolitical and gender context. For example, the 'Just therapy' approach of the Family Center in Lower Hutt New Zealand promotes a therapy which takes into account the gender, cultural, social and economic context of clients. Additionally, this team of therapists has formed gender and cultural caucuses composed of people from dominated groups which they regularly consult regarding matters of therapy or policy (Waldegrave, 1990; Tamasese & Waldegrave, 1993). Therapists see their work as a political enterprise freeing clients from oppressive cultural assumptions and empowering them to become active agents in charge of their own lives.

The previously addressed social constructionist tenets attempt to capture the essence of the second article of the Treaty of Waitangi that confirms Maori rights to self-

determination and autonomy. The main endeavour is to provide culturally just and ethical services to all peoples as made evident by the New Zealand Psychological Society (Love & Whittaker, 1997). Some general guidelines for practice stated by Raymond Nairn and the National Standing Committee on Bicultural Issues (1997, p. 134), suggest that "mental health professionals must be aware of the cultural preconceptions, both those of the discipline and their own, which shape their practice. They must be able to practice within the limits of their competence, in the presence of history with a strong awareness of the social context – its present reality and historical development- and how that impacts on themselves, their client and their relationship".

### **Solution-Focused Brief Therapy**

Steve de Shazer and Insoo Kim Berg, developed solution-focused brief therapy as a pragmatic treatment that emphasises on helping construct solutions rather than solve problems. The main therapeutic task involves helping clients to imagine how they would like things to be different and what it will take to make that happen. Therapists assume clients want to change, have the capacity to envision change, and are doing their best to make change happen. Furthermore, solution-focused therapists assume that the solution, or at least part of it, is already happening (Weiner-Davis, de Shazer, & Gingerich, 1987).

With in this approach little attention is paid to diagnosis, history taking, or exploration of the problem. Instead specific therapeutic techniques include the miracle question, which

asks the client to pretend that a miracle has happened and imagine a solution to the problem (DeJong & Berg, 1998; de Shazer, 1988). A second technique routinely used is the scaling question, which asks the client to rate on a 10-point scale how things are today.

Michael Durrant and Kate Kowalski have established the use of solution-focused approach in Australia. Durrant (1993, 1995) has written about, taught and applied solution-focused and competency based treatments within residential treatment centers, and child welfare. He affirms that the ideas of de Shazer and those of White have influenced him and a number of Australian and New Zealand therapists. Durrant also mentions that the practice of externalising the problem is a useful tool with in his “solution-focused” approach (Durrant, 1994; Eron & Lund, 1996)). This approach is currently used in family service and mental health settings, in public social services and child welfare, in prisons and residential treatment centers as well as in schools and hospitals (Miller, Hubble, & Duncan, 1996).

### **Summary**

Influential theories of family therapy have been reviewed and have been categorized into three main family therapy paradigms (psychological, systems and social constructionist). While approaches have been separated into organizing categories and differences in philosophy about the nature of families and how best to intervene continue to exist

between approaches, these have not developed in a vacuum. The field of marriage and family therapy has undergone a rapid growth, product of distinct and completing theories adapting to the ever-changing society demands. As a result a multiplicity of different theoretical ideas, gives practitioners an abundance of options to choice from. Presently a clear trend exists towards identifying common factor across approaches leading to an integration of family therapy models (Blow & Sprenkle, 2001). Consequently, these approaches are becoming less mutually exclusive. As Broderick and Schraeder (1991) affirm the field is moving into more holistic and comprehensive ways of assessing and intervening with families.



## CHAPTER 4

### Comparative Studies in the Professional Practice of Family Therapy

Bor et al. (1998), Doherty and Simmons (1996), Simmons and Doherty (1995, 1998) and Nelson and Palmer (2001) reported important findings relevant to the present study. In each study family therapy practitioners were surveyed regarding demographic characteristics, educational background and practice related characteristics. These studies main findings were that MFT practices are relatively short-term, especially when compared to individual therapies. As well the studies found that MFT treats a wide range of severe clinical problems.

The two studies on the clinical practice patterns of MFT in Minnesota and on a USA national sample conducted by Simmons & Doherty (1995) and Doherty & Simmons (1996) respectively, found that MFT's practice a relatively short-term therapy. Therapy conducted with families and couples was briefer than individual therapy. Treatment continued for an average of 12 sessions, 11.5 sessions for couples therapy and nine sessions for family therapy, tending to be shorter than individual therapy which on average continued for 13 sessions. About half of the treatment provided by MFTs is individual psychotherapy, and the other half is mostly divided between couple and family

therapy, or a combination of modalities. Therapists and clients also reported that marriage and family therapy is an effective treatment that results in substantial improvement in individual, family, work and social functioning. MFTs also reported that they treat a wide range of serious clinical problems including depression, marital problems, anxiety, child behaviour problems, parent-child problems, and other psychological problems of adults and children.

Nelson and Palmer's (2001) study provided descriptive information on members of the Utah Association for Marriage and Family Therapists ( $n=77$ ). Findings indicated that respondents were mostly male, white, and a highly educated group of practitioners who hold primary licensure in MFT and identify themselves primarily as MFTs. The results from the Minnesota (Simmons & Doherty, 1995) and national (Doherty and & Simmons, 1996) samples were compared with the Utah study. Conclusively, respondents in the three studies were similar in age (late forties to early fifties) and years of practice (13-15 years). However, main differences were found with regards to gender (more males than females), length of treatment (completed therapy in fewer sessions) and problems diagnosed (fewer adjustment and anxiety disorders diagnosed and depression diagnosed more frequently). Utah MFT's also reported less utilisation of DSM "V" codes than did their colleagues in other states.

A similar study to the ones conducted in the U.S.A was aimed at members of the Association of Family Therapy in the UK (Bor et al., 1997). A 33% response rate was

obtained (N = 495) and the major finding indicated that family therapists were more likely to work for NHS trust, to use family therapy techniques, predominantly used systemic ideas, and treat a broad range of client issues. They were more likely to work with families and family therapy was short term (5 to 8 sessions) whether they were treating families, couples or individuals.

Among the issues most frequently treated in therapy were relationship problems (93%), followed by parent child problems (86%) and marital problems (82%). The researchers also found that among the approaches, which have most influenced practice in the UK, were the Milan systemic (43%), the psychodynamic (27%) and the structural (21%) approaches. Another important point was the fact that the majority of respondents reportedly sought supervision.

Comparably, Phillips (1996) interviewed 12 New Zealand family therapists and found that practitioners regarded supervision as paramount and referred to it as important in "keeping" the therapists involved focused and most importantly accountable (p.127).

Additionally, a survey conducted in Australia of members of the Victorian Association of Family Therapists, contrasted the study carried out in Utah, stating that family therapy and family therapy supervision is a mainly female occupation, with 89% of its respondents being females. Comparably, an older working force was practising family therapy, with more than half of the respondents aged between 45 and 55. Respondent

reported having an average of 15 years of experience as MFT and being involved in supervision. This same survey reported that the common theoretical framework underpinning supervision were systemic theories, and that psychodynamic theory was also prominent (Cocking and Miocevic, 2001).

Booth's study showed (1996) that the majority of therapists (N = 204) were primarily adhering to the systems paradigm or practising from a combination of paradigms including primarily systems and social constructionist approaches. The approaches under the social constructionism paradigm seemed to be used by a smaller but significant percentage of therapists (13.7%).

Similarly, in a study about common factors across theories in marriage and family therapy, Blow & Sprenkle (2001) required experienced panellists (N=35) to rank the top three theories that they adhered to in their work. Integrative therapy was the first choice of 32% of the panellists; 16% chose solution focused therapy; 11% chose structural therapy and 6% chose Bowenien therapy. The theoretical orientation of the panellists as a whole did not appear to reflect traditional models of family therapy such as strategic and structural theories, although the author believe that those who selected integrative approaches surely would have been utilising these traditional forms in some way in their work.

In 1998, Simmons & Doherty advanced to investigate whether academic background is associated with differences in practice patterns and client outcomes. Clinical members of the AAMFT with academic training in psychology, social work, counselling and marriage and family therapy were compared on a wide range of clinical practice variables, and their clients were surveyed about their satisfaction with therapy and their outcomes. Findings indicate similar practice patterns and client outcomes across all four disciplinary groups.

Clearly, the aforementioned studies signaled that family therapy practitioners at the time surveyed were mainly middle aged, had been practicing for an average of 14 years, and were engaging in short term therapy. Practitioners seem to spend about the same amount of time in individual therapy as in couples and family therapy combined. Academic background was not found to be indicative of client outcome. MFTs treat a wide range of severe clinical problems, including relationship problems, parent-child problems, depression, anxiety and adjustment disorders. Mainly systemic therapies were influencing practice, with a trend to more integrative and social constructionist approaches.

Following this evidence it seems relevant to review some conclusive studies on MFT outcome that may be influencing practice.

Dunn and Schwebel (1995) completed a meta-analytic review of 15 methodologically rigorous published outcome studies on marital therapy. They found that behavioural marital therapy, cognitive-behavioural marital therapy, and insight oriented marital

therapy were all more effective than no treatment in bringing about change in spouse's behaviour and in the general assessment of the marriage relationship. According to the latest meta-analysis of the findings of 163 outcome studies on the effectiveness and efficacy of marriage and family therapy, Shadish et al. (1995) conclude that, based mainly on efficacy studies, marital/family therapy clients did better than untreated control group clients. While different marital and family therapy approaches were all found to be superior to no treatment, the reviewers found no single model's efforts stood out over others. It should be noted, however, that one approach may "fit" certain families better than do others, or work best for certain presenting problems. In some cases, a combination of therapeutic efforts (psychoeducational, medication, individual therapy, and group therapy) may be the treatment of choice (Pinsof et al., 1996).

It appears lately that the field as a whole has been moving away from the pure practices of one model of MFT. Social constructionist approaches have also been gaining many advocates and, the studies previously addressed are reflective of these trends. Outcome studies to date show no one therapeutic approach is better than the next. Therefore, practitioners are possibly being lead into either selecting freely from a variety of models, selectively borrowing techniques from different approaches or using especially designed integrative models (Nichols & Schwartz, 2001). However, research is not keeping up with the multiple theoretical ideas making empirically documented evidence scarce.

### **Research in Family Therapy**

Sprenkle & Moon (1996) noted that "the chasm between research and clinicians seems as wide as ever" (p.3). Many reasons have been offered for this lack of collaboration. Some clinicians feel that much research is insignificant to practice (Cohen, Sargent, & Sechrest, 1986; Johnson & Sandberg 1999) or that a systemic perspective is not compatible with research (Lebow, 1988). Kennedy (1998) suggested that clinicians also ignore research because the results have not appeared conclusive enough, or because the outcome of clinical intervention has been the sole focus of the study with insufficient attention to the treatment process. Clinicians may also reject research when the research contains too many variables to make the results interpretable and applicable to practice.

Furthermore, Nichols and Schwartz (2001) explained another issue that may be influencing this "chasm". They believe that "while much of the 1990s has been guided by postmodernism's mistrust of traditional science, groups of serious, full time clinician/researchers have been conducting unabashedly modernist studies of families and family therapy.... In conducting rigorous, quantitative research, they are swimming against the postmodern current of research skepticism " (p. 330). Skeptical postmodernists believe that the subjectivity of the human individual impedes the possibility of science discovering objective truth. They also view objectivity as an illusion of science subverting those of oppressed groups. Postmodern attacks on empirical

research are based on the belief that there is no true objectivity. Therefore, some sceptical postmodernists contend the scientific method is not possible.

Of equal importance to this study are the research styles that MFT engage in. As Pinsof and Wynne (1995) affirmed, for family therapy to mature as a discipline and become respectable in the mental health field, it must be able to authenticate its efficacy through high quality research.

Johnson & Sandberg (1999) assessed the willingness of MFTs to participate in research projects and their use of research in clinical practice. Results indicated a moderate level of research involvement among practitioners. However, the authors explain that clinical research is often plagued by lack of co-operation among clinicians. For example, having too few clinicians respond favorably to a request to respond to survey questionnaires that ask questions about their clinical practice often compromises research. Although most social survey research studies have at least a 50% response rate, the response rate among clinicians is often considerably lower. A 34% response rate was obtained in Doherty & Simmon's (1996) USA national survey of MFTs, which they indicated was a "typical response rate for professionals" (p.12).

The believe of some MFT approaches that research is not compatible with their philosophies, as well as the idea that research is not consistent with clinical practice, results in unwillingness of clinicians to partake in research. The lack of validated



information is most likely having a consequence on the approaches individuals seeking training and supervision are selecting.

### **Training and Supervision**

Considering the rapid growth of MFT, the availability of training and supervisory programs has increased considerably in the last two decades. Sprenkle and Wilkie (1996) mentioned that the types of programs available in family therapy supervision and training take place in two major settings, academic degree-granting programs, and free-standing institutes. However, Phillips (1996) evidenced that on-the-job training and supervision was probably the main setting among trainees in New Zealand, and attributed this phenomenon to the overlap between mental health professionals' roles. While family therapy is regarded by some as a distinctive discipline with specialised training, others emphasise that family therapy is not limited to the practice of family therapists, nor is it all that family therapists do (Wynne, McDaniel & Weber, 1987).

In an effort to adjust to higher demands, trainees today are likely to be exposed to a number of current issues in the field of family therapy. These issues may include, but are not limited to, raised consciousness regarding the role played by ethnic, social class, and cultural factors in influencing outlooks and behaviour (Falicov, 1988). Greater sensitivity to feminist thinking and its relevance for overcoming trainee gender-bias and sex-role-stereotyped thinking is also advocated (Avis, 1996; Tamasese & Waldegrave,

1993). Knowledge of family law as well as relevant ethical issues (Welfel, 1998); and a familiarity with both simple cybernetics and second-order cybernetic ideas regarding therapists' roles and influences in changing family patterns is considered a necessity too. Awareness and sensitivity to these issues are necessary to better differentiate among universal, transcultural, culture-specific, or idiosyncratic family behaviours.

Attention to culture is yet another indication of the expanding view of family therapy. However, at this point it seems important to mention the fact that minorities are still under-represented in training programs and in mental health professions in general. This is of great concern (Garret personal Communication, May 2002). Efforts are being made to train more minorities, but that addresses only part of the problem. What is needed is an acknowledgement and appreciation of how minority families are different from and similar to non-minority families, and an acceptance of "not knowing everything" (Green, 1998). Waldegrave affirms "practices that do not address cultural meaning webs in informed ways are racist" (1998, p. 412).

All family therapy training programs, of whatever theoretical orientation, recognize that both conceptual knowledge and clinical skills need to be acquired and integrated in the process of becoming a professional (Todd & Storm, 1997). Nichols et al. (1990), argue that learning to think of human problems in systems terms remains axiomatic today, although not nearly the radical idea it was three decades ago when first proposed by family therapy pioneers. The growing influence of social constructionist thinking has

begun to impact many contemporary-training programs (Anderson & Swim, 1993, 1995; Bobele, Gardner and Biever, 1995. Cantwell & Holmes, 1994 sustain that any training to be successful must model within their program the same value trainees will then exercise with their clients. Social constructionist approaches advocate a collaborative, non-expert stance to therapy and suggest that there is no right way of doing therapy. Consequently, trainees are encountered by a myriad of decisions regarding their professional careers sometimes with no substantial evidence as to the effectiveness of the options available to them.

The ability to measure affiliation with a particular theoretical orientation or paradigm is important in assessing changes in orientations and evaluating effects of educational and training programs on therapists. Studies conducted by Norcross and Prochaska, (1983) and Norcross and Wogan, (1983) on the degree of utilisation of different clinical orientations and the particular characteristics involved in selecting a particular orientation, provide evidence that training experiences have a powerful influence on a clinician's choice of theoretical orientation. It has also been reported that a supervisor's theoretical orientation influences a trainee's subsequent choice of orientation (Guest & Beutler, 1988; Steiner, 1978).

Some studies reviewed by Sprenkle & Wilkie, (1996 p. 356) examining the theoretical orientations of supervisors-trainers suggested that research in the early 1980s indicated that the majority adopted an eclectic or integrative view (Quinn & Davidson, 1984).

However, later findings indicated a decline in eclecticism as an orientation, with a major shift towards systems based approaches. Regarding training the McKenzie et al. (1986) and Saba and Liddle (1986) studies found that supervisors were using the structural and strategic models most frequently. However, Sprenkle and Wilkie predict "contemporary preferences would include a large percentage of trainers with orientations influenced by social constructionism, including narrative, solution-focused and collaborative language systems models" (p. 356).

Looking closer at this issue some studies have explored aspects that may influence a practitioner's theoretical orientation. For example, Norcross and Prochaska (1983) asked psychologists to rate on a five point Likert scale how much each variables from a list influenced their current theoretical orientation. Graduate training (3.6), postgraduate training (3.4), and internship experience (3.3) were rated as having some influence (3.0), to a strong influence (4.0), and were ranked third, fourth, and sixth most influential on use of theoretical orientation. Clinical experience and values and personal philosophy were the two highest rated variables influencing selection of theoretical orientation. Comparably, a study conducted by Kolevzon, Sowers-Hoag and Hoffman (1989) suggests that the personality attributes of the family therapist do play a role in predicting adherence to the belief and action systems unique to a particular approach.

Another study conducted by Cummings and Lucchese (1978) underscored the importance of educational and training experiences in their discussion of adopting a particular

theoretical orientation. They indicated that a student's ideas about orientation are influenced considerably in graduate school and that pre- and post-degree practicum or internship training exerts much influence on adherence to an orientation through contact with clinical supervisors, directors of training institutes, and more experienced clinicians.

In an article about factors involved in a clinician's adherence to a particular orientation, Cummings and Lucchese (1978) also stated that "first-hand clinical experience and supervisory encounters serve as primary sources of influence in the cultivation of an orientation" (p. 326). They went on to say that a beginning therapist is greatly influenced by the theoretical preferences of clinical supervisors at the internship and other training sites so that competing or inherently different approaches may be much less likely to impact on the therapist.

Booth (1996) indicated that the paradigm preferred by the therapist's current or most recent supervisor was significantly related to paradigm adherence. This finding was also consistent with prior research. Guest and Beutler (1988) found that the most consistent predictor of a therapist's theoretical orientation at three and five years following the training experience was the orientation of supervisors during training. In addition, Sundland (1977) discussed several studies showing some degree of relationship between a trainee's choice and utilisation of a theoretical orientation and the supervisor's theoretical orientation.

### Variables Related to Theoretical Orientation Preference

As suggested by Sundland, (1977), and studied by Booth and Cottone (2000), other variables found to be related to the adherence to a particular theoretical orientation included age, gender and years of clinical experience. Some studies reviewed (Norcross & Prochaska, 1982a, 1982b; Prochaska & Norcross, 1983; Sprenkle, Keeney, & Sutton, 1982; Steiner, 1978; Strano, 1989; Wogan & Norcross, 1985) reported that older therapists were more likely to identify psychodynamic therapies as the primary clinical orientation, while younger therapists selected newer approaches such as cognitive, behavioural, and systems approaches. Similar results were evidenced when comparing experience level. More experienced therapists endorsed psychodynamic approaches significantly more, than less experienced therapists. However, gender differences in adherence to specific theories are not clear, although some evidence exists that males report preferences for more directive and structured therapies and techniques, than females (Strano, 1989; Wogan & Norcross, 1985).

Booth (1996 p. ii) found that the current or most recent supervisor's preferred paradigm was the only individual predictor variable showing some ability to significantly discriminate between paradigm adherence groups. She mentioned that the set of predictor variables (age, gender, years of clinical experience and supervisor's preferred paradigm), only accounted for 16.5% of the variance in paradigm adherence. However,

this was seen as having some practical significance in explaining choice and utilisation of theoretical framework.

### **Summary**

A profile of the "typical" marriage and family therapists has been identified. MFT practitioners are usually middle aged, engage in short term therapy and treat a variety of client issues. Outcome studies have concluded that no one approach seems to work better than others do, but that a combination of therapeutic efforts may be the treatment of choice. Following this point, the importance of research in family therapy has been discussed. Training and supervision experiences appear to be most influential on a clinician's choice of theoretical orientation. Other characteristics that seem to influence MFT practitioners' preference of a particular theoretical orientation include age, gender, personality attributes and years of clinical experience. Systems approaches were primarily influencing a majority of therapists, however integrative and social constructionist approaches were seen to be gaining many advocates. Based on the main findings of the studies reviewed here the following hypotheses for this study have been constructed.

### Hypotheses

- 1) Marriage and family therapists in Australasia will more likely adhere to a social constructionist paradigm than to a psychological or systems paradigm.
- 2) Australian and New Zealand MFT practitioners will more likely adhere to a social constructionist paradigm than their counterparts in the USA.
- 3) Women will more likely have a stronger adherence to the social constructionist or the systems paradigm, and a weaker adherence to the psychological paradigm than men will.
- 4) Marriage and family therapists in private practice will have a stronger adherence to the psychological paradigm; whereas therapists involved in public practice will have a stronger adherence to the systems or social constructionist paradigm.
- 5) Strength of adherence to the psychological paradigm will be directly related to age, years of clinical experience, years working in MFT and number of sessions.
- 6) Strength of adherence to the social constructionist or to the systems paradigm will be directly related to age, years of clinical experience, years in MFT, weekly contact hour, and inversely related to number of treatment sessions.
- 7) Marriage and family therapists with a professional qualification in psychology will more likely have a stronger adherence to the psychological paradigm and a weaker adherence to the systems or the social constructionist paradigms than marriage and family therapists with a professional qualification in social work, counselling or psychotherapy.



- 8) Marriage and family therapists' strength of adherence to either the psychological, systems, or social constructionist paradigm's will be directly related to their supervisors' preferred paradigm.
- 9) Strength of adherence to a particular paradigm will gradually increase from the pregraduate supervisor's preferred paradigm to the postgraduate supervisor's preferred paradigm and then to the most recent or current supervisor's preferred paradigm.

## CHAPTER 5

### METHODS

This study was a partial replication of Therese Booth's (1996) study, and the demographic questionnaire was expanded incorporating questions used by (Doherty and Simmons (1996) in their survey of a USA National sample. It was adapted for New Zealand and Australian participants. The objectives of the present study were to explore characteristics of marriage and family therapy (MFT) practitioners in New Zealand and Australia, in order to learn about theoretical framework trends in MFT practice and to compare these findings with Booth's study as well as other relevant overseas findings.

#### Participants

The present sample comprised 445 adults currently practising marriage and family therapy in New Zealand and Australia. One hundred and eight questionnaires were returned by the deadline. Of these 15 were unusable, (e.g. circling more than one response for various items) resulting in a total of 88 participants, representing a 20% response rate. Five questionnaires were returned unanswered and a note was attached explaining reasons for not participating in the study.

**Table 1.**  
*Demographics of the Sample (N=88).*

Characteristics		Participants	
Age	<i>M</i>	<b>48.6</b>	
	<i>SD</i>	9.5	
	Minimum	27.0	
	Maximum	70.0	
Gender		<i>n</i>	<i>%</i>
	Male	40	45.5
	Female	48	54.5
Ethnicity	NZ Pakeha	29	33.0
	Australian	20	22.7
	European	24	27.3
	American	3	3.4
	Maori	2	2.3
	Pacific Islander	3	3.4
	Asian	3	3.4
	No response	4	4.5
Qualification	Undergraduate	17	19.3
	Postgraduate	69	78.4
	No response	2	2.3
Discipline of Qualification	Social work	13	14.8
	Psychology	18	20.5
	Counselling	28	31.8
	Psychotherapy	23	26.1
	Other	6	6.8
Primary work setting	Private practice	46	52.3
	Public practice	42	47.7

As shown in Table 1., the sample (N=88) consisted of 48 females (54.5%) and 40 males (45.5%). The age of respondents ranged from 27 years to 70 years, with a mean age of 48.56 years and a standard deviation of 9.5. Twenty-nine participants (33%) identified themselves as New Zealander or "Pakeha". Twenty (22.7%) identified themselves as

Australian, and 24 (27.3%) as European, comprising 83% of the sample. The remaining 11 (12.5%) participants were Americans, Maoris, Pacific Islanders and Asians. Four participants (4.5 %) gave no response regarding their ethnic identity. Seventeen participants (19.3%) reported having an undergraduate qualification, while 69 participants (78.4%) held a postgraduate qualification.

Participants were asked about the field or discipline of their highest qualification and the responses are as follows: 13 participants (14.8%) obtained a degree in social work; 18 participants' (20.5%) degrees were in psychology; 28 participants (31.8%) reported a degree in counselling; 23 participants (26.1%) had degrees in psychotherapy (including, child, family and or adult); 6 participants (6.8%) indicated "other". The participants were also asked about the primary setting in which they worked. This question was recoded into private or public practice with 46 participants (52.3) working primarily in a private setting and 42 participants (47.7%) working in a public setting (Table1).

## **Instruments**

The Paradigm Adherence Scale (PAS) (Appendix A) developed by Booth in 1996, was used as the main instrument for this research. The PAS was selected to partially replicate Booth's study and also to adapt this research to best fit the New Zealand and Australian Family Therapist population. Another aim was to compare and contrast findings with regards to emerging trends and predictor variables.

The PAS is a nominal scale, which produces a forced choice outcome of paradigm adherence: psychological, systems, social constructionist, or a combination of these. The PAS consists of 24 items targeting a therapist's theoretical assumptions and beliefs related to marriage and family therapy, as well as their techniques and the interventions they employ in clinical practice (Booth & Cottone, 2000). Participants are required to select the statement which best indicates their current practice among three responses to a single question.

Items on the PAS consist of a statement describing a clinical situation (involving a family, couple, or individual) faced by a therapist. Three responses are listed in multiple-choice format. The responses include statements regarding assumptions, beliefs, and clinical techniques consistent with each of the three paradigms utilised in marriage and family therapy. Participants are advised to respond to each item according to how they

primarily operate with the majority of their clients on a theoretical and practical level (Booth, 1996).

To establish content validity for the PAS, Booth (1996, p. 53) first consulted a panel of four experts in family therapy. The panel of experts made recommendations related to appropriate theoretical terminology, created clear distinctions among item responses reflective of the systems and social constructionist paradigms, and also made general comments about the appropriateness and clarity of items. Second, Booth gave two separate groups of graduate students a revised pool of 30 items from the PAS. Based on the first group's responses to items on the PAS, scores that categorised adhering to one of the three paradigms were decided (Booth, 1996 p. 56). For the second group a validity check was included in this administration of the PAS. Participants were first asked to complete the PAS, then they were instructed to select the paradigm description which best represented their primary approach with clients. Approximately two thirds of the participants demonstrated a match between the primary paradigm selected and the paradigm with the greatest item score.

Booth also obtained a measure of test-retest reliability, by conducting a pilot study with an experienced group of mental health professionals (N=16). Agreement between individual item responses from the first to second administration of the instrument (usually two to three weeks) was tallied for each subject. The average percentage agreement of item responses across subjects was 74%.

A final revision to the PAS was completed based on an item-by-item analysis using data obtained from the pilot study. Several items were deleted based on this review, resulting in a total of 24 items in the final version of the PAS (Booth & Cottone, 2000 p.332-333).

In addition to the PAS, a Demographic Data Questionnaire inquiring about background and clinical practice information was used in the present study (Appendix B). The questions asked included age, gender and ethnic identity. Inquires were made with regards to the highest qualification earned, academic degree discipline (psychology, counselling, social work, psychiatry, education), years of clinical practice, years working in MFT and continuing education units in MFT. Work setting, primary modes of practice, caseload, weekly contact hours and average number of sessions were also included in the questionnaire as well as most frequently seen presenting problems and most frequent "disorders" dealt with. A question inquiring about participant's confidence in treating different client populations was also included. The last question inquired about the participants' clinical supervisor's theoretical framework. A brief description of the psychological, systems, and a social constructionist paradigm were presented. For this question, the participant was advised to indicate which description best represented the perspective of the clinical supervisor, based on what occurred during supervision sessions with the primary pre-graduate practicum/internship supervisor, the postgraduate supervisor, and the current or most recent clinical supervisor.

## **Procedure**

The target population for the present study included mental health professionals currently practicing marriage and family therapy in New Zealand and Australia. An application for human ethics consideration was peer-reviewed by Massey University academic staff in the School of Psychology before the research was undertaken.

Four hundred and forty five letters and emails (Appendix C) were sent to potential participants, whose names and addresses were publicly available inviting them to take part in this study. In addition, advertisements inviting practitioners to participate were published in the Australian and *New Zealand Journal of Family Therapy* (June 2001) as well as in the newsletter of the New Zealand Association of Counselors (July 2001).

Included in the mailing the participants received a cover letter (Appendix C) explaining the purpose of the study, a statement of informed consent. Attached were a copy of the PAS, a copy of the demographic information questionnaire, as well as a prepaid return envelope. The participant was advised not to record his or her name on these materials.

The statement of informed consent included the rights of the participant and it clarified that after the questionnaires were submitted there was no way of identifying individual participants, making withdrawal from the study at that point impossible. All participants



were offered the opportunity to receive further information about and/or a brief summary of the results of the study.

Four weeks after the first mailing 67 questionnaires were returned, making it necessary to send a follow up note of first mailing. This note was sent to 150 possible participants who were automatically selected at random through the computer from the original mailing list. In addition, and to increase response rates a web page was set up and participants had the option of completing the questionnaire on a hard copy or through the internet <http://psych-research.massey.ac.nz/amealla/infopage.html>.

By the deadline of November 2001, a total of 103 questionnaires were returned, eight were incomplete and unable to be processed and seven responded repeatedly to more than one choice making them unusable for this research. A remaining 88 questionnaires were completed appropriately.

New Zealand and Australian participants' data were combined and treated as one group. This was primarily due to the fact that the questionnaire did not ask participants to mention where they were practicing and it was difficult to ascertain where web page responses originated. The limited sample size also contributed to the decision to group both New Zealand and Australian participants together for statistical analyses.

### **Data Analysis**

Data were analysed using descriptive and inferential statistics on SPSS package 10.1 (Coakes & Steed, 2000). Due to missing data and fewer participants than anticipated, three variables were recoded by combining categories. The categories for which data were regrouped include highest qualification earned, discipline of highest qualification and primary work setting. Highest qualification earned, initially covered six options which were then narrowed to two -undergraduate or graduate qualification. Discipline of highest qualification was narrowed from eight options to four, social work, psychology, counselling and psychotherapy. Primary work setting had twelve options that were narrowed down to two, private or public primary work setting.

Following Booth's (1996) procedure, first each participant's PAS questionnaire was scored for adherence to one of the three family therapy paradigms (psychological, systems, or social constructionist) or to a combination of the paradigms. In order for a participant to adhere to one specific paradigm a score consisting of at least 12 responses (50%) reflective of that paradigm was necessary, and no more than eight items (33%) for each of the other paradigms. Participants whose responses did not meet these criteria were classified as the paradigm combination group. (For scoring specifics please see Appendix D).

This first classification of PAS adherence was undertaken to compare the proportions of the present sample falling within each paradigm, with the proportions of Booth's sample. Later, the PAS was scored again according to the number of times that a participant endorsed each of the three paradigms. For example, if a participant endorsed five questions pertaining to the psychological paradigm, 10 pertaining to the systems paradigm and nine pertaining to the social constructionist paradigm, his or her score would be 5, 10 and 9, respectively out of 24. Participants who did not answer an item had their scores prorated on a paradigm to give a raw score out of 24. The purpose of obtaining paradigm adherence scores as continuous variables was to enable more powerful statistical tests on the significance of differences between groups and association between variables to be undertaken with a smaller sample than expected. Therefore, the criterion variable was the strength of adherence to one of three paradigms.

T-tests of independent means were computed to compare men's and women's paradigm adherence scores and to compare the adherence score of participants in private versus public practice. Correlation coefficients were computed to test the associations of paradigm adherence scores with participant's age, years of clinical experience, years working in marriage and family therapy, weekly contact hours with clients, current family caseload and average number of sessions.

One-way analyses of variance were conducted for paradigm adherence and professional qualification (social work, psychology, counselling, or psychotherapy), as well as for

paradigm adherence and supervisors' preferred paradigms. For each appropriate statistical test of significance of difference, Levene's test for equality of variances was computed.

## CHAPTER 6

### RESULTS

This chapter presents the results of the study and the data analysis. The characteristics of the sample of participants are described through the presentation of demographic data. Descriptive statistics related to the variables are included, as well as the results of the correlations and one-way analyses of variance (ANOVA).

#### Characteristics of the Sample

Data were analysed for the 88 participants who returned completed and usable questionnaires. Means and standard deviations (*SD*) for the continuous variables, years of clinical experience, years working in family therapy, family case load, weekly contact hours, average number of sessions and continuing education units (CEU) can be seen in Table 2. The number of cases with missing values for a specific variable can be noted by observing the *N* reported for that variable and subtracting from the total *N* of 88.

**Table 2.**  
*Characteristics of the Sample of Marriage and Family Therapy Practitioners*

	<i>n</i>	Mean	Std. Deviation	Minimum	Maximum
Years of clinical experience	87	14.77	8.86	2	37
Years working in MFT	87	11.69	7.97	2	37
Family caseload	84	12.30	9.75	1	45
Weekly contact hours	84	22.06	11.81	3	65
Average number of sessions	84	9.45	6.14	3	50
CEU	61	48.67	119.70	0	700

*Note:* 1. MFT= marriage and family therapists  
 2. CEU= continuing education units

The mean years of clinical experience (since receiving a graduate degree in a mental health field) for respondents was 14.77 years ( $SD = 8.86$ ), with a range from two years to 37 years. Years spent working in marriage and family therapy ranged from two to 37, with a mean of 11.69 years ( $SD = 7.97$ ). The current family caseload ranged from one to 45 families, with a mean of 12.30 families ( $SD = 9.75$ ). The mean for weekly contact hours is 22.06 hours ( $SD = 11.81$ ) ranging from three hours to 65 hours a week. Respondents reported working for a mean of 9.45 sessions ( $SD = 6.14$ ) ranging from three to 50 sessions.

Participants were also asked about the number of continuing education units (CEU) completed in MFT since initial training. Responses show a large variability, with a mean of 48.67 CEU ( $SD = 119.70$ ), ranging from zero to 700 CEU. This range of variability

may have been related to the characteristics of the participant population, errors in the design of the demographic questionnaire which did not specify whether responses were required in hours or number of workshops or seminars attended. This should be taken into account when observing the standard deviation reported for this variable.

Additionally, a large number of missing values were seen for CEU. Thirty percent of the participants did not indicate a value for number of CEU. Some participants made non-numerical or vague responses to these items (e.g., "a lot," "hundreds," "heaps") left the item blank, or indicated that they had no memory or record of CEU (e.g., "too many to remember," "cannot easily access information"), resulting in a large number of missing values.

Participants were asked to rate their primary mode of practice according to the frequency with which they worked with individuals, children, couples, families, groups and/or a combination of these practice modes. Frequencies and percentages of primary modes of practice can be seen in Table 3.

**Table 3.**  
*Frequencies and Percentages by Primary Mode of Practice (N=88)*

Primary Mode of Practice	Ratings					
	Often <i>n</i> %	Sometimes <i>n</i> %	Few <i>n</i> %	Never <i>n</i> %	Total <i>n</i> %	
Individual	69 (78.4%)	17 (19.3%)	2 (2.3%)	0	88 (100%)	
Child	19 (21.6%)	36 (40.9%)	25 (28.4%)	8 (9.1%)	88 (100%)	
Couple	41 (46.6%)	37 (42.0%)	8 (9.1%)	0	86 (97.7%)	
Family	27 (30.7%)	42 (47.7%)	18 (20.5%)	0	87 (98.9%)	
Group	2 (2.3%)	21 (23.9%)	32 (36.4%)	25 (28.4%)	80 (90.9%)	
Combined	9 (10.2%)	23 (26.1%)	27 (30.7%)	15 (17.0%)	74 (84.1%)	

*Note: n's vary because not all respondents gave a rating for all modes of practice*

From this table it can be seen that individuals are treated with most frequency (often or sometimes) by 97.7% of participants. Couples follow with 88.6% of participants treating them either often or sometimes, whereas families were also treated often or sometimes by 78.8% of respondents.



### **Problems, Diagnosis and Confidence in Treatment of Specific Populations**

In addition to the aforementioned sample characteristics, participants in the present study responded to three questions regarding most frequently seen presenting problems, most frequent disorders dealt with and their confidence in treating specific groups of people. Percentages for each question were computed according to the number of respondents. Frequencies and percentages for each of these questions are presented in Tables 10, 11 and 12, respectively (Appendix E).

When asked about presenting problems seen by marriage and family therapy practitioners ( $n=86$ ), responses indicate that marital problems (81.4%), depression (79.1%), grief and loss (76.7%) and communication problems (74.4%) were among the issues most frequently encountered. Parent-child problems, child behaviour, alcohol and/or drug problems and anxiety were also frequently seen by more than 50% of the sample. Whereas financial problems was the issue least presented to this sample (17.4%).

The disorders most frequently treated by this sample ( $n=52$ ) included depressive disorders (82.7%), posttraumatic stress disorders (63.5%), alcohol and drug related disorders (63.5%) and anxiety disorders (59.6%). Psychotic disorders (15.4%) and schizophrenia (13.5%) were the disorders less frequently treated by the respondents.

Participants were also asked to indicate their confidence in treating specific populations. These populations included gender, developmental stages, homosexual identification, physical impairment or mental disabilities and specific ethnic groups. Males (100%) were treated with slightly more confidence than females (96.3%). Adults were treated with confidence by 98.8% of the sample, adolescents by 79.0%, children by 71.6%, and elderly clients by 56.8%. Homosexual females and homosexual males were treated with confidence by 75.3% and 71.6% of respondents, respectively. Clients with physical impairments were treated with confidence by 79.0% of respondents whereas people with intellectual disabilities by 40.7%. New Zealand European or Pakeha (96.3%) and Australian European (87.7%) clients were treated with more confidence by this sample followed by Maori (46.9%) and Pacific island (42.0%) clients. Asians (30.9%), Australian Aboriginals (19.8%) and Torres Straight Islanders (12.3%) were treated with confidence by a smaller percentage of the sample (Table 12).

### **Paradigm Adherence and Supervisor's Preferred Paradigm**

#### **Comparisons with Booth's (1996) Paradigm Adherence and Supervisor's Preferred Paradigm Results**

Paradigm adherence and supervisor's preferred paradigm results are reported for both the present study and Booth's (1996) study in Tables 4 and 5. These studies are reported together to highlight similarities and differences between samples. Booth's sample is described in order to make clear comparisons.

Participants ( $N = 204$ ) in Booth's (1996) study came from a diversity of mental health disciplines which were represented in a fairly even fashion. These included psychology, marriage and family therapy, social work and counselling. The group of respondents were middle aged ( $M = 54.7$  years), evenly distributed in terms of gender, with slightly more doctoral degrees (55.4%) than master's degrees (44.1). The majority of respondents were engaged in private practice (55.9%) as a primary work setting, with mean 20.96 years of clinical experience.

**Table 4.**  
*Frequencies and Percentages for Paradigm Adherence Scale Scores.*

Paradigm Adherence	Present Study		Booth's Study (1996)	
	Frequency	Percent	Frequency	Percent
Psychological	5	5.7	1	0.5
Systems	10	11.4	89	43.6
Social Constructionist	35	39.8	28	13.7
Paradigm Combination	38	43.2	86	42.2
Total	88	100.0	204	100.0

The primary paradigm adherence variable consisted of nominal data. The frequencies and percentages for each group are displayed in Table 4.

In the present study five respondents (5.7%) met the adherence criteria for the psychological paradigm, 10 respondents (11.4%) were classified into the systems paradigm group and 35 participants (39.8%) met the criteria for the social constructionist paradigm group. The remaining 38 participants (43.2%) were categorised as operating from a combination of paradigms, with no one primary paradigm adherence.

Of the 38 (43.2%) respondents representing the combined paradigm group 67.6% indicated a bimodal item response pattern by selecting the majority (at least 75%) of item

responses associated with the systems and social constructionist paradigms, and choosing item responses associated with the psychological paradigm less than 25% of the time.

Compared to the present study Booth's result showed that one respondent (.5%) met the criteria for the psychological paradigm group, 89 respondents (43.6%) were classified into the systems paradigm group and 28 participants (13.7%) met criteria for the social constructionist paradigm group. A high percentage of respondent 86 (42.2%) were categorised as operating from a combination of paradigms with no one primary paradigm adherence.

Frequencies and percentages for supervisors' preferred paradigm variables (see Appendix B), labelled supervisor 1 (pregraduate supervisor), 2 (postgraduate supervisor), and 3 (most recent supervisor), are listed in Table 5.

**Table 5.**  
*Frequencies and Percentages for Supervisor's Preferred Paradigm*

Supervisor's Paradigm	Present Study						Booth's Study (1996)					
	Supervisor 1		Supervisor 2		Supervisor 3		Supervisor 1		Supervisor 2		Supervisor 3	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Psychological	38	(43.2)	24	(27.3)	20	(22.7)	97	(47.5)	43	(21.1)	43	(21.1)
Systems	20	(22.7)	33	(37.5)	24	(27.3)	75	(36.8)	119	(58.3)	76	(37.3)
Social Constructionist	10	(11.4)	15	(17.5)	39	(44.3)	14	(6.9)	23	(11.3)	47	(23.0)
Missing Cases	20	(22.7)	16	(18.2)	5	(5.7)	18	(8.8)	19	(9.3)	38	(18.6)
Total	88	(100)	88	(100)	88	(100)	204	(100)	204	(100)	204	(100)

As seen in Table 5, in the present study, the psychological paradigm was the preferred paradigm for supervisor 1 for 43.2% of participants ( $n=38$ ). However, this paradigm was utilised less often by subsequent supervisors since it was chosen by 27.3 % of the participants ( $n=24$ ) for supervisor 2 and 22.7 for supervisor 3 ( $n= 20$ ). The systems paradigm was chosen for the pregraduate supervisor (supervisor 1) by 22.7% of respondents ( $n=20$ ). This figure increased to 37.5% ( $n=33$ ) for the postgraduate supervisor and then decreased back to 27.3% ( $n=24$ ) for the current or most recent

supervisor. There was a gradual increase in the utilisation of the social constructionist paradigm by participants' supervisors as this paradigm was chosen by 11.4% of participants ( $n=10$ ) for supervisor 1, 17.5% of participants ( $n=15$ ) for supervisor 2, and 44.3% of participants ( $n=39$ ) for supervisor 3.

For missing values, some participants left the item blank or made comments such as "I did not have one" or "not applicable".

By comparison, in Booth's study (1996) the psychological paradigm was the preferred paradigm for supervisor 1 for 47.5% of the participants ( $n=97$ ), but again subsequent supervisors utilised this paradigm less often since it was chosen by 21.1% of the participants ( $n=43$ ) for supervisor 2 and supervisor 3. The systems paradigm was chosen for the pre-graduate supervisor (supervisor 1) by 36.8% ( $n=75$ ) of respondents, increasing to 58.3% ( $n=119$ ) for the post graduate supervisor and then decreased back to 37.3% ( $n=76$ ) for the most recent supervisor. The social constructionist paradigm also saw a gradual increase in its utilisation by participants' supervisors. This paradigm was chosen by 6.95% ( $n=14$ ) of respondent for the pre-graduate supervisor, 11.3% ( $n=23$ ) of respondent for the post graduate supervisor 2, and 23.0% ( $n=47$ ) of respondent for the most recent supervisor.

### Statistical Analyses for Paradigm Adherence

In order to test the research hypothesis, t-tests and analysis of variance procedures were computed on the paradigm adherence data using SPSS 10.1. The dependent variable in these analyses of variance was paradigm adherence. Men's paradigm adherence scores were compared with women's. Comparisons were also made for participant's primary mode of practice, discipline of highest qualification earned, and their pregraduate, postgraduate and most recent supervisor's preferred paradigm.

**Table 6.**  
*Means and Standard Deviations of Males and Females Preferred Paradigm (N=88)*

Paradigm Adherence	Total			Males			Females			<i>t</i> (df=1)
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Psychological	88	4.17	3.80	48	4.49	3.71	40	3.78	3.92	0.87
Systems	88	7.99	3.63	48	8.47	3.76	40	7.42	3.43	1.36
Social Constructionist	88	11.81	4.96	48	11.04	4.74	40	12.75	5.11	-1.62

*Note:* 1. Scores on each paradigm range from 0 to 24.

2. All *t* values are not significant ( $p > .05$ )

As seen in Table 6, there were no significant differences between men's and women's mean paradigm adherence scores. Therefore, the remaining analyses of data were conducted for the men's and women's scores combined.



From Table 7, it can be seen that there were no significant differences between participants practising in a private or in a public setting.

**Table 7.**  
*Means and Standard Deviations of Preferred Paradigm Relating to Private and Public Practice (N=88)*

Paradigm Adherence	Total			Private Practice			Public practice			<i>t</i> (df=1)
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Psychological	88	4.17	3.80	46	4.49	3.79	42	3.82	3.83	0.82
Systems	88	7.99	3.63	46	8.52	3.60	42	7.42	3.63	1.43
Social Constructionist	88	11.81	4.96	46	10.95	4.93	42	11.82	4.96	-1.73

*Note:* 1. Scores on each paradigm range from 0 to 24.  
2. All *t* values are not significant (*p* > .05).

Correlation coefficients were computed for each of the three paradigm adherence scores using the variables of participant's age, years of clinical experience, years working in marriage and family therapy, weekly contact hours with families, current family caseload and average number of sessions.

Strength of adherence to the psychological paradigm was negatively related ( $r = -.69, p < .001$ ) to adherence to the social constructionist paradigm. Adherence to a systems paradigm was also negatively related ( $r = -.63, p < .001$ ) to the social constructionist paradigm. These two negative correlations indicate that the greater the adherence to the psychological paradigm or the systems paradigm, the less the adherence to a social constructionist paradigm and vice versa.

In addition, the systems paradigm strength of adherence scores were found to be significantly and negatively correlated with family caseload scores ( $r = -.26, p < .05$ ), indicating that the stronger that the participants adhered to a systems paradigm, the fewer weekly caseloads were reported by them. Age, years of clinical experience, years working in family therapy and weekly contact hours were not significantly correlated with any paradigm adherence.

From Table 8, it can be seen that there were no significant differences between participants' professional qualification on any of the three mean paradigm adherence scores.

**Table 8.**  
*Means and Standard Deviations of Participants' Preferred Paradigm and Professional Qualification (N=82)*

Paradigm Adherence	Professional Qualification	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i> ( <i>df</i> =3,78 )
					3.35
Psychological	Social work	13	3.38	3.73	
	Psychology	18	6.39	5.08	
	Counselling	28	4.28	3.66	
	Psychotherapy	23	2.83	2.27	
					.55
Systems	Social work	13	7.15	2.44	
	Psychology	18	7.67	2.97	
	Counselling	28	7.61	3.36	
	Psychotherapy	23	8.48	3.65	
					1.69
Social Constructionist	Social work	13	12.46	4.65	
	Psychology	18	9.17	5.23	
	Counselling	28	11.50	4.76	
	Psychotherapy	23	12.00	4.18	

One-way ANOVAs were computed in order to compare the mean paradigm adherence scores for each of the supervisors' preferred paradigms. As shown in Table 9, for the pre-graduate supervisor the mean score of psychosocial, systems or social constructionist paradigm adherence was not significantly related to the supervisor's preferred paradigm. However, for the post-graduate and most recent supervisors preferred paradigm, one of the three paradigms was significantly related to the supervisors preferred paradigm.

From Table 9, it can be seen that for participants' post-graduate supervisor (2), the mean score for psychological adherence was significantly greater if the supervisor had a psychological orientation ( $M=6.46$ ,  $SD= 3.35$ ) than if the supervisor had a systems ( $M=2.96$ ,  $SD= 3.01$ ) or a social constructionist ( $M=3.60$ ,  $SD= 4.37$ ) orientation,  $F (2,69) =7.54$ ,  $p< .01$ . If participants' post-graduate supervisor (2), preferred a psychological orientation the mean score for adherence to systems paradigm ( $M=8.89$ ,  $SD= 2.36$ ) was significantly greater than if the supervisor preferred a social constructionist ( $M=5.47$ ,  $SD= 3.42$ ) approach,  $F (2,69) =4.44$ ,  $p< .05$ . It was also evident that the mean score for social constructionist paradigm adherence was significantly greater if the supervisor preferred a systems ( $M=13.28$ ,  $SD= 4.90$ ) or a social constructionist approach ( $M=14.93$ ,  $SD= 5.36$ ),  $F (2,69) =11.70$ ,  $p< .001$ .

Also shown in Table 9, if participants' most recent or current supervisor (3) preferred a psychological orientation, the mean score ( $M=6.22$ ,  $SD= 4.80$ ) of psychological paradigm adherence was significantly greater than if the supervisor preferred a social

constructionist paradigm ( $M=3.02$ ,  $SD= 3.38$ ),  $F (2,80) =5.16$ ,  $p< .01$ . The mean score for a systems paradigm adherence was significantly greater if the supervisor preferred either a psychological ( $M=9.29$ ,  $SD= 3.37$ ), or a systems paradigm ( $M=8.66$ ,  $SD= 3.53$ ) than if the supervisor preferred a social constructionist paradigm ( $M= 6.56$ ,  $SD= 3.15$ ),  $F (2,80) =5.56$ ,  $p< .01$ .

Additionally, if the most recent supervisor (3) preferred a social constructionist approach the mean score of social constructionist paradigm adherence was significantly greater ( $M= 14.42$ ,  $SD= 4.73$ ) than if the supervisor followed a psychological or systems approach,  $F (2,80) =14.48$ ,  $p< .001$ .

**Table 9.**  
*ANOVA of Participants' Mean Paradigm Adherence Scores and Supervisors' Preferred Paradigm.*

Paradigm Adherence	Supervisor 1 (Pre-graduate)					
	Supervisors' Paradigm	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i> ( <i>df</i> =2,65)	Bonferroni/Games-Howell comparison
Psychological					0.82	
	(1) Psychological	38	4.84	3.57		
	(2) Systems	20	3.48	4.27		
	(3) Social Constructionist	10	4.48	4.06		
	Total	68	4.38	3.81		
Systems					2.22	
	(1) Psychological	38	8.62	3.70		
	(2) Systems	20	6.90	3.21		
	(3) Social Constructionist	10	6.46	4.43		
	Total	68	7.80	3.74		
Social Constructionist					2.92	
	(1) Psychological	38	10.54	4.35		
	(2) Systems	20	13.62	5.77		
	(3) Social Constructionist	10	13.06	5.31		
	Total	68	11.82	5.08		

Table 9 continues...

Paradigm Adherence	Supervisor 2 (Post-graduate)					
	Supervisors' Paradigm	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i> ( <i>df</i> =2,69)	Bonferroni/Games-Howell comparison
Psychological					7.54**	(1 )> (2) = (3)
	(1) Psychological	24	6.46	3.35		
	(2) Systems	33	2.96	3.01		
	(3) Social Constructionist	15	3.60	4.37		
	Total	72	4.26	3.74		
Systems					4.44**	(1) > (3)
	(1) Psychological	24	8.89	2.36		
	(2) Systems	33	7.76	4.16		
	(3) Social Constructionist	15	5.47	3.42		
	Total	72	7.66	3.67		
Social Constructionist					11.70***	(1) > (2) = (3)
	(1) Psychological	24	8.64	2.66		
	(2) Systems	33	13.28	4.90		
	(3) Social Constructionist	15	14.93	5.36		
	Total	72	12.10	5.02		

Table 9 continues...

Paradigm Adherence	Supervisor 3 (Most recent)					
	Supervisors' Paradigm	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i> ( <i>df</i> =2,80)	Bonferroni/Games-Howell comparison
Psychological					5.16**	(1) > (3)
	(1) Psychological	20	6.22	4.80		
	(2) Systems	24	4.64	3.07		
	(3) Social Constructionist	39	3.02	3.38		
	Total	83	4.26	3.87		
Systems					5.56**	(1) = (2) > (3)
	(1) Psychological	20	9.29	3.37		
	(2) Systems	24	8.66	3.53		
	(3) Social Constructionist	39	6.56	3.15		
	Total	83	7.82	3.49		
Social Constructionist					14.48***	(1) = (2) < (3)
	(1) Psychological	20	8.39	3.23		
	(2) Systems	24	10.70	4.22		
	(3) Social Constructionist	39	14.42	4.73		
	Total	83	11.89	4.93		

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Note: For Bonferroni/Games-Howell comparisons, only significant differences appear in table.



## CHAPTER 7

### DISCUSSION

#### Overview

The first part of this study was descriptive. Thus it was designed to gain information about demographics and to describe the clinical practice of New Zealand and Australian MFT practitioners. The second part of the study was aimed at identifying practitioner's strength of adherence to a particular MFT paradigm. It also explored the relationship between the strength of adherence to each paradigm and specific demographic characteristics and clinical practice characteristics. Supervisors' paradigm preference and its relationship to participants' choice of paradigm were also examined.

The present study was a partial replication of Therese Booth's (1996) study. However, the demographic questionnaire was expanded to incorporate questions used by (Doherty and Simmons (1996) in their survey of a USA National sample of MFTs. Results were focused on the current research but where data were available, appropriate comparisons have been made with relevant overseas studies. Discussion of the main findings of this and of the results from testing the hypotheses as well as the study's limitations and contributions to research are presented.

### Summary of Main Findings

Regarding the characteristics of Australian and New Zealand MFT practitioners, their level of training, and their professional qualifications it was found that the sample of participants comprised middle-aged ( $M = 48.6$  years) marriage and family therapy practitioners, with slightly more females than males, self-identified as New Zealander "Pakeha", Australian or European. More had postgraduate (78.4%) than undergraduate degrees (19.3%). Practitioners were evenly engaged in private and public practice. This group of therapists illustrates the multidisciplinary nature of people practising family therapy, with a diversity of mental health disciplines (social work, psychology, counselling and psychotherapy) represented among them (Table. 1).

Participants in the present study had a mean of 15 years of clinical experience since receiving a qualification in mental health and had been practising for a mean of 12 years. The typical MFT practitioner had 22 weekly contact hours and carried an active caseload of 12 clients.

In comparison with similar studies, (Booth, 1996; Doherty and Simmons, 1996; Simmons & Doherty 1995, 1998; Nelson & Palmer 2001) in the USA and in the United Kingdom (Bor et al., 1998), MFT practitioners in all studies seem to have similar characteristics. They were middle aged (late forties to mid fifties), Caucasian, and highly educated individuals. In all studies but the one conducted by Nelson and Palmer (2001), the

majority of respondents were females. This is particularly true of respondent in the study conducted in Victoria Australia (Cocking & Miocevic, 2000). However, in Booth's study practitioners were equally distributed in terms of gender.

In contrast to the United Kingdom study, more therapists in this study were engaged in private practice. This finding is similar to Booth's sample in that more than half of participants responded to private practice as the primary work setting.

An interesting finding is that family therapy practitioners in Australasia as well as overseas come from a variety of mental health disciplines. As shown in Table 2, the majority of participants responded to social work, psychology, counselling or psychotherapy as being the discipline of their highest qualification. However, very few indicated MFT as their primary discipline, which contrasts to overseas studies in which the majority responded they were MFT trained. Explanations for this may be first, MFT is just being recognised as a separate discipline in Australasia and second, the question was asked with respect to their discipline of highest qualification and not how they identified themselves professionally. It seems possible that more people would have responded to MFT if the question were formulated differently, especially since the mean years practising MFT are similar to what was reported overseas.

Regarding how long practitioners engage in treatment, it was found that participants were mainly practising short-term therapy, treating clients for an average of 9.45 sessions.

Participants in the USA reported seeing clients for an average of 12 sessions, while UK practitioners saw clients from five to eight sessions.

When addressing the question, what primary mode of practice do practitioners engage in, participants responded by ranking the frequency (often, sometimes, few, never) in which they saw individuals, children, couples, families, groups, or a combination of these.

Findings indicate that individuals are treated with most frequency (often or sometimes) by 97.7% of participants. Couples follow with 88.6% of participants treating them either often or sometimes, whereas families were also treated often or sometimes by 78.8% of respondents (Table 3). This coincides with Doherty and Simmon's (1996) study indicating that MFT practitioners appear to be treating individuals more often than couples and families.

When asked about the presenting problems most frequently encountered in treatment, each respondent reported more than one. In the present study, as well as overseas the findings indicate that marriage and family therapists see a range of individual, couple, child and family problems. As can be identified in Table 10 (Appendix E), marital problems (81.4%), depression (79.1%), grief and loss (76.75), and communication problems (74.4%) were among the issues most frequently encountered. Parent-child problems, child behaviour, alcohol and/or drug problems and anxiety were also frequently seen by more than 50% of the sample. Similarly in the UK study the most frequent issues were relationship problems, parent-child problems and marital problems.

In addition to describing the presenting problems seen, therapists were asked to identify “DSM-IV” disorders dealt with in their practice. The findings were computed according to the number of respondents ( $n = 52$ ) and indicated that MFTs deal most frequently with “Axis I” disorders. These include depressive disorders (82.7%), posttraumatic stress disorders (63.5%), alcohol and drug related disorders (63.5%) and anxiety disorders (59.2%). Psychotic disorders and schizophrenia are treated with less frequency (see Table 11, Appendix E).

Of particular interest is the number of participants (41%) who chose not to respond to this particular question. Some participants included notes in the questionnaire indicating that diagnoses were not consistent with their practice (e.g. diagnoses are simply labels, “oppressing” clients). This seems to be consistent with the fact that psychodiagnostic labels are incongruent with both systems and social constructionist philosophies of assessing and treating people.

MFT practitioners reported confidence in treating diverse client populations. These populations included gender, various developmental stages, homosexual identification, physical impairment or mental disabilities and specific ethnic groups. As seen in Table 12 (Appendix E), males were treated with slightly more confidence than females. Adults (98.8%) were treated with confidence by a larger percentage of respondents, than were adolescents (79%) and children (71.6%), and elderly clients (56.8%). Homosexual female

(75.3%) and homosexual male (71.6%) clients were treated with confidence by about the same number of participants. However, clients with physical impairments were treated with confidence by 79% of respondents, whereas people with intellectual disabilities by only 40.7%.

New Zealand European or Pakeha (96.3%) and Australian European (87.7%) clients were treated with confidence by more participants than were Maori (46.9%) and Pacific Island (42.0%) clients. It is relevant to note that Caucasian practitioners seem to be treating Maori and Pacific Islanders with confidence, since only six percent of participants identified as either Maori or Pacific Islanders. Interestingly so, Asian (30.9 %) clients were also treated with confidence by more participants than were either, Australian Aboriginals (19.8 %) or Torres Strait Islanders (12.3%).

These findings tie in with the available literature, in that mental health professions are representative of the norms and values of the dominant western cultures. Mainstream mental health practices have been established within a culture of philosophy and science that values the individual, the objective, the material and the efficient, above collective collaboration, and spirituality. Both New Zealand and Australia have great multicultural diversity. However, minorities are still under-represented within mental health professions. Only recently has adequate attention been paid to cultural and ethnic differences and needs (e.g. McGoldrick, 1998; Waldegrave & Tamasese, 1993). The need to provide ethical and culturally just services for both clients and trainees has proven

paramount. This can be seen within the initiatives of Michael White and the Dulwich Center in Australia, David Epston and the Family Center in Auckland and Charles Waldegrave and Kiwi Tamasese in the Lower Hutt Family Center with their “Just Therapy” approach, among others.

With respect to what kind of supervisory experience practitioners have and what paradigm their supervisors prefer, participants were requested to answer a question regarding their supervisors’ preferred style of therapy. Findings indicate that 77.2% of participants had received supervision during their pregraduate training, 81.8% of participants had received supervision during post-graduate training and 94.3% were currently in supervision. Thus, the present findings show that supervision plays a major part in MFT practice in Australasia and this is consistent with previous reports by Cocking & Miocevic (2001). However, from the way the question was formulated it is difficult to ascertain whether participants responded twice, if their most recent or current supervisor was the same supervisor during their postgraduate or pregraduate training.

When responding to their supervisor’s preferred paradigm, an interesting theoretical trend was apparent. As shown in Table 5, the majority of therapists reported the preference of the psychological paradigm by their pre-graduate supervisors (43.2%), the preference of the systems paradigm by their postgraduate supervisor (37.5%) and the use of the social constructionist paradigm by the most recent or current supervisor (44.3%). The fact that 15 years was the average number of years of clinical experience and 12 years was the

average for participants practicing marriage and family therapy, seems to parallel the evolution of the social constructionist paradigm during the 1990s in Australasia (Goldenberg & Goldenberg, 2000; Nichols & Schwartz, 2001 Durrant. 1994.).

Additionally, the fact that MFT is a second profession for the majority of therapists in this region, implies that their initial training was in a different discipline and that they were most likely being supervised by people grounded in a psychological paradigm.

These findings add to findings by Booth, which suggest that the psychological paradigm was reported to be used less by the current supervisor, while the social constructionist paradigm seemed to be used more by current supervisors than by pre-graduate supervisors. The implications of this phenomenon will be discussed more extensively in the following section.

## **Summary**

As discussed, this first part of the study highlights the main demographic and practice related characteristics of MFT practitioners in Australasia and situates practice within a wider international framework. All in all, findings clearly show that MFT practitioners are a heterogeneous group of professionals. Most of them are highly qualified and work with a diversity of client populations and attend to a variety of client issues. The majority of respondents identified themselves as Caucasian and this represents the mainstream “western dominant” approach to mental health practised in Australasia. However, the



fact that participants responded to social constructionist approaches as being preferred by their most recent supervisor, shows an attempt at conciliating mainstream mental health approaches with more culturally relevant views of mental health. Additionally, within this sample supervision is seen as an essential tool for training as well as for practice. This connotes the importance of therapists' accountability for the services they provided.

### **Results of Hypothesis Testing**

Based on a review of the literature and the main findings in Booth's study, the following nine hypotheses were tested. The **first** hypothesis was that New Zealand and Australian marriage and family therapists were more likely to select the social constructionist paradigm than a psychological or systemic paradigm. This hypothesis was supported. The result showed that the majority of participants in this study were either classified as primarily adhering to a social constructionist paradigm (39.8%) or using a combination of paradigms (43.2%) in their practice. A surprisingly low percentage of participants (11.4% and 5.7 %) were found to be adhering to the systems or psychological paradigms, respectively.

The **second** hypothesis was that Australian and New Zealand MFT practitioners would more likely adhere to a social constructionist paradigm than their counterparts in the USA. This hypothesis was also supported. Whereas the majority of participants in both studies were using a combination of paradigms, a considerably larger percentage of

respondents in the present study (39.8%) were adhering to a social constructionist paradigm, than were USA respondents (13.7%).

It is believed that these two hypotheses were confirmed due to the evident popularity of social constructionist approaches in Australasia. This trend also mirrors the evolution of social constructionists theories to date. Differences in figures can also be attributed partly to the interval between Booth's 1996 study and the current study.

However, the large number of participants practising from a combination of paradigms was consistent with Booth's study, particularly when a bimodal (systems and social constructionist) response selection was detected in both studies. This particular aspect of Booth's findings provided an indication of the trends expected in Australasian MFT practice. Two possible explanations for this were that practitioners are either transitioning from one paradigm to another, or are most likely engaging in "integrated" approaches (Blow & Sprenkle, 2001; Case & Robinson, 1990; Pinsof, Wynne, & Hambright, 1996; Durrant, 1994).

The rapid growth of the field and the need to keep up with society's constant changes, are responsible for the diversity of theoretical frameworks available. This added to the fact that outcome studies to date have shown no one therapeutic approach is better than the next, explains the current tendency to practice from an integration of family therapy models (Blow & Sprenkle, 2001).

approaches, however, focus more on how clients' social and language processes can construct alternative stories or realities related to their gender, culture, socio-economic and, political context. Treatment can be focused on the individual, the family or larger institutions, and it is also relatively short term. Therefore, it was believed that practitioners in private practice were more likely engaging in individual based therapy, whereas practitioners in public practices were more likely treating families or larger systems.

The **fourth** hypothesis was that marriage and family therapists in private practice would have a stronger adherence to the psychological paradigm, whereas therapists involved in public practice would have a stronger adherence to the systems or social constructionist paradigm. As shown in Table 7, this hypothesis was not confirmed. A possible explanation for this is the way in which therapy is funded and what approaches are seen as most cost-effective by "managed care" decision-makers. Alternatively, clients within the private sector in Australasia may not have the financial resources to afford longer-term therapies, which are evident in that sector of the USA population. However, this issue goes beyond the scope of the present research.

Since the field of MFT in Australasia originated in the 1970s, when systems approaches were surfacing overseas, it seems possible that practitioner's age, years of clinical experience and years working in MFT would be related to paradigm preference. As previously mentioned it is also evident that social constructionist as well as systems

Some earlier studies suggested that gender might be related to the clinical orientations practitioners are more likely to employ in their practice. Strano (1989) and Wogan and Norcross (1985) presented some evidence that males report preferences for more directive and structured therapies and techniques than females. Two other studies also suggested that family therapy is mainly a female occupation. The same studies also found that the main theoretical frameworks underpinning practice were systemic theories (Cocking and Miocevic, 2001; Nichols et al.). Therefore, the **third** hypothesis was that women were more likely to have a stronger adherence to the social constructionist or the systems paradigm, and a weaker adherence to the psychological paradigm than men. As shown in Table 6, this hypothesis was not confirmed, showing no significant differences between gender and paradigm preference in this sample.

In chapter two the characteristics of each of the three paradigms were reviewed as they have developed to date. Each paradigm adopts a different approach to treatment and more importantly to whom they treat. The psychological paradigm focuses on the individual, and assessment and treatment are used to eliminate specific symptoms or behaviours presented by the individual. Treatment usually takes a considerable amount of time, particularly psychodynamic based treatments, which focus on in-depth analyses of intrapersonal issues. In contrast, systems approaches focus on relationships and treatment is focused on the family system. Individual issues are resolved within the family context, and treatment is usually shorter than individual treatment. Social constructionist

approaches are relatively short-term compared to the more traditional individual focused approaches. Thus, the possibility that these characteristics would be related to paradigm preference was assessed.

The **fifth** hypothesis was that strength of adherence to the psychological paradigm would be directly related to age, years of clinical experience, years working in MFT and number of sessions in treatment. This hypothesis was not supported by the findings.

It was hypothesised as well that strength of adherence to the social constructionist or to the systems paradigm would be directly related to age, years of clinical experience, years in MFT, and inversely related to number of treatment sessions and family caseloads. The **sixth** hypothesis was not confirmed. Except for the fact that strength of adherence to the systems paradigm scores were found to be negatively correlated with weekly family caseload scores ( $r = -.26, p < .05$ ), indicating that the stronger the participants adhered to a systems paradigm, the fewer caseloads were reported by them. This can be explained by the fact that MFTs practising from systems paradigms treat families and/or larger systems. Therefore, the client would probably be the entire family or system, which would consume more time and reduce the number of clients a practitioner treats weekly.

The multidisciplinary approach to MFT is representative of the wider mental health profession. In Australasia MFT is a second profession for mental health practitioners. Practitioners with a primary qualification in psychology, social work, counselling and

psychotherapy have undergone different training as required by their particular discipline. Therefore, treatment will be conducted in a diversity of ways as evidenced by the different approaches. Hence, this study explored the relationship between professional discipline and strength of adherence to a particular paradigm (Table 8).

The **seventh** hypothesis was that marriage and family therapists with a professional qualification in psychology were more likely to have a stronger adherence to the psychological paradigm. They were also more likely to have a weaker adherence to the systems or the social constructionist paradigm than marriage and family therapists with a professional qualification in social work, counselling or psychotherapy. This hypothesis was not confirmed.

The **eighth** hypothesis was that marriage and family therapists' strength of adherence to either the psychological, systems, or social constructionist paradigms would be directly related to their supervisors' preferred paradigm. This hypothesis was confirmed for the postgraduate and for the most recent or current supervisor's preferred paradigm, but was not supported for the pre-graduate supervisor (Table 9).

The last or **ninth** hypothesis was that strength of adherence to a particular paradigm would gradually increase from the pregraduate supervisor's preferred paradigm to the postgraduate supervisor's preferred paradigm and then to the most recent or current supervisor's preferred paradigm. This hypothesis was supported for strength of adherence

to both the systems and social constructionist paradigms. However, strength of adherence to the psychological paradigm decreased from the post-graduate to the most recent or current supervisor's preferred paradigm.

The eight and ninth hypotheses tested the relationship between practitioners' paradigm adherence and their supervisors' preferred paradigm. Some studies revealed that supervision has an important influence on the theoretical orientation selected by MFTs (Norcross & Prochaska, 1983; Norcross & Wogan, 1983). The supervisor's theoretical orientation is also believed to influence a trainee's subsequent choice of orientation (Cummings & Lucchese, 1978; Guest & Beutler, 1988; Steiner, 1978). Additionally, Booth (1996) found that the most recent supervisor's preferred paradigm is predictive of membership into a particular paradigm adherence group. This study confirmed Booth's findings, and additionally, indicated that not only the most recent supervisor but the post-graduate supervisor has an influence on practitioner's orientation choice.

As previously mentioned, MFT is a second profession for many Australasians thus, practitioners have been previously trained in a different mental health discipline. For many practitioners their post-graduate supervisor might be their initial contact in training as a MFTs. Therefore, the preferred paradigm of their postgraduate supervisor should have more influence on their choice of MFT orientation than their pre-graduate supervisor's orientation. This explanation can also be related to the fact that participants' professional qualifications were not related to their adherence to a particular paradigm

(seventh hypothesis). Following the same logic, and assuming that the most recent or current supervisor is a different supervisor from their previous one, as well as referring back to the fact that participants have been practising for an average of 12 years. It seems probable, that practitioners are currently being supervised by someone with similar interests and ideas about treatment. This suggests that the current supervisor's preferred paradigm is the most influential on practitioner's current practice.

As shown in Table 9, this positive relationship between strength of adherence to a paradigm, and the postgraduate and most recent supervisor's preferred paradigm, was found to be particularly strong for the social constructionist paradigm. This finding once again confirms the acceptance and the enthusiasm for the social constructionist approaches in the Australasian MFT profession.

### **Limitations**

The results of this study must be seen within the limitations it encountered. The present findings are mainly limited by a response rate of 20%. Findings by Johnson & Sandberg (1999) indicate that few clinicians respond favorably to a request to respond to survey questionnaires that ask questions regarding their clinical practice. Doherty & Simmons (1996) reported a 34% response rate, and Booth a 20% response rate. Therefore, a high response rate for this study was not anticipated. However, to increase responses, follow-up notes were posted and participants were given a choice of posting back questionnaires



or responding through a webpage. Despite these attempts the higher response rate desired was not achieved. Still, the number of questionnaires returned were usable (N=88), and allowed a profile of some aspects of MFT practitioners to be established.

The limited sample size also contributed to the decision to group both New Zealand and Australian participants together for statistical analyses. Since a considerable number of participants responded through the web page it was also difficult to ascertain where these responses originated. Therefore, comparisons between New Zealand and Australian practitioners were not conducted. Findings might have applied more to one country than to the other.

Another limitation was the need to regroup specific question items into categories that otherwise might have provided more accurate figures on aspects such as levels of training and employment. Additionally, an accurate representation of practitioners' engagement in continuing education (e.g. workshops, seminars) was limited by the way the question was formulated. Continuing education units (CEUs) can be defined or calculated differently by different institutions, respondents were free to interpret the question, resulting in a large range of answers and missing data.

Using the present research methodology also limited the information participants shared. Of the three paradigms most practitioners were adhering to the social constructionist paradigm and a quantitative study is at variance to some practitioners' beliefs. Some

practitioners explained this as being a reason for not participating. It is also probable that more practitioners were non-compliant due to methodology and the manner in which they were approached (i.e. low response rates associated with surveys).

This study reinforces the fact that the paradigm preferred by the therapist's postgraduate and current or most recent supervisor is significantly related to paradigm adherence. However, from the findings it cannot be concluded that supervisors preferred paradigm is causative of practitioner's adherence to the same paradigm. It could be possible that the post-graduate supervisor for this sample is the first contact a trainee has had with MFT practice and therefore has mirrored the supervisor's practice. However, the most recent or current supervisor, for a sample with an average of 12 years practising MFT, is more likely to have been chosen based on theoretical orientation.

### **Contributions to Research and Future Directions**

The initiative for this study was to provide marriage and family therapy practitioners in Australasia information about contemporary MFT practice locally and internationally, while establishing a position with regards to a larger international framework. Data gained from this study, used in combination with overseas findings extend this type of research, providing information that describes both similarities and unique aspects of MFT and its practice in Australasia. The comparison of the findings did provide a baseline for future surveys, making it possible to describe the development of marriage

and family therapy in Australasia. Further research comparing Australian and New Zealand practitioners and follow up studies would help clarify how different practitioners experience the therapeutic process and how marriage and family therapy practice is being conducted.

In addition, a qualitative study of supervision experiences could clarify the causality of the practitioner's paradigm preference and supervisor's preferred paradigm. It could also address how supervision is catering for different genders, clients from different ethnic groups, socio-economic levels and socio-political contexts. This would provide useful information that would benefit the development of the field and the welfare of all the people it is accountable for.

### **Conclusions**

While Booth's study revealed a combination of gender, supervisor's preferred paradigm, and years of experience showed some ability to predict paradigm adherence, there was a great deal of variance unaccounted for by these variables. The present study included additional variables in the analyses expecting to identify relationships that might be more predictive of choice of a particular marriage and family therapy paradigm. However, no additional conclusive evidence was found on this matter.

Even though the statistical power of this study was limited by its sample size as well as by the large number of variables included, the pattern of influence (power of adherence) suggested by this study's results is coherent and generally consistent with prior literature. Furthermore, the preceding hypotheses that were supported by the present findings add to previous research, specifically to the assumption that practitioner's supervision has a powerful influence on the choice of theoretical framework.

Additionally, an interesting discrepancy was found that illustrates issues encountered by many mental health practitioners today. Psychology was the professional discipline reported by 20.5% of participants, and 22.7% reported that their most recent supervisor preferred a psychological paradigm, while only 5.7% were adhering to a psychological paradigm. These findings accounted for part of the 59% of participants who responded to the question re DSM-IV disorders treated. One explanation for this finding, which is consistent with the apparent trend highlighted, is that participants are practising from a combination of paradigms. Today Australasian MFTs seem to be following more integrative approaches in their family practice. For example, solution focused therapy is a combination of systemic techniques and social constructionist philosophies, and is being used in combination with narrative therapy (Durrant, 1994; Eron & Lund 1996). This explains the evident overlap between an individual approach to therapy and a couple or family approach.

These findings gain more strength when placing the present study within the context in which family therapy is being practiced. Currently, mental health practitioners are caught in a struggle between the need to validate the effectiveness of different MFT approaches, and the need to keep up with the ever-changing issues present in our society.

Social constructionist approaches have gained many advocates due to their socially responsible approach, and as such are serving as an agent of social change. The socio-cultural values of a colonised country and the multicultural issues brought forth by populations, such as those in Australia and New Zealand provide challenges for mental health professionals that social constructionist approaches have taken on board.

Therapists are assisting family members in creating an alternative story that is more egalitarian and more consistent with the family's view of the world.

Furthermore, as Pinsof and Wynne (1995) state, for family therapy to mature as a discipline and become respectable in the mental health field, it must be able to authenticate its efficacy through rigorously conducted high quality research. A gap already exists between empirically validated research and clinical practice (Sprenkle & Moon, 1996) and the fact that social constructionists are sceptical of traditional science, is not helping close this gap. Unwillingness of clinicians to partake in research, results from the perspective of some MFT approaches that positivist research is not compatible with their philosophies, as well as the idea that research is not consistent with clinical practice.

However, new developing approaches to research are continuing to evolve in attempts to explore new therapeutic approaches in ways that are more consistent with its philosophies and ways of treating people. In postmodern research the role of interpreter becomes more important. This is because postmodern researchers are not simply reporters but constructors of the social areas they research. In researching they are adding to the social world. For example, deconstruction is considered an appropriate method for addressing research questions which are related to the way language is constructed and the effect that is gained by a particular construction (Burr, 1995). These newer methods could provide crucial information about the effectiveness of different ways of treating people.

Postmodernism concentrates on the tensions of difference and similarity erupting from globalisation processes and consequently, might give us insight into cross-cultural interaction and interaction of local and global knowledge.

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## Appendix A

### Paradigm Adherence Scale (PAS)

Please indicate which statement best fits your point of view by circling only *one* response.

1. **Mr. and Mrs. Smith are frustrated about their child's problematic behaviour at home and take him to a therapist. The therapist is likely to hypothesise that:**
  - a. The child and each parent may have multiple, possibly competing, perspectives about the "problem behaviour".
  - b. The child may be inadvertently benefiting from misbehaviour.
  - c. The child's behaviours may be symptomatic of parental discord.
  
2. **A client comes to therapy with complaints of feeling anxious and having relationship problems. The therapist believes the client may feel less anxious after:**
  - a. Discussing and negotiating a different view of relationships with self and others.
  - b. Engaging in counselling and experiencing a positive change in his or her relationship.
  - c. Identifying and modifying thoughts, feelings, or behaviours associated with the anxiety.
  
3. **A client attends the first meeting with a therapist. The therapist should ask about:**
  - a. The client's ideas about the problem and significant meanings the problem has for him or her.
  - b. The description of the problem, including the frequency and duration of symptoms experienced by the client.
  - c. Who is involved in the problem and interactional patterns around the problem?
  
4. **Family members each tell a therapist their accounts of what happened during a recent family conflict. The therapist:**
  - a. Wishes he or she had been "a fly on the wall" during the conflict in order to know who was really at fault.
  - b. Believes that each member of the family participated in the creation of the problem.
  - c. Believes that each person's version of what happened is equally valid and plausible, and that negotiation would need to occur in order to reach a conclusion about the problem.
  
5. **A therapist who was assisting a family struggling with a problem assumed that:**
  - a. Family members can change only after they understand and deal with their individual problems.
  - b. Getting different interactions to occur can lead to healthy changes in family relationships.
  - c. Discussing and negotiating ideas for solutions with family members can lead to positive change.

6. **When working with parents and misbehaving teenagers, it is most helpful for the therapist to try to:**
  - a. Foster more consensus about appropriate behaviours and develop agreements about how to resolve differences.
  - b. Assist the parent with behaviour management and assist the teenager in modifying feelings, thoughts, or behaviours so that he or she may function in a healthy way.
  - c. Change family interactional sequences within which the problem is being maintained.
  
7. **When parents seek therapy related to managing their child's behaviour at home, an effective therapeutic intervention is:**
  - a. Setting up a program whose goal is to help the parents modify the child's behaviours.
  - b. Facilitating discussions whose goal is to create agreement about the nature of the problem and proposed solutions.
  - c. Making assignments whose goal is to alter family structure and hierarchy.
  
8. **A husband and wife bring their child to a therapist saying that the girl has low self-esteem and seems depressed. The therapist decides it would be best to:**
  - a. Define characteristics of "depressed" and "not depressed" with the family members and to help them to emphasise and expand their experiences of "not depressed".
  - b. Examine the family relationships and, having discovered how being depressed serves to maintain balance in the family system, work to facilitate a new balance that does not require depression.
  - c. See the girl individually to examine and to treat the self-esteem problems and depression and to include the parents to facilitate their understanding of these interventions.
  
9. **Mr. and Mrs. Jones are having problems in their marriage. The therapist believes the problem is most likely due to:**
  - a. Unsuccessful attempts to negotiate mutually acceptable ideas for change.
  - b. A difficulty in how they are relating to each other and in how they are attempting to solve the problem.
  - c. A psychological disturbance of one or both of the partners.
  
10. **Family members were seeking the advice of a therapist about problems getting along together. The therapist believed it was her or his job to:**
  - a. Understand the interpersonal parameters of the problem and perhaps assign tasks for family members.
  - b. Assess and to assist in modifying each family member's thoughts, feelings, and/or behaviours to facilitate a healthier adjustment to others in the household.
  - c. Help the family members to come to some agreement about how to resolve differences and improve family functioning.
  
11. **In meeting with clients, therapists:**
  - a. Assume they cannot help but influence and be influenced by the description and meaning of a problem brought to therapy.
  - b. Can maintain an objective stance about the client's symptoms, problems, and ways to treat these given their experience in the area of human behaviour.
  - c. Are aware that they may become part of the client's or family's "system" but can still maintain objectivity about what is going on and how best to intervene.



**12. A primary general goal of therapy when seeing a couple for marriage counselling is:**

- a. To facilitate change in each partner's feelings, thoughts, or behaviours.
- b. To facilitate change in the relationship through alteration of interactional sequences.
- c. To facilitate change through consensus building about what needs to happen for the relationship to improve.

**13. In order to help clients it is important to:**

- a. To try to get the cause of the problem so that it may be solved.
- b. Focus on constructing with clients a future where the problem does not occur.
- c. See that problems occur in reciprocal interactions and focus on patterns of interaction for finding solutions.

**14. The therapist's role in working with individuals, couples of families is to:**

- a. Facilitate change in the resolution of problematic patterns of interaction.
- b. Emphasise and expand processes of change, which are already occurring with clients.
- c. Assess clients and suggest interventions designed to produce healthier feelings, thoughts, and/or behaviours.

**15. Couples will find therapy to be helpful when:**

- a. Each person gains an understanding of the other's motivation or feeling behind particular behaviour.
- b. Both experience a positive change in their way of interacting.
- c. They are able to construct a new definition of a good relationship.

**16. A marriage therapist in the initial stages of therapy should:**

- a. Discuss with the couple ideas regarding the problem and proposed solutions.
- b. Observe the couple's interactional dynamics around the presenting problem.
- c. Assess each partner's personality style before proceeding with therapy.

**17. A therapist addressing a problem within a family context should:**

- a. Work on altering relationship patterns occurring between family members.
- b. Negotiate with family members how to guide the process of change in a more satisfying direction.
- c. Attempt to intervene on those emotional, behavioural or belief processes causing problems for family members.

**18. In couples therapy, the therapist should ask the clients to:**

- a. Create agreement about how to change the relationship.
- b. Modify internal beliefs of expectations and change behaviours to facilitate adjustment to the partner's personality.
- c. Engage in interactional tasks either during of outside the session that interrupts current interpersonal patterns.

**19. A family involved in therapy because one of the children is having school problems would observe the therapist:**

- a. Viewing the identified child as the symptom bearer for the family and helping the family change their interactions.
- b. Enlisting the family's help in getting the child to a higher level of emotional and behavioural functioning at school.
- c. Seeking input from the child, family, school, and any others involved with the problem in order to develop a consensus about how it should be solved.

**20. A client tells a therapist that he is depressed and nervous because his wife constantly nags at him. It would be helpful for the therapist:**

- a. To explore a variety of equal plausible explanations for the client's depression.
- b. To consider the client's depression and the wife's nagging behaviour as two important components of a reciprocal interactional sequence in which each affects the other.
- c. To view the client's depression as caused by the marital distress as well as problematic internal feelings and beliefs.

**21. A therapist is working with a couple and the partners have reported ongoing arguing and bickering with each other. The therapist may assume that:**

- a. The partners have been unable to come to agreement on the nature of their problems and solutions for change.
- b. They have not learned to accept each partner's limitations.
- c. The partners are "stuck" in a conflictual relationship pattern.

**22. A therapist meets with the family after the parents have expressed concern about the children's constant fighting with each other. The therapist is likely to focus on:**

- a. Identifying the children's beliefs and feelings underlying the fighting behaviour and having the parent provide incentives for getting along.
- b. Negotiating common grounds for how interactions could be more satisfying.
- c. Sequences of behaviours around the fighting and facilitating new patterns of interactions.

**23. When clients report feeling anxious the therapist should:**

- a. Assess the relationship context within which the anxiety is manifested.
- b. Ask about definitions of anxiety and what it would take to agree that anxiety is no longer a problem.
- c. Assess the feelings, thoughts, or behaviours that are related to the anxiety.

**24. A therapist:**

- a. Should assist families with finding solutions through negotiation and consensus building in order to be helpful to them.
- b. Should get to know the structural characteristics and interactional patterns of the whole family in order to be helpful to clients.
- c. Needs to examine the internal and external processes occurring with family members in order to be helpful to clients.

## Appendix B

### Demographic Data

Please answer the following questions only after finishing the PAS.

PLEASE TICK THE APPROPRIATE BOX OR FILL IN THE DESIGNATED SPACE

**1. Gender:**

1. Female .....☐      2. Male .....☐

**2. Age** \_\_\_\_\_

**3. Ethnic Identity:** \_\_\_\_\_

**4. Highest Qualification Earned:**

- |  |   |
|--|---|
| 1. Undergraduate Diploma or Certificate ... <input type="checkbox"/> | 4. Masters ..... <input type="checkbox"/> |
| 2. Bachelors ..... <input type="checkbox"/>                          | 5. PhD. .... <input type="checkbox"/>     |
| 3. Postgraduate Diploma ..... <input type="checkbox"/>               | 6. Other (please specify) _____           |

**5. Discipline of Highest Qualification:**

- |  |   |
|--|---|
| 1. Social Work ..... <input type="checkbox"/>    | 5. Marriage & family therapy.. <input type="checkbox"/> |
| 2. Psychology ..... <input type="checkbox"/>     | 6. Nursing ..... <input type="checkbox"/>               |
| 3. Counselling ..... <input type="checkbox"/>    | 7. Child psychotherapist ..... <input type="checkbox"/> |
| 4. Psychiatry/M.D. .... <input type="checkbox"/> | 8. Other (please specify) _____                         |

**6. Years of Clinical Experience (since receiving mental health qualification):** \_\_\_\_\_

**7. Primary Work Setting (Please tick the one you do most work in.):**

- |  |  |
|--|--|
| 1. Outpatient mental health (adult) ..... <input type="checkbox"/> | 7. University ..... <input type="checkbox"/>             |
| 2. Private Practice ..... <input type="checkbox"/>                 | 8. School ..... <input type="checkbox"/>                 |
| 3. Hospital ..... <input type="checkbox"/>                         | 9. EAP ..... <input type="checkbox"/>                    |
| 4. Community social service agency ..... <input type="checkbox"/>  | 10. Residential treatment ..... <input type="checkbox"/> |
| 5. CAFS ..... <input type="checkbox"/>                             | 11. Training Institute ..... <input type="checkbox"/>    |
| 6. CYFS ..... <input type="checkbox"/>                             | 12. Other (please specify) _____                         |

**8. Approximate Number of Years Working in Marriage and Family Therapy:** \_\_\_\_\_

9. Approximate Number of Continuing Education Units (workshops, seminars, etc.) Completed in Marriage and Family Therapy since Initial Training: \_\_\_\_\_

10. Current Family Caseload: \_\_\_\_\_ (cases or families/couples)

11. Weekly Clinical Contact Hours: \_\_\_\_\_

12. Average Number of Sessions Per Case: \_\_\_\_\_

13. Primary Modes of Practice (For each mode of practice, please tick one box):

	Often	Sometimes	Few	Never		Often	Sometimes	Few	Never
Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Couple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Combined	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Most Frequently Seen Presenting Problems (Please tick one or more.):

- |                                |                          |                                  |                          |
|--------------------------------|--------------------------|----------------------------------|--------------------------|
| 1. Marital problems .....      | <input type="checkbox"/> | 11. School problems .....        | <input type="checkbox"/> |
| 2. Parent-child problems ..... | <input type="checkbox"/> | 12. Financial problems .....     | <input type="checkbox"/> |
| 3. Child behaviour .....       | <input type="checkbox"/> | 13. Sexual problems .....        | <input type="checkbox"/> |
| 4. Depression .....            | <input type="checkbox"/> | 14. Eating Disorders .....       | <input type="checkbox"/> |
| 5. Anxiety .....               | <input type="checkbox"/> | 15. Sexual abuse .....           | <input type="checkbox"/> |
| 6. Alcohol/drugs .....         | <input type="checkbox"/> | 16. Suicide risk .....           | <input type="checkbox"/> |
| 7. Work problems .....         | <input type="checkbox"/> | 17. Communication .....          | <input type="checkbox"/> |
| 8. Post-divorce problems ..... | <input type="checkbox"/> | 18. Physical illness .....       | <input type="checkbox"/> |
| 9. Stepfamily problems .....   | <input type="checkbox"/> | 19. Grief/loss .....             | <input type="checkbox"/> |
| 10. Family Violence .....      | <input type="checkbox"/> | 20. Other (please specify) _____ |                          |

15. Most Frequent Disorders dealt with (Please tick one or more.):

- |                                |                          |                                  |                          |
|--------------------------------|--------------------------|----------------------------------|--------------------------|
| 1. Adjustment disorders .....  | <input type="checkbox"/> | 8. ADHD .....                    | <input type="checkbox"/> |
| 2. Anxiety disorders .....     | <input type="checkbox"/> | 9. Conduct disorders .....       | <input type="checkbox"/> |
| 3. Depressive disorders .....  | <input type="checkbox"/> | 10. Bipolar disorders .....      | <input type="checkbox"/> |
| 4. PTSD .....                  | <input type="checkbox"/> | 11. Psychotic disorders .....    | <input type="checkbox"/> |
| 5. Personality disorders ..... | <input type="checkbox"/> | 12. Schizophrenia .....          | <input type="checkbox"/> |
| 6. Alcohol/drug abuse .....    | <input type="checkbox"/> | 13. Sexual disorders .....       | <input type="checkbox"/> |
| 7. Eating disorders .....      | <input type="checkbox"/> | 14. Other (please specify) _____ |                          |

**16. Do You Feel Competent Treating (Please tick one or more.):**

- |  |                          |   |
|--|--------------------------|---|
| 1. Males .....                             | <input type="checkbox"/> | 10. Clients with an intellectual disability. <input type="checkbox"/> |
| 2. Females .....                           | <input type="checkbox"/> | 11. NZ European/Pakeha .....  |
| 3. Adolescents .....                       | <input type="checkbox"/> | 12. Australian .....  |
| 4. Children .....                          | <input type="checkbox"/> | 13. Maori .....   |
| 5. Adults .....                            | <input type="checkbox"/> | 14. Pacific Islander .....  |
| 6. Elderly .....                           | <input type="checkbox"/> | 15. Torres Strait Islanders.....                                      |
| 7. Homosexual males .....                  | <input type="checkbox"/> | 16. Asian.....  |
| 8. Homosexual females .....                | <input type="checkbox"/> | 17. Other (please specify) _____                                      |
| 9. Clients with physical impairments ..... | <input type="checkbox"/> |   |

*\*Please read the brief descriptions of three different styles of therapy (A, B, and C) and indicate which description best represents the perspective of the clinical supervisors you have had, based on what occurs during supervision sessions.*

**Style A:** This therapist focuses on the individual and intrapersonal processes, whether or not family members are present. Therapeutic change occurs through interventions designed to facilitate changing a person's thoughts, feelings, and/or behaviours. Clients are assessed and diagnosed using DSM-IV or other psychological criteria. Treatment decisions are made based on the results of this assessment, which identifies causes of problems and the target of intervention.

**Style B:** This clinician focuses on relationships and interpersonal processes. Individual concerns are usually redefined to a relational context. Therapeutic change occurs through social relationships, as problems brought to therapy are viewed as symptomatic of what is wrong in the client's relationships of significance. Social and familial interactions tend to be the primary targets for therapeutic interventions.

**Style C:** This practitioner focuses on the social and language processes that lead to clients (and therapists) deciding that a problem exists. Attention is given to the various perspectives and "realities" about the problem and its solutions, and ways in which these different views may be acknowledged and co-ordinated. The client may be an individual, a whole family, or varying groups of family members or significant others. Solutions in therapy usually arise through negotiating, creating agreements, constructing alternatives, and other consensus-building processes.

**17. For each of the supervisors listed below, please indicate which style of therapy best represents their perspective by circling only one of A, B, or C:**

	Therapy Style
1. Your primary pre-graduate practicum/internship clinical supervisor	A B C
2. Your postgraduate clinical supervisor	A B C
3. Your current or most recent clinical supervisor	A B C

## Appendix C

Dear Practitioner:

My Name is Alexandra Mealla, I am a graduate student in the School of Psychology at Massey University in New Zealand. As part of my MA thesis I wish to survey therapists from various disciplines who work with families. My main objective is to collect information about the professional practice of family therapy in New Zealand and Australia. I intend to compare these results with similar studies conducted in the United States.

I am writing to you in the hope that you will be willing to participate in the research study regarding various theoretical frameworks and therapeutic techniques utilised by marriage and family therapy professionals. Should you agree to participate, you will be asked to complete the enclosed questionnaire, consisting of the Paradigm Adherence Scale (PAS), and a demographic/background information sheet.

The PAS focuses on theoretical assumptions and beliefs related to marriage and family therapy, and techniques and interventions employed in clinical practice. By completing the questionnaire, you will contribute to knowledge about contemporary theoretical and practical trends in the field in New Zealand and Australia. You can also get feedback about how your techniques or orientation compares to other practitioners in child and family therapy.

The implementation of this study is bound by the New Zealand Psychological Society Code of Ethics and there are no anticipated risks in your participation in the study. The survey will take approximately 15 to 20 minutes of your time.

This questionnaire is anonymous and no one except the principal investigator and her thesis supervisors will have access to the information collected. Each questionnaire has been given an identification number to keep track of responders and non-responders; you are not asked to disclose your name on the survey. To further preserve your confidentiality, the list of names corresponding to identification numbers will be stored separately from the questionnaire data and will be destroyed at the end of the study. I would appreciate you answering all questions on the PAS; however, you are free to choose not to answer individual questions. You are also free to withdraw from the study at any time.

When you respond to the questionnaire, please complete the PAS first, before responding to the demographic data sheet. Please return the questionnaire in the freepost envelope provided by September 21, 2001.

If you wish to obtain a summary of the findings of the study when completed please send in the attached slip with your name and address. The slip will be separated from the questionnaire so there will be no association between your contact details and the completed questionnaire.

Completion of the questionnaire implies that you have consented to take part in the study. Should you desire further information, or if you have any questions about the research now or at a later date you may contact the principal investigator at the address above.

Thank you in advance for your time and effort.

Yours sincerely,

Alexandra Mealla  
Principal Investigator &  
Masters Candidate

E- mail: [Maria.Mealla.1.@uni.massey.ac.nz](mailto:Maria.Mealla.1.@uni.massey.ac.nz)

Phone: 025-641-2425

✂-----

I would like to receive a summary of the findings of the study upon completion.

Please post it to the following address:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_

City: \_\_\_\_\_

## Appendix D

### Scoring Key for the PAS

P = Psychological Paradigm

S = Systems Paradigm

SC = Social Constructionist Paradigm

1a. SC	7a. P	13a. P	19a. SC
1b. P	7b. SC	13b. SC	19b. P
1c. S	7c. S	13c. S	19c. SC
2a. SC	8a. SC	14a. S	20a. SC
2b. S	8b. S	14b. SC	20b. S
2c. P	8c. P	14c. P	20c. P
3a. SC	9a. SC	15a. P	21a. SC
3b. P	9b. S	15b. S	21b. P
3c. S	9c. P	15c. SC	21c. S
4a. P	10a. S	16a. SC	22a. P
4b. S	10b. P	16b. S	22b. SC
4c. SC	10c. SC	16c. P	22c. S
5a. P	11a. SC	17a. S	23a. S
5b. S	11b. P	17b. SC	23b. SC
5c. SC	11c. S	17c. P	23c. P
6a. SC	12a. P	18a. SC	24a. SC
6b. P	12b. S	18b. P	24b. S
6c. S	12c. SC	18c. S	24c. P

Someone is categorised as adhering to one of the three paradigms if 12 or more item responses (at least 50%) are reflective of one primary paradigm and if the person chose not more than 8 items (33% or less) for each of the other two paradigms. For instance, a subject would be classified as primarily adhering to the systems paradigm if 15 item responses were associated with the systems paradigm, and 6 and 3 responses were associated with the social constructionist and psychological paradigms, respectively. A subject receiving scores of 12, 10, and 2 for the social constructionist, systems and psychological paradigms would be classified as adhering to a combination of paradigms.



## Appendix E

**Table 10.** *Percentages of Sample Reporting Most Frequent Presenting Problems (N=86).*

Presenting Problem	<i>n</i>	%
1. Marital problems	70	81.4
2. Parent-child problems	59	68.6
3. Child behaviour	53	61.6
4. Depression	68	79.1
5. Anxiety	47	54.7
6. Alcohol/drugs	48	55.8
7. Work problems	23	26.7
8. Post-divorce problems	32	37.2
9. Stepfamily problems	26	30.2
10. Family violence	33	38.4
11. School problems	26	30.2
12. Financial problems	15	17.4
13. Sexual problems	40	46.5
14. Eating disorders	24	27.9
15. Sexual abuse	37	43.0
16. Suicide risk	37	43.0
17. Communication problems	64	74.4
18. Physical illness	27	31.4
19. Grief/loss	66	76.7
20. Other	1	1.2

**Table 11.** *Percentages of Sample Reporting Most Frequent Disorders Treated (N=52).*

Disorders Treated	<i>n</i>	%
1. Adjustment disorders	16	30.7
2. Anxiety disorders	31	59.6
3. Depressive disorders	43	82.7
4. PTSD	33	63.5
5. Personality disorders	10	19.2
6. Alcohol/drug abuse	33	63.5
7. Eating disorders	17	32.7
8. ADHD	27	51.9
9. Conduct disorder	22	42.3
10. Bipolar disorder	10	19.2
11. Psychotic disorders	8	15.4
12. Schizophrenia	7	13.5
13. Sexual disorders	28	53.8
14. Other	3	5.8

**Table 12.** *Percentages of Sample's Confidence Treating Specific Populations (N=81)*

<b>Confidence in treating:</b>		
	<i>n</i>	<i>%</i>
1. Males	81	100
2. Females	78	96.3
3. Adolescents	64	79.0
4. Children	58	71.6
5. Adults	80	98.8
6. Elderly	46	56.8
7. Homosexual males	58	71.6
8. Homosexual females	61	75.3
9. Clients with physical impairments	64	79.0
10. Clients with intellectual disabilities	33	40.7
11. NZ European/Paheka	78	96.3
12. Maori	38	46.9
13. Australian European	71	87.7
14. Australian Aboriginal	16	19.8
15. Pacific Islander	34	42.0
16. Torres Strait Islander	10	12.3
17. Asian	25	30.9
18. Other	8	9.9