

1

The Beginning Family Therapist: Taking on the Challenge

Tom is handed the intake paperwork for his first client at his new practicum site. Both excited and anxious, he scans the information. In the section on "primary reason for coming to therapy" the client has written "need ways to cope with my husband's drinking and his hitting the children." Tom grows more apprehensive as he wonders where to start. Should he simply listen to the woman's story as it unfolds? Or should he take a more direct approach and immediately assess for a substance abuse problem? Still another focus is the indication of child abuse. Perhaps this very serious matter takes precedence over every other issue.

Sally reviews today's back-to-back schedule and wonders if she will make it through the day. After learning yesterday that her father has cancer and is likely to die within the year, she tossed and turned all night. Exhausted but wanting to do a good job with her clients, she begins thinking about her first client family that day. The Joneses have an 8-year-old son with a multitude of problems: leukemia and attention-deficit/hyperactivity disorder, to name two. He has been referred by the family's physician "to develop coping skills." For a fleeting moment, Sally wonders if the pain she feels about her father will affect her therapy today, but she does not have much time to reflect on this question because her first session starts in 5 minutes.

Ann winces as she recalls her group supervision session yesterday. She had thought the videotaped session of her work with Mrs. Thomas showed what excellent joining skills she had. It would be clear to her

supervisor and her fellow students that Mrs. Thomas liked therapy and took Ann's suggestions very seriously. But instead of focusing on the therapist-client rapport, the group had overwhelmed Ann with assessment questions she had not even considered. How was Mrs. Thomas's divorce connected to her depression? Did Ann think her late-night alcohol use reflected a substance abuse problem? Were Mrs. Thomas's children being neglected because she had little energy or time for parenting? What should Ann's level of involvement be in "helping" Mrs. Thomas find a job? Ann wondered if she had the necessary qualities to even be the therapist when she had so clearly missed important assessment questions for her client.

Most beginning therapists experience a host of anxious feelings when they start clinical work. They are aware of their inadequacies more than their strengths, and need help to learn how to acquire the skills, knowledge, and sense of competency necessary to do good clinical work.

Many therapists complete the didactic part of their training with a sense of mastery and competence. After all, by the time they enter graduate school, the life of a student is very familiar, and they are accustomed to academic achievement in their course work. Academic accomplishments, however, do not necessarily translate into therapeutic competence. Indeed, Figley and Nelson (1989) have pointed out that most of the core competencies of therapists are qualities that cannot be taught in a traditional didactic manner. Faculty and students are left wondering how best to impart and acquire, respectively, the skills basic to clinical work.

The gap between academic work and the implementation of techniques or the application of theories in clinical sessions can seem huge. After a year of intense academic instruction, students often begin their clinical work with unstated questions:

"What am I supposed to say to the client?"

"How do I handle situation X?"

"What should happen after I complete the intake form?"

"Can clients tell I'm new at this and feeling completely inadequate and overwhelmed?"

"How do I keep all the information from the session clear and how do I know what is most important?"

"If I don't use a powerful intervention or technique during the first couple of sessions, am I a failure?"

"I know I should have a theory for this case but I just don't understand how to apply information from my theories class to this acting-out adolescent and her hostile mother."

"How will I know if the clients actually get better?"

What students need is a way to develop their skills as therapists as they begin their clinical work. This book provides practical, "how to" guidelines on essential therapeutic skills from thorough assessment to careful treatment planning, from the nuts and bolts of specific interventions to the nuances of establishing therapeutic relationships and troubleshooting when treatment gets "stuck."

Reflecting the trend toward integrative approaches in family therapy, mental health, and the medical field, we stress a biopsychosocial view of assessment and treatment. This approach is designed to meet the changing demands of mental health care provision, and it means that beginning family therapists will need to acquire new skills and hone traditional ones. The concrete guidelines in this book address these issues. For example, therapists are increasingly required to assess, diagnose, and treat clients in a more expedient manner. The existence of new research on the efficacy of specific treatments for specific problems means that therapists must know the literature on a certain problem or diagnosis. Dubbed "differential therapeutics" and the "specificity question" by diverse professionals, the issue of treatment fit was judged by Piercy and Sprenkle (1990) to be fundamental to therapy in this decade. In their review of the previous decade of family therapy research, these authors highlight the question of "what treatment works best for what problem under what set of circumstances" (p. 1120).

The ability to integrate family therapy theory and interventions with individual diagnosis and treatment will be especially valuable as therapists begin their careers. While family therapy offers a unique and important perspective in clinical work, much of what goes on in treatment shares common assumptions with all therapies. Certain clinical skills—assessing for suicide risk or substance abuse, making an effective referral—are intrinsic to any good therapy. This book goes beyond the boundaries of traditional family therapy to be as inclusive as possible of essential clinical skills.

Frequently, beginning family therapy students make treatment decisions based on their supervisors' favorite theoretical orientation or the specific theoretical approach predominant in their clinic. We believe that assessing the appropriateness of a family therapy treatment for a specific problem is an essential clinical skill. It is important to be able to recognize when a problem is outside the scope of a family therapist's practice (or skill level) and could best be treated by another mental health professional or in tandem with another health care professional.

Indeed, research on biological etiologies of mental illness and psychopharmacology suggests that therapists must be conversant with more than "talk therapies." A growing focus on treatment teams and multi-

disciplinary treatment approaches means that therapists must increasingly attend to the biological component of the biopsychosocial model and learn to collaborate with other health care professionals. A knowledge base in medication management and the ability to consult with physicians is one aspect of this new approach.

In addition, strong demands for quality assurance, timeliness, and cost-effectiveness are being placed on therapists by managed care companies. The movement toward quality assurance panels and set-treatment protocols in managed care suggests that students must learn the state of the art treatment for a given problem. Consideration of these changes underlie many of the approaches and practices discussed in this book, fitting with our view that current clinical issues go beyond the beginning therapist's need to translate theory into practice. Thus, while family interaction remains a focus of attention herein, our goal is to prepare beginning therapists to integrate information and skills in order to best meet the needs of diverse client families.

While the bulk of this book discusses specific processes and skills that are important throughout the therapeutic journey, we devote the first chapter to that most basic of concerns for the beginning therapist—understanding and managing beginners' jitters.

GETTING STARTED

"It was my first session with a client and my heart was racing. I had no idea what to do with this family, and I wasn't really sure if they knew why they were all there. I was talking with the mother, who requested the appointment, to find out how much the other family members knew about why they came in when I realized that I didn't really like this lady. . . ."

This story, shared by a practicum student, encompasses two essential and pressing issues shared by most beginning therapists. One revolves around the question "What to do?" and the other involves managing one's own feelings and reactions to diverse clients and clinical situations.

Learning the art and science of doing therapy is a challenging task, particularly when first seeing clients. Many beginning therapists have periodic feelings of inadequacy and insecurity about their clinical abilities. Some may fear that they will directly harm their clients or cause their condition to deteriorate because of clinical mistakes. Others fear that they will not be able to help their clients because of their inexperience. A few doubt their talent and ability as therapists to the extent that they seriously question whether or not to remain in the field.

Therapists and supervisors alike need to see confidence issues from a developmental perspective. Given their lack of clinical experience, it is only natural that beginning therapists question their competence. In fact, as supervisors, we worry more about beginning therapists who seem extremely confident in their abilities. This feeling of confidence is incongruent with the complexity and difficulty of learning to do therapy well.

MANAGING ANXIETY AND ISSUES OF CONFIDENCE

How does the beginning therapist deal with a lack of confidence, or with feeling overwhelmed and anxious? First, therapists must recognize that these feelings are completely normal. Although the intensity of the feelings and the way of coping will vary from therapist to therapist, every beginning therapist struggles to some degree with these feelings. Therapists who do not acknowledge this often get trapped in a vicious circle. They interpret feelings of being overwhelmed as a possible sign that they are not cut out to be therapists, which only serves to fuel their anxiety.

Second, beginning therapists need to share these experiences with other therapists and supervisors. Sharing feelings of anxiety or lack of confidence can help to normalize the experience. Unfortunately, it is fear of being incompetent or a failure that prevents beginning therapists from sharing their struggles with others. When a therapist does take the risk and shares his or her fears with peers, others generally disclose the same worries. This in turn helps the beginning therapist to accept that these struggles are developmentally appropriate rather than a sign of being unsuited for the profession.

Third, distorted cognitions or beliefs may contribute to a therapist's fears or struggles with confidence. These can be addressed using cognitive restructuring. The first step is for the therapist to identify cognitions or beliefs about the ability to do therapy effectively. For example, some beginners have questioned the ethicality of treating difficult clients (or any client at all!) when more experienced therapists are available. When distortions are identified, perhaps with a supervisor's help, they can be "replaced" with more constructive thoughts that benefit coping and decrease anxiety. Recalling that such seasoned clinicians as Salvador Minuchin and Virginia Satir were once beginners can help. A good battery of constructive thoughts and images goes a long way toward soothing beginners' jitters.

Fourth, it is crucial to realize that the therapist-client relationship is inherently therapeutic. A therapist doesn't need to *do* something to be experienced positively by clients. This is very reassuring to most begin-

ning therapists because they generally have confidence in their relational skills. When beginning therapists are instructed as to the importance of joining and empathically listening to their clients, most therapists are relieved, feeling "I can do that!"

Finally, beginning therapists need to recognize that their early experiences in seeing clients often involve a steep learning curve, like any other new job. You will be less anxious doing an intake with a family if you have one or two intakes "under your belt." It takes time, however, to gain enough experience before many situations become familiar.

Many beginning therapists wonder at what point they will stop struggling with issues of confidence. Experienced clinicians indicated that after 5 to 7 years (or about 5,000 to 7,000 hours) of clinical experience, they had encountered most clinical issues or problems several times before. As a result, they felt very secure or confident in their abilities as therapists.

Fortunately, therapists don't need to complete 5,000 to 7,000 hours of work to see a notable improvement in their confidence. The intense feelings of anxiety and being overwhelmed that are common in the very beginning generally subside after a month or so of seeing clients. Beginning therapists also become less fearful that they will do something to harm their clients, although they continue to struggle with feelings of being ineffective or unhelpful.

Obtaining 500 to 700 hours appears to be another significant turning point in the growth of therapist confidence. At this level of experience, beginning therapists generally report greater confidence in conceptualizing cases. They often report knowing what needs to be changed, but are unsure of how to intervene to bring that change about.

Most therapists will have confidence in their overall abilities by the time they have had 1,000 to 1,500 hours of clinical experience. At this point, they are better at conceptualizing cases and have also developed a repertoire of effective interventions. Of course, therapists can still experience periodic doubts about their abilities, particularly when struggling with difficult cases or issues. Issues of confidence may also reemerge if therapists start working with new and unfamiliar populations. However, most therapists at this stage are not plagued by doubts about their clinical ability.

STAGES OF THERAPIST DEVELOPMENT

McCollum (1990) notes that therapists trained in individual therapy generally go through three stages of development when learning to do family therapy. In the first stage, they focus on acquiring the skills necessary to work with families. In the second stage, they learn to apply systemic theory

to their clinical work, and in the third, "self of the therapist" stage, they focus on more personal issues in relationship to their clinical work, such as exploring how their family of origin experiences affect their work with families.

Although McCollum's observations were based on teaching experienced therapists to do family therapy, these stages also apply to individuals learning family therapy without prior clinical experience. In essence, the initial skills stage is characterized by therapists trying to figure out what to do with clients. This focus then shifts in the theory stage to how to think. In the final stage, the therapist focuses on the use of self in being with a family.

Although each stage has a particular emphasis, all three may overlap from time to time. While developmental stages are differentiated by time and experience, other factors can bring any or all of their foci to the fore—particular client families and clinical issues, the emphasis of a certain supervisor or training program, and the abiding interests of the therapist, among others.

Stage One: Learning Essential Skills

Before therapists start their clinical work, they often experience a mixture of feelings. Most report an excitement at finally beginning to "do" therapy, and some even express impatience to see clients. They are eager to apply what they have learned in their classes by working with people in therapy. But the predominant emotion that most therapists report before seeing their first client is significant anxiety.

It is natural for therapists to have these worries before they see their first client and even after they begin to work. Beginning therapists report feeling overwhelmed by the experience. Many report going home after seeing clients and crying, while others report that the stress results in headaches, difficulty sleeping, stomachaches, or changes in appetite.

This early stage is a time for beginners to learn and practice basic skills. Learning to relax and be present in the therapy room with first clients is a good place to start. A solid assessment and effective treatment hinge on the therapist's ability to listen and attend to the client's story, and to show the client that he or she is understood. Beginners can learn to replace their anxiety about "doing something" with relaxed curiosity and empathy. This approach leads to useful questions and inquiries, which is where therapy begins.

Stage Two: Learning to Conceptualize Cases

Beginning therapists soon recognize that the therapeutic relationship is a necessary but not always sufficient ingredient for change. They no longer

are content simply to be with their clients; they realize that some clients need concrete ideas or suggestions for change. At the same time, therapists also become aware that to be effective, interventions must be rooted in a clear understanding of family dynamics. As a result, therapists soon move into a second stage, where emphasis is placed on conceptualizing what is happening in their cases.

Learning to conceptualize cases can be difficult and frustrating. In this stage, therapists frequently struggle with issues such as the following:

"How do I know what is the most important information to attend to in a case?"

"My clients keep coming in with a different problem each week. How do I figure out what to focus on?"

"I know I should have theory for this case, but I'm not sure what theory would 'work' here."

"I thought I knew what we should be working on last week, but now I'm confused again."

"I know I should be focusing on the process, but I feel like I'm stuck in the content."

Typically, beginning therapists are able to develop good insights and hypotheses, but will have difficulty connecting these pieces together into a coherent picture or treatment plan. Gradually, there will be moments of clarity wherein the pieces fit together. With the passage of time, these moments begin to last longer than the periods of haze and confusion.

Early in the second stage, many therapists find it helpful to adopt a particular theoretical orientation for conceptualizing cases (McCollum, 1990). As they gain intensive experience with one theoretical framework, they begin to recognize its limitations and may try others. As therapists explore different theories, they eventually develop their own framework, integrating the best parts of the different orientations that they have adopted.

Stage Three: The Therapist-as-Self

As therapists become more skilled at and comfortable with conceptualizing cases, they shift more of their focus to looking at themselves in therapy. There is a growing recognition that the self of the therapist can greatly influence therapy, and beginning family therapists gradually become more interested in identifying their unique contributions to the therapeutic encounter.

During this stage, therapists will often explore how the therapist-as-self is both an asset and liability in therapy. Many of our personal experiences can become catalysts for new ideas and understanding in therapeutic

work. For example, a therapist who has been able to successfully develop an adult-to-adult relationship with his or her parents may use that personal experience in working with clients who are struggling with issues of differentiation. Specific life experiences—trauma, parenthood, separation, illness—may all come into play in a way that benefits therapeutic work.

However, therapists' unresolved issues or "growth areas" can become impediments in therapy. Therefore, some therapists choose to explore their personal issues more closely at this stage, often by seeking therapy for themselves. The growth and insight derived from working on these issues can provide the perspective necessary to make constructive use of life experiences in therapy.

OBSESSING ABOUT CLINICAL WORK

Many beginning therapists report that they cannot stop thinking about therapy or their clients. In fact, thinking about clients seems to fill every waking moment and even many nonwaking moments. It is not unusual for beginning therapists to report having dreams about their clients or doing therapy.

Learning to do anything new, particularly something as challenging as therapy, can easily consume much of one's time, thoughts, and energy. Furthermore, most people who choose therapy as a profession have a deep compassion and concern for people. It is often difficult not to think about clients, particularly when they are in considerable pain or distress.

Thinking (or even obsessing) about clients is something that tends to subside with time and experience. Most experienced therapists report thinking very little about their clients outside the therapy hour. One reason for this change is that the therapist gradually gains a greater sense of clinical mastery by virtue of experience. In addition, therapists learn to balance objectivity and emotional involvement with clients. In a sense, therapists learn how to construct an emotional boundary. If the boundary becomes too diffuse, the therapist may be overwhelmed and inducted into the family system. If it is too rigid, he or she may lack the empathy necessary to adequately understand the issues and join with the family. The former problem is characteristic of beginning therapists, who, with time, learn to better regulate this boundary.

CONCLUSION

Building confidence and competence in one's clinical work is part of the larger process of learning to do good therapy. The greatest task for a be-