About the Author

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CHAPTER 12

Process–Outcome Research and the Family-Based Model

Refining and Operationalizing Key Theoretical Concepts

The aim of this chapter is to show how I used the process–outcome research method of "task analysis" (Rice & Greenberg, 1984) to create the 15-step family-based model for difficult adolescents.* I describe how I used videotaped counseling sessions and focus group interviews with both counselors and clients to shape and refine the model itself. The findings from these sessions and interviews served as feedback to clarify and strengthen the theoretical concepts developed in earlier phases of the research. For example, in the focus group interviews, parents reported that disrespect was an "ace" that neutralized their effectiveness. This information led to a change in the original model and the addition of disrespect as one of the "five aces." This chapter also shows how concepts drawn directly from this model can be operationalized and tested for effectiveness via outcome measures. Finally, future implications of this type of process–outcome research for family therapy and other mental health fields are discussed and highlighted.

CURRENT CHALLENGES AND CONTROVERSIES IN MENTAL HEALTH CARE RESEARCH

Ready or not, our field is caught up in a health care revolution that demands accountability. Health care insurers require demonstrations of our services'

*I would like to give special recognition to Dr. Neil Schiff and Jay Haley for their review of and help with this chapter. They are among the first to open up their videotape library for the scrutiny and analysis of an entire case study. Because of their foresight and vision, as well as their help and guidance, this research was possible.

effectiveness with particular problems and treatment populations. Many counselors write books and articles that claim effectiveness, but fail to demonstrate the processes and empirical outcomes that back up such claims. This lack of accountability and credibility gives little comfort to third-party payers, legislators, students, or fellow professionals. The problem can be traced to three main causes: (1) treatment models with procedures that are abstract, generalized, and difficult to implement; (2) outcome studies that answer the question "Does it work?" before answering the question "How does it work?"; and (3) a failure to combine process and outcome research to create, refine, or operationalize treatment models.

Treatment Models That Lack Specificity

Most treatment models either lack specificity or contain procedures that are abstract, generalized, and difficult to implement. A particular model is often employed because it is popular at the time, because it fits with a particular counselor's treatment philosophy, or because it mirrors the philosophy of the school where the counselor received his or her training. In an article on research into the effectiveness of marital and family therapy, Pinsof and Wynne (1995) conclude that "in almost all of [this] research, it is impossible to know what actually occurred in counseling" (p. 606). This should certainly concern counselors as the 21st century approaches. Without the specification of key concepts, it is difficult if not impossible to assess what takes place in any particular counseling session so that its effectiveness can be determined. Counseling then becomes a mystical process behind closed doors, rather than a systematic one that is well articulated. Under these conditions, it is not surprising that third-party payers are leery about funding undefined and untested treatments.

Outcome Studies That Fail to Account for Their Results

The majority of current research consists of comparative/competitive or "who won" studies, which pit one treatment approach against another (e.g., cognitive therapy vs. structural family therapy with depressed women aged 19–35) but fail to specify what factors within the model were associated with improvement and deterioration. Without this information, the study may have little relevance for an individual counselor. The counselor reads that one treatment approach is better than another, but has no idea what particular techniques might be responsible for the superiority of the first approach. Outcome research without process research is therefore minimally informative.

In a review summarizing trends in theory and research from 1980 to 1987, Bednar, Burlingame, and Masters (1988) stated that 140 family counseling studies revealed a virtual absence of treatment variables drawn from systems theory literature. The reviewers concluded by saying that rigorous experimental outcome research was premature for a field that had yet to operationalize its essential theoretical concepts. Wynne (1988) reached a similar conclusion:

> The term "research" is often understood by psychotherapists as referring to confirmatory studies, such as comparative studies of the outcome of the two methods of counseling. In sharp contrast to this usual view, at the present stage of development of the family therapy field, a strong emphasis should be given to exploratory, discovery-oriented and hypothesis-generating research, rather than primarily or exclusively to confirmatory research. (p. 251)

Before a particular counseling model can be applied, the concepts must be operationally defined. Outcome studies that answer the question "Does it work?" before answering the question "How does it work?" are suspect and premature.

Failure to Combine Process and Outcome Research

Once investigators have an idea of how a model performs through process research, they must conduct outcome studies to determine whether the model does work. Often one step is conducted without the other. If the outcome studies fail to show effectiveness, this is invaluable feedback. It informs the researchers that parts of the model are not working or that this particular model does not work with a particular problem (e.g., alcohol or drug use, depression, psychosis) or treatment population (e.g., adult, individual, child). The researchers are then forced to reevaluate the model to strengthen or revise it in specific ways.

GOALS AND OBJECTIVES OF MY PROJECT

To address these challenges, I focused on the following two objectives in my research: (1) developing a treatment manual, and (2) combining process and outcome research. This section describes how focusing on these areas addressed each of the research gaps noted above.

Developing a Treatment Manual

Before embarking on this project in 1994, I realized that I had to address each of the above-described research gaps. First, I had to provide counselors with a

road map of step-by-step procedures, techniques, themes, and therapeutic maneuvers. This was needed because current books and articles on treatment with difficult adolescents often lacked specificity. The current treatment models (i.e., multitarget ecological treatment, functional family therapy, social learning counseling, strategic therapy, and structural therapy) articulated key theoretical concepts (e.g., hierarchy, boundaries, power, ecosystems, coercive interaction patterns), but failed to provide readers with a step-by-step account of how and when these concepts should be implemented. In addition, there was an abundance of "who won" studies with difficult adolescents (e.g., Chamberlain & Rosicky, 1995), but these studies lacked relevance for the individual counselor because they failed to provide information on the specific treatment components that affected change.

With such a challenging population, I wanted to be able to tell a counselor what to do and when to do it if *A*, *B*, or *C* should occur. For example, what should the counselor do the next time the parents refuse to take charge? Can he or she choose from a menu of creative and innovative techniques? Although I realized that there is no magic formula, I needed a more explicit road map to increase my chances of helping the counselor succeed and keep one step ahead of the cunning adolescent or resistant parent.

Second, the treatment manual also had to be flexible enough to be customized to meet the needs of individual clients without stifling the flexibility, innovation, and creativity of the counselor. My goal was not to produce a rigid application of treatment, but to give guidelines that were systemic yet adaptable enough to encompass novel situations and circumstances. For example, what does one do with a single mother who cannot take charge because she has no support systems? Or with an adolescent who is protected by a highly dysfunctional set of peers? Many manuals feature a simplistic, "one size fits all" approach that is simply unrealistic with difficult adolescents. A counselor only has to be around them for a short time to realize that creativity and quick thinking are essential qualities for success.

Finally, I felt that the manual itself had to emerge directly from an intensive case-by-case study of counseling sessions and focus group interviews with both clients and counselors, rather than strictly from a literature review in the library. As stated earlier, many family counseling models have yet to operationalize essential theoretical concepts or to map out these concepts in clinical practice rather than in a laboratory setting. As a result, I felt that theory had to be linked directly with clinical practice.

Combining Process and Outcome Research

To accomplish my second goal, I used a "task analysis" method (Rice & Greenberg, 1984) to conduct the process research portion of the study, and then I used outcome measures to test the key theoretical concepts that

emerged. A task analysis methodology would help me discover key moments of change within counseling sessions from an intensive analysis of videotaped interviews and self-reports from clients and counselors. The characteristics of these moments of change could then be written up as hypotheses and tested through outcome measures. Results from these outcome measures would then be used to clarify or strengthen these moments of change. For example, pretest measures supported the hypothesis that difficult adolescents and their parents enter treatment with severe conflict and a lack of nurturance. This outcome data strengthened the need for the procedural step or restoring nurturance and tenderness within the 15-step model. Elsewhere, my colleagues and I have discussed the benefits and procedures of blending qualitative process research and quantitative outcome research within the same study, and have described how these two methods can reciprocally help clarify, strengthen, or refine key theoretical concepts (see Sells, Smith, & Sprenkle, 1995).

DEVELOPMENT OF THE 15-STEP MODEL: A TASK ANALYSIS APPROACH

In this section, I illustrate through sample flow charts and coding manuals how the 15-step family-based model was created. The entire process can be referred to as "discovery-oriented" because the key concepts were generated not from a review of the literature, but directly from an intensive study of clinical practice cases. The research consisted of the following five phases: (I) creating idealized performance models, (II) creating revised performance models, (III) broadening the range of application, (IV) consolidating the theoretical yield, and (V) combining process and outcome research.

Phase I: Creating Idealized Performance Models

During the first phase of the project, I went to the library and located books and articles that outlined theoretical concepts and treatment procedures for difficult adolescents (i.e., teenagers between the ages of 12 and 18 who meet the DSM-IV diagnostic criteria for either oppositional defiant disorder or conduct disorder).* I extracted the major concepts from this literature and

*The books and articles under study came from structural, strategic, solution-focused, and multidimensional treatment models (i.e., Fishman, 1988; Haley, 1976, 1980; Keim, 1996; Liddle, 1995; Madanes, 1991; Minuchin, 1974; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Price, 1996; Selekman, 1993). Other treatment models were not selected because they were not theoretically congruent with the 15-step family-based model or a systems theory framework. All of the models selected for review were theoretically congruent with a family systems perspective.

placed them into a spreadsheet format. I combined these spreadsheets into three idealized performance models—what should theoretically happen throughout the treatment process. The key concepts were then placed in a step-by-step treatment or laid out within the literature. The process of consolidating the many different concepts on spreadsheets and arranging them in the three hypothesized series of optimal procedural steps was like taking hundreds of tiny puzzle pieces and trying to place them together in the proper order, with little to go on except similar shapes and colors. The three idealized theoretical models corresponded to three separate stages consisting of "markers"—clinically significant events appearing to change the course and direction of the treatment process. Each of the models is described and illustrated below, to show the step-by-step process by which the models were created.

Model 1/Stage 1: The Parents Decide Whether or Not to Take Charge

According to the literature, the first stage of treatment seems to begin with the counselor's calling the parents to set up the first appointment and to end with the adolescent's functioning without behavior problems. There also appears to be a proverbial "fork in the road," at which point the parents choose to accept or not to accept a position of changing their teenager's problem behavior. Which road the parents choose often seems to depend on the quality of the parents' rapport with the counselor and on whether or not the counselor is seen as a credible expert. Once the decision is made, a series of steps should follow. If the parents refuse to take charge, the teenager or other outsiders will take charge, and treatment will end unsuccessfully. If the parents do take charge, the counselor will assist the parents through a series of steps to keep the parents in this position of authority, troubleshoot potential problems with interventions, and stop the teen's extreme behavior problems.

Each step within each of the three idealized models was operationalized in terms of observable behaviors. These behaviors were then defined in a coding manual format. For example, the concept of "presession preparation" (Step 1 of the first model) was defined in the following manner:

> **Step 1: Presession Preparation**
>
> Before the first session, the counselor personally contacts the parents and explicitly asks them to come in with their son or daughter to help him or her with the identified problem by providing information and guidance that only they can provide. They should not be asked to come in to have "therapy," because few people want "therapy." Following this same rationale, members of the extended family (including other siblings, grandparents, etc.) are also asked to attend.

> This observational code is defined with statements made by the counselor to the parents asking them to come in with their teenager "to help the teenager with his [her] problems by providing valuable information to the counselor." Everyone in the family, including other siblings, is asked to attend.

Model 1/Stage 1 is illustrated in Figure 12.1.

Model 2/Stage 2: Therapist and Family Deal with Crises and Relapses

It appears from the literature that Stage 2 begins with a relapse of the difficult teenager and ends with the parents' weathering the storm by devising a plan to prevent further relapses. There are basically two reasons for this relapse. First, once the teenager is functioning without problems, the parents are lulled into a false sense of security. They think that these changes are permanent. However, the teenager is not likely to hand over his or her power and authority without a fight and at least one major relapse to test the waters. The teenager wants things to return to the status quo. A teenager functioning without behavior problems has not yet had enough time to realize that most of his or her needs can be met through good behavior. For many teenagers, being "good" is a change in identity and feels awkward and different. As a result, the risk and temptation for at least one major relapse are high.

Second, the teenager's problem may be a conscious or unconscious attempt to shift the focus off more threatening issues in the family, such as marital conflict, depression, or substance misuse. If the parents or other family members remain focused on the teenager's problem, other issues are not addressed. Consequently, every time the teenager begins to function normally and without problems, the family becomes unstable and other problems surface. The adolescent must again function incompetently and relapse, to shift the focus off these other problems so that the family can restabilize. This cycle will repeat itself again and again until the underlying family issues are solved or resolved.

These two reasons may be occurring separately or together. The teenager will probably always want to test the waters, regardless of whether or not there is a connection with other family issues. The counselor can spot whether such a connection exists if other family problems surface immediately or soon after the behavior problems are solved.

In either case, the parents' reaction to the relapse is usually negative. They feel personally betrayed and take a "here we go again" attitude. When this happens, the parents' inclination is either to remove the teenager from the family and place him or her in an institution, or to feel apathetic and give up. At this point, the counselor must take charge and somehow convince the

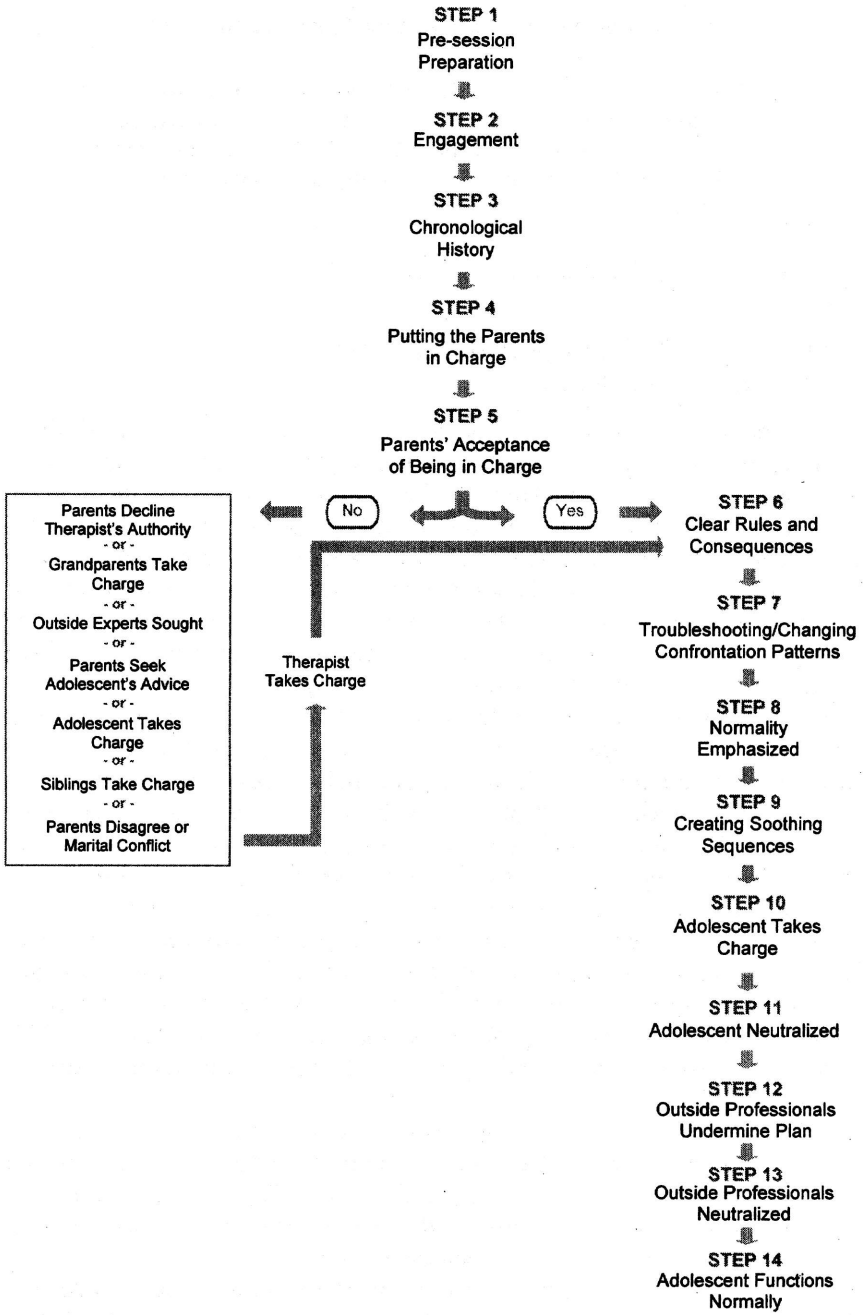

FIGURE 12.1. Model 1/Stage 1: The parents decide whether or not to take charge. The steps of this model are illustrated to show what the family will go through, depending on whether the parents choose to take charge or refuse to accept this responsibility. Each step is operationalized within a coding manual format in terms of observable behaviors. Stage

parents to stand firm and not give up. Instead, they must devise a plan of action to address the present relapse and prevent further relapses from occurring in the future. The counselor must try to prevent institutionalization; otherwise, the parents risk starting from scratch when the teenager finally returns home.

Model 2/Stage 2 is illustrated in Figure 12.2.

Model 3/Stage 3: Peace Sets In and Teenager Moves into Adulthood

It appears from the literature that Stage 3 begins when the adolescent continues to test the limits, but does so in a way that is not extreme (not, e.g., violence, running away, truancy, etc.). The stage ends when relapse ends on a permanent basis. The adolescent is then able to move freely through the developmental stage of individuation by leaving home and becoming an adult.

In essence, at the end of Stage 1, the parents survive the initial onslaught of the hurricane and briefly experience calmness in the eye of the storm, but do not buckle or fold when the hurricane resumes its gale force winds in Stage 2. In Stage 3, the parents survive the hurricane and can finally enjoy the fruits of their labor, as the hierarchy is permanently reversed and they maintain their authority even when it is tested. As a result, calmness and peace set in within the household on a consistent basis. The teenager is now free to shift his or her time and energy from trying to maintain power and authority to pursuing employment, dating, sports, and/or college, and eventually leaving the home to become an adult. It is important to note that this disengagement from the family is also contingent upon the resolution of underlying family issues. Otherwise, the teenager will be unable to disengage from the family and will display self-destructive behavior that prevents him or her from leaving home to become self-supporting.

Model 3/Stage 3 is illustrated in Figure 12.3.

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1 begins with the therapist's calling the parent to set up the first appointment in Step 1 and ends with the adolescent's functioning without behavioral problems in Step 14. Concepts within Model 1 were drawn directly from the literature (i.e., structural, strategic, solution-focused, and multidimensional). For example, the concept of the parents' taking charge emerged directly from the structural and strategic writings about hierarchy (Minuchin et al., 1967; Minuchin, 1974) and power (Haley, 1980; Madanes, 1991). The concept of engagement in Step 2 emerged from the work of Liddle (1995). The concept of how outsiders neutralize the parents' or therapist's authority emerged from the descriptions of conducting a multidimensional assessment within the Liddle (1995) article and the writings of Haley (1980). In addition, the creation of soothing sequences or the restoration of nurturance originated in the writing of Keim (1996).

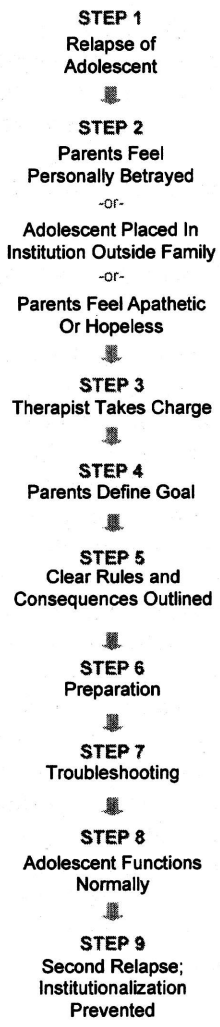

FIGURE 12.2. Model 2/Stage 2: Therapist and family deal with crises and relapses. The steps of this model illustrate the onset of Stage 2 with the adolescent's relapsing and the actions that follow to prevent institutionalization or a future relapse. Stage 2 ends after the parents implement their plan of action and another relapse is prevented. Each step is operationalized within a coding manual format in terms of observable behaviors. Many key concepts in Model 2, such as relapse and the therapist's taking charge, emerged from Haley's (1976, 1980) work. Other concepts, such as preparation and troubleshooting, emerged from the work of Madanes (1991). In sum, Haley's work provided the framework of Model 2, while Madanes's work helped fill in the missing pieces.

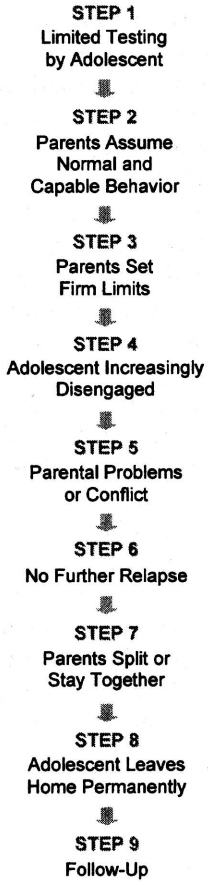

FIGURE 12.3. Model 3/Stage 3: Peace sets in and adolescent moves into adulthood. The steps of this model illustrate the onset of Stage 3 with the adolescent's continuing to test limits, but in a way that is not extreme (not, e.g., violence, running away, truancy, etc.). The stage ends when a state of nonrelapse continues and the adolescent is free to move through the developmental stage of individuating from the family by eventually leaving home and becoming an adult. Key theoretical concepts in Model 3, such as disengagement and parental problems, emerged from the work of both Haley (1980) and Minuchin (1974). The overall process of leaving home and pursuing adulthood came from Haley's (1980) work.

Phase II: Creating Revised Performance Models

When Phase I was completed, I began Phase II by following Rice and Greenberg's (1984) recommendation to acquire and analyze videotapes from "expert clinicians regarded by colleagues, trainees and clients as being instrumental in facilitating substantial amounts of positive client change" (p. 291).

I analyzed each videotaped counseling session and created a description in coding manual format and a performance model diagram to accompany each session. Each procedural step was a "marker," or series of interventions hypothesized to be optimal for promoting change.

After each tape was completed, I compared the performance model diagram and the coding manual with the appropriate portion of my three idealized models to locate similarities and differences. If a marker in a model based on an actual counseling session was similar to a marker in an idealized model, the matching idealized theoretical concept was strengthened. If there were discrepancies or new discoveries, I made revisions accordingly. For example, after the first videotaped session was analyzed, one marker closely matched the idealized model's concept of engagement. This idealized theoretical concept was therefore supported and strengthened. In contrast, a new concept also emerged from this session—one that involved the parents' redefining the son's problem behavior. This led me to include the new procedural step of defining and redefining the problem in the revised performance model.

This process of shifting back and forth between analyzing actual videotapes and revising models continued for each videotaped treatment session. A final revised performance model emerged at the conclusion of Phase II; this model contained both original theoretical ideas and new and exciting discoveries from the videotapes. Below is a brief description of each part of Phase II, together with several performance model diagrams to demonstrate the research process. The final revised performance model is also illustrated, to highlight the developmental steps in creating the 15-step family-based treatment model.

Part 1: Acquiring Videotapes of Expert Clinicians

As stated earlier, an intensive study of videotaped treatment sessions conducted by expert clinicians is an ideal approach. This is because most process researchers select the work of student counselors or counselors who are not regarded as experts in the model under investigation (Mahrer, 1988; Rice & Saperia, 1984). A closely related issue is a lack of "treatment integrity," or the failure of counselors to adhere to the guidelines specified within the treatment model (Pinsof & Wynne, 1995). It becomes increasingly difficult to locate key moments of change when one is uncertain whether change is even occurring or whether the treatment model guidelines are being followed.

To address these problems, I asked Jay Haley, the founder of strategic family therapy, if I could analyze videotaped counseling sessions that he felt were instrumental in facilitating significant amounts of positive change. After hearing about the project, he consented and suggested an intensive, beginning-to-end analysis of a 28-session case involving an 18-year-old male who exhibited extreme behavior problems (i.e., threats and acts of violence).

Haley stated that this case contained all the essential theoretical concepts and procedures for promoting change in difficult adolescents, and that it was therefore representative of how to work with this population. In addition, Haley stated that the counseling was successful in this case, as indicated by an annual follow-up for 10 years that showed no relapses or return to previous problem behaviors. The adolescent had since graduated from college and was functioning successfully as a high school art teacher.

Neil Schiff was the counselor in this case, while Jay Haley supervised each session from behind a one-way mirror. Both Schiff and Haley are considered by colleagues, trainees, and clients to be the leading experts in treating difficult adolescents and their families.

Part 2: Constructing a Performance Model from an Analysis of Videotapes

Briefly, a performance model was constructed from an intensive analysis of all 28 sessions. Each videotaped session was transcribed; the markers were operationalized within a coding manual format; and the procedural steps were illustrated on a schematic diagram. Each code was accompanied by an actual transcript from the session to support the inclusion of that particular code. For example, the marker of "task check" emerged from the third session and was operationally defined in the following manner:

Step 3: Task Check

The counselor asks the parents and the adolescent whether the teenager and/or the parents completed the tasks assigned at the end of the last session. After giving a task, the counselor should always ask for a report at some time in the next interview. In this way, the teenager and parents are accountable for completing each task.

This observational code is defined as one or more statements by the counselor asking the parents and the teenager whether the tasks assigned at the end of last session were completed.

Sample Dialogue from Session

Time: 3 minutes and 30 seconds into video session

67 Ther: Well I'm delighted that you had some more normal
68 moods, but I'm disturbed about you crashing, and I wish, I
69 hope that there's something we can set up that will alleviate
70 the pain associated with that. Anyway, let me go on a bit and
71 then come back to this. Did you register for a course?

Figure 12.4 is the performance model diagram that emerged from the third counseling session. Notice that the parents vacillated between taking

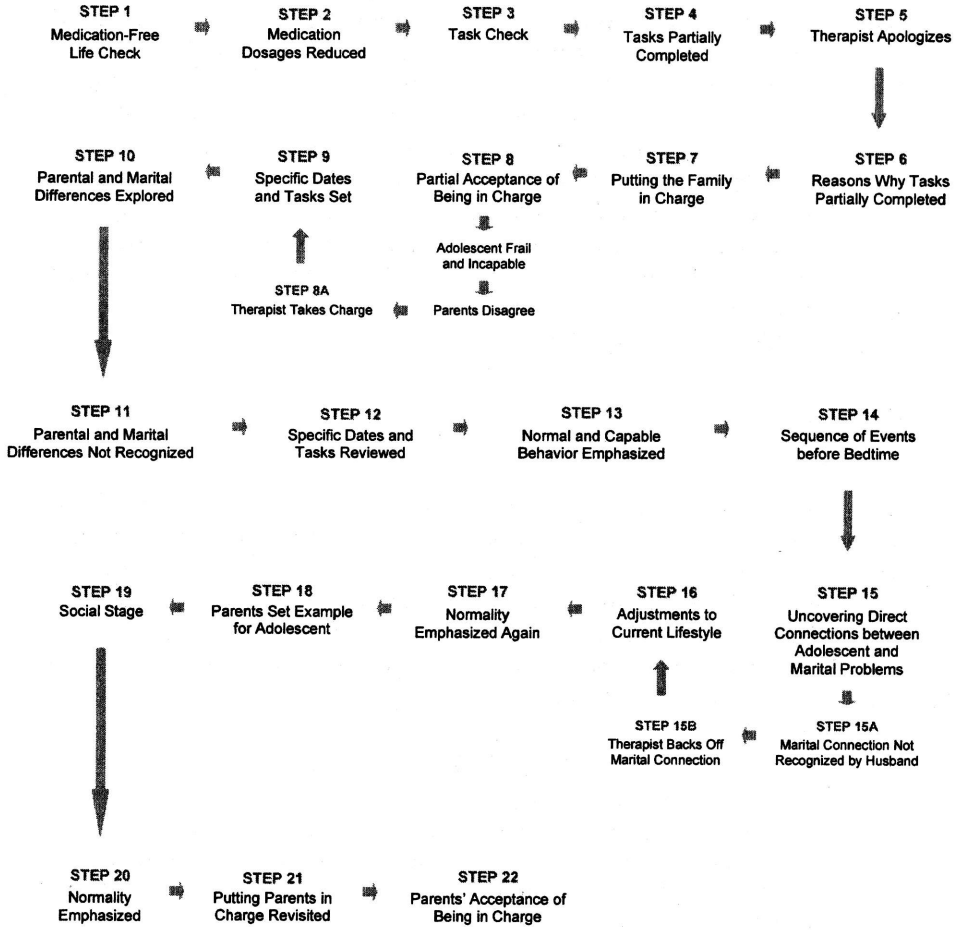

FIGURE 12.4. Session 3 of counseling: Videotape-based performance model diagram.

charge and refusing to take charge in Steps 8, 21, and 22. In response, the counselor asked the parents in Step 8A to take charge and set tasks with specific time frames for completion. Notice also how the parents struggled with defining their son as frail, incapable, and not responsible for his extreme behavior under Step 8. The counselor countered by redefining the adolescent as normal, capable, and responsible for his actions in Steps 13, 17, and 20. The counselor also emphasized the normality of the son in Steps 1 and 2 by convincing the parents to decrease the son's medication. As stated earlier in this book, the use of medication can result in an adolescent's being labeled as a chemically imbalanced mental patient, rather than as a misbehaving teenager

responsible for his or her own behavior. This theme of emphasizing normality, capability, and responsibility also emerged in later sessions and was influential in the construction of Step 3 (parental empowerment) and in Step 2 (defining and redefining problems) of the family-based treatment model.

Part 3: Informant Verification

After each session was analyzed, the coding manual and diagram for that session were sent to both Neil Schiff and Jay Haley. I interviewed each clinician by phone and asked whether he agreed or disagreed with my conceptualization of each procedural step contained in the coding manual. If there were discrepancies, the concept was modified accordingly. For example, Schiff and Haley both stated that a third relapse was avoided due to Schiff's use of "troubleshooting," whereas I described the same event as "problem solving." The concept was then modified to fit the definition of "troubleshooting" and operationalized according to Schiff's and Haley's descriptions. The term "informant verification" refers to the extent to which a set of meanings held by multiple observers are sufficiently congruent that they describe the phenomenon in the same way and arrive at the same conclusions (Goetz & LeCompte, 1984). I used informant verification to assess the reliability of the codes; that is, I checked to see whether Schiff, Haley, and I independently described the codes in the same way and arrived at the same conclusions.

In addition to checking reliability, these interviews helped shape the final revised performance model by expanding my conceptual definitions and highlighting key interventions that promoted optimal change. These brainstorming sessions by telephone generated rich clinical data. For example, we discovered that the use of role plays or "dry runs" was essential to prepare the parents for future confrontations with their teenager. A turning point in the case came when the father asked his son to return the house keys and move out because of his extreme acts of violence. Schiff prepared the father for this critical confrontation by playing the part of the son while the father practiced his delivery of what he would say. We all felt that this preparation was key to the father's ability to take charge. These valuable discussions led to the creation of role plays or "dry runs" as a strategy or mini-step in the larger step of troubleshooting.

Part 4: Comparing the Videotape-Based Performance Models with the Idealized Models

After the videotape-based performance model diagram for each session was further refined on the basis of my telephone interviews with Haley and Schiff, I compared it with the approximate portion of the three idealized models. If there were similarities, then the idealized theoretical concepts were

validated. On the other hand, if there were discrepancies, I made revisions accordingly. I demonstrate this process by providing and discussing three diagrams: one for the idealized Stage 1 model, or Model 1 (Figure 12.5A); one for the videotape-based performance model for Session 1 of counseling (Figure 12.5B); and one for the revised performance model for Session 1 that resulted from my integration of these two models (Figure 12.5C).

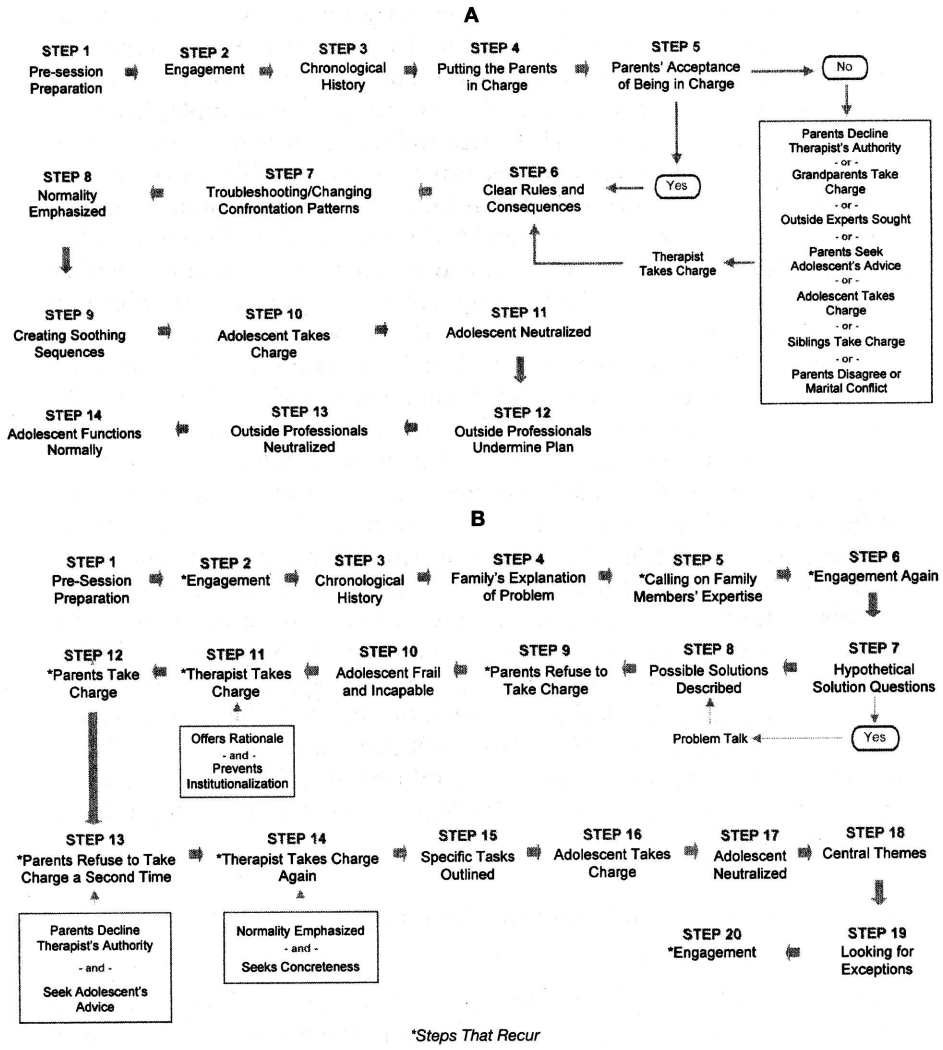

FIGURE 12.5. (A) The idealized Stage 1 model (Model 1). (B) The videotape-based performance model for Session 1 of counseling.

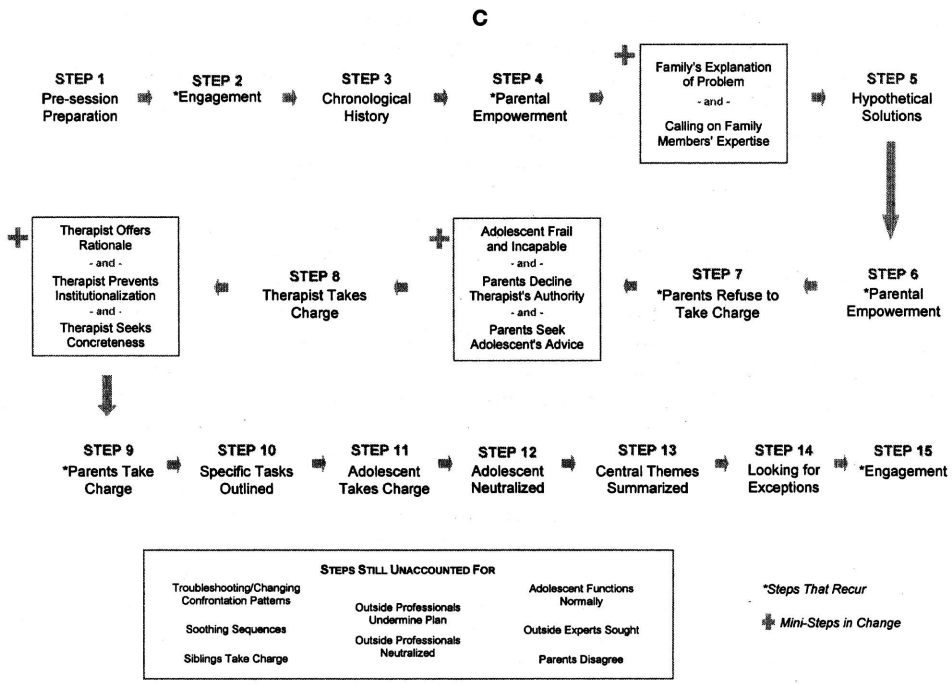

FIGURE 12.5. (C) The revised performance model for Session 1 of counseling, based on my integration of the models shown in A and B.

Comparison of Session 1 and the Idealized Model

Notice how the first three steps within the Session 1 videotape-based performance model were identical to those of the idealized model. From this point on, however, there were discrepancies and similarities. Step 4 (family's explanation of the problem) and Step 5 (calling on family members' expertise) of the Session 1 model did not occur anywhere within the idealized model. Thus, these concepts were organized under Step 4 of the revised Session 1 model under the broader category of parental empowerment. This was done because calling on the family's expertise and asking them to define the problem were both strategies designed to empower the family members to solve their own problems. The two models were similar with regard to the parents' decision to take charge or not to take charge. As a result, these concepts in the idealized model were substantiated.

An exciting breakthrough came with the discovery that two key procedural steps recurred throughout the counseling session. The Session 1 videotape-based model indicated that the parents vacillated between assuming and refusing authority throughout the counseling session. In addition, engagement was not a one-time step and continued to surface

throughout the first counseling session. The idealized model made it appear that certain steps occurred only once throughout the counseling process; however, the Session 1 model indicated the opposite. Counseling with a difficult adolescent was discovered to be a very fluid and circular process, as key steps continued to resurface again and again. These repeating patterns made it easier to identify steps that were optimal for change.

Other discrepancies between the models centered around the use of solution-focused hypothetical and exception questions, as well as the concept of revisiting central themes. As I continued to make revisions, these steps were rearranged under broader categories. For example, the use of solution-focused questions was classified in Step 5 of the final revised performance model (clear rules and consequences outlined) when analysis showed that the counselor used these types of questions as a way to define rules and consequences clearly.

The revised Session 1 performance model that resulted from comparing the Session 1 videotape-based model with the idealized Model 1 thus retained the idealized concepts from Model 1, but added the following new components: *recurrence of empowerment; recurrence of parents' taking charge; recurrence of engagement; hypothetical solutions; looking for exceptions;* and *summarizing central themes.* Steps within the idealized model that were not observed or that were still unaccounted for after my analysis of Session 1 were listed next to the revised performance model, in the event that they arose in future videotaped sessions.

In sum, each cycle of looping back and forth between the idealized model and a videotape-based performance model both clarified and further operationalized existing theoretical concepts. The process also uncovered new and exciting discoveries. The process could be compared to the work of an anthropologist who has books and ancient descriptions of a particular population, but goes to the ruins of this civilization to discover new artifacts that both confirm and deny these original writings. These artifacts not only lead to an expansion and clearer definition of these original writings, but also generate new and exciting discoveries.

Part 5: Constructing the Final Revised Performance Model

After analyzing all 28 taped sessions and comparing the results with the three idealized models, I constructed a final revised performance model by integrating all of the preceding models and noting similarities and discrepancies. Steps that were similar in concept were placed under one main category. For example, several revised performance models contained steps that pertained to seeking concreteness, outlining specific tasks, and setting specific dates. Each of these described the same basic process of outlining clear rules, consequences, and task procedures. Consequently, these steps were integrated under one main category called Step 5 (clear rules, tasks, and consequences outlined).

Another interpretation of this process is that "mini-steps" were united into one main step. For example, executing role plays or "dry runs" and constructing "what if" scenarios were the mini-steps the counselor took in conducting the larger step of "troubleshooting." These mini-steps were particularly helpful because they represented the step-by-step procedures used to achieve the end result. This process of integrating smaller, related steps under one main category continued until one final revised performance model remained. Figure 12.6 is an illustration of this final model. The question mark next to Step 8 in Figure 12.6 indicates that although the concept of soothing sequences was contained within the idealized models, it was not identified in any of the 28 taped sessions. This step was implied during several of Schiff's interventions, but without the clarity needed to make these observable actions into a distinct step. As a result, further investigation was needed.

Phase III: Broadening the Range of Application

After Phase II was completed, the next phase was to take the final revised performance model and test its procedural steps in the field with a variety of different counselors, clients, and behavior problems. The goal was to fine-tune the model by pursuing any anomalies or new ideas resulting from a broader range of its application. If anomalies were discovered, the revised model was modified accordingly. I continued this process until analyses of the focus group interviews and the videotaped sessions failed to provide any new information.

It is important to note that this does not mean that no additional discoveries can be made in the future. If a variety of counselors in different parts of the United States or other countries use this model with a larger sampling of difficult adolescents, additional concepts may well emerge. The idea that any treatment model can be theoretically saturated and produce no new concepts is naive and misleading. One of my hopes in writing this chapter is that other counselors will utilize this model and provide feedback on whether or not new discoveries are made that require further refinement. Thus, this model should be seen as a work in progress, rather than as the definitive treatment model for difficult adolescents. Readers should refer to my Website (www.difficult.net) for further inquiries on this issue.

It can be argued that the real work of model building began during Phase III, as the process of enrichment and elaboration of the treatment steps through a broader application unfolded. In developing the 15-step family-based model, I started with the three idealized models and moved in a progressive fashion toward more intricate models that more closely reflected the complexity of working with difficult adolescents. The basic steps in creating

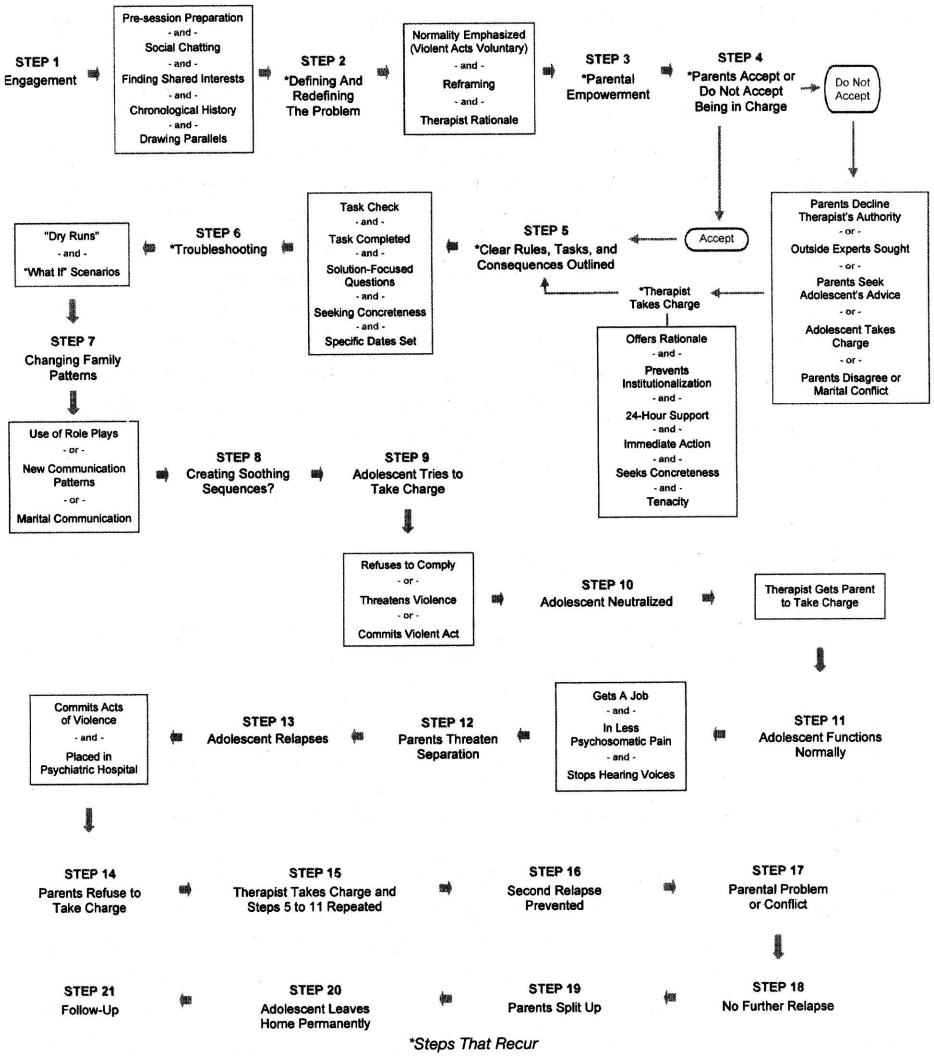

FIGURE 12.6. Final revised performance model.

the performance models of Phase III were similar to those outlined for Phase II. The differences between this phase and Phase II included (1) the analysis of sessions by four counselors involving a variety of cases, rather than the analysis of one case by two expert clinicians; and (2) qualitative focus group interviews with clients, to gain access into their thoughts about the use of this treatment model.

Description of Counselors, Clients, and Target Problems

A team of four counselors was selected to implement field testing of the final revised performance model from Phase II. The counselors included three recent graduates of an MSW program with 3 to 7 years of experience, and a supervisor with a PhD and more than 10 years of experience. Over a 2-year period, 83 difficult adolescents and their families were seen for a minimum of five sessions. The average length of counseling was 10 sessions.

Most of the adolescents treated were males (78.9%), with an average age of 15 years (SD = 1.5). Over half of the adolescents (52.2%) had a history of fighting or assault; 56% had a history of stealing or shoplifting; 43.5% were truant from school; 39.9% had drug or alcohol problems; 39.1% had problems with running away; and 8.7% had been charged with property damage, use or possession of weapons, or sexual abuse. These percentages reveal that the majority of the adolescents had multiple problems. The demographic data showed that 54% of all families served had an income between $10,000 and $35,000. A majority of the adolescents had numerous stays in detention, prison, and residential treatment (M = 2.1 stays). These adolescents were also multiple offenders, having an average of 3.3 arrests each.

As the descriptions above indicate, the three counselors selected were recent graduates with only limited experience in treating difficult adolescents. The adolescent population was primarily characterized by severe conduct problems and low-income households. This use of inexperienced counselors and a population of difficult adolescents was an intentional choice, for two reasons. First, I felt that the applicability of the model and the ease of its implementation might be better understood under these conditions. If inexperienced counselors were successful as demonstrated through pre–post outcome measures, a case could be made that the treatment model was prescriptive and highly applicable. In addition, if the model was effective in producing change with extremely difficult problems, it might result in even greater success with less severe cases and families with greater economic and social resources.

Second, I felt that anomalies or unsuccessful change episodes would be more revealing. Since the counselors were rather inexperienced, they might make mistakes on the most basic of steps. In turn, these mistakes would force me to make each treatment step clearer, more concrete, and more user-friendly. In addition, unsuccessful change episodes would be much more common and challenging with extremely difficult adolescents from families with limited economic and social resources. This would force me to become more innovative with the treatment steps. An example of this was the development of neutralizing the "five aces," in which a creative menu of strategies was outlined to help struggling counselors stop extreme behavior problems.

Treatment Integrity

As stated earlier, a major problem in research is whether or not the counselor treating the case is actually following the steps of the treatment model (Wynne, 1988). I addressed this concern in two ways. First, each counselor was given the final revised performance model to read and memorize like a play book before entering the first counseling session. Each was then asked by the supervisor to demonstrate each step through role plays. If there were problems during implementation, the supervisor would stop the role play and model the correct procedures. In addition, the supervisor observed each counselor through a one-way mirror during the first three sessions and once a week afterwards, to ensure that the treatment steps were being followed fairly closely. Videotapes of the sessions were also analyzed.

It is important to note that the training and role playing did not require a rigid application of each treatment step; they were demonstrations of general guidelines. This forced the counselors to hone their skills of creativity and intuition. In addition, the model was still a work in progress, and many steps either had not yet been developed (e.g., restoring nurturance and tenderness, neutralizing the "five aces") or were not yet concretely defined (e.g., troubleshooting, working with outsiders). These gaps revealed the weaknesses and the strengths of the model, and showed me where it needed to be revised or more clearly defined.

Focus Group Interviews

As also stated earlier, clients' thoughts and feelings about counseling are as important as observable behaviors, since a comprehensive process analysis requires both (Pinsof, 1988). For instance, comparisons of how differently family members view treatment provide valuable information about practice effectiveness as a prelude to clinical-trial outcome research (Gurman, Kniskern, & Pinsof, 1986).

To address this issue, the procedures from an earlier study (Sells, Smith, & Moon, 1996) served as a template for conducting client interviews. In this earlier study, my colleagues and I used ethnographic interviews that immediately followed counseling sessions to elicit the clients' thoughts and feelings about their sessions. Since one goal of the present project was to tap into these same areas, procedures from this earlier study were replicated during this phase of the project. Each counselor asked each client a series of questions at the end of every third session; I felt that this time frame would give interventions a chance to prove successful or unsuccessful. The answers revealed a wealth of information on what clients perceived as effective and ineffective interventions, important counselor qualities, and recommendations for future counseling sessions. The following eight questions were asked:

1. Could you tell me in detail all the things that have been most helpful so far?
2. What are the most helpful things I have done or said as your counselor so far?
3. Could you tell me in detail all the things that have been least helpful so far?
4. What are the least helpful things that I have done or said as your counselor so far?
5. What needs to be done in the future to make your sessions more useful or helpful?
6. How would you describe to a friend what we do here or the approach that I am using?
7. What are all the things you like about it?
8. What are all the things you dislike about it?

Each interview was either audiotaped or videotaped and then transcribed. Major themes were uncovered from these interviews and coded in the same manner as they were from the videotaped treatment sessions. These codes were then compared with the idealized models and the final revised performance model for discrepancies and similarities.

Several very interesting findings emerged that helped refine and shape the 15-step model. For example, interviews with 37 teenagers revealed that they saw the opportunity to regain trust as one of the most important things needed to improve future counseling sessions. These teenagers reported that when they lost the opportunity to rebuild trust, they lost hope, and resentment set in. Before these interviews were conducted, the area of trust was not looked at as an intervention; after the interviews, it was made one of the seven strategies for restoring softness and nurturance between parents and teenager. I then field-tested the concept and closely analyzed the videotapes when this marker was being used by the counselors. We also conducted more focus group interviews with both teenagers and parents to locate any further inconsistencies. Each new set of information led to additional refinements of this strategy or mini-step. For example, we found that parents must give trust in increments proportional to the level of supervision (mandatory, structured, or limited) at which a teenager is currently functioning. The level chosen should guide the parents on how much trust to give and how much to hold back.

Explanation of Anomalies

The most important action of this step was the intense scrutiny of instances in which the model did not appear to work for clients. Whenever this happened, I looked for potential explanations of the anomaly by asking the following four questions:

1. Was the counselor marker or the concept poorly defined?
2. What factors could account for the anomaly?
3. Did something specific the counselor did or said account for the intervention's not being effective?
4. Were there particular characteristics of the client that seemed to make the counselor's intervention particularly difficult or impossible?

One of the anomalies that emerged from this analysis is presented below, with Figure 12.7 illustrating the mini-steps uncovered.

Discovering the Mini-Steps of Setting Clear Rules and Consequences

During the analyses of two different videotaped sessions, I found that the procedural step of setting rules and consequences did not appear to be working. This was indicated by the fact that the parents failed to follow through with rules and consequences that were outlined with the counselors the week prior. After considering the answers given in this case to the four questions listed above, I began to find reasons for this anomaly. First, both counselors outlined the rules, but only in very vague terms. The rule of showing respect, for example, was not operationally defined by listing concrete behaviors considered "disrespectful," such as swearing and refusing parental requests. In addition, consequences were not clearly defined. One consequence might be grounding, but there was no discussion of when the grounding would occur, how long it would last, or who would enforce and monitor it.

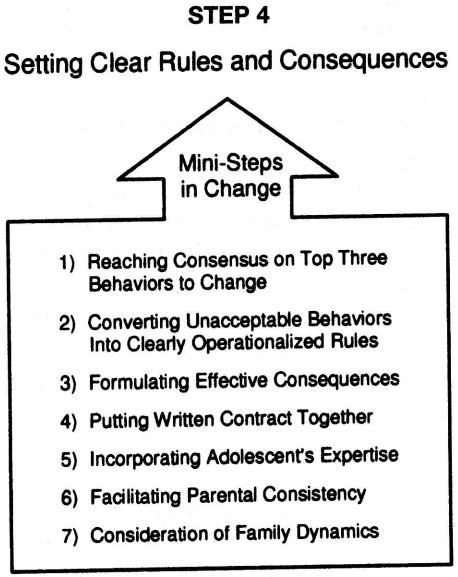

FIGURE 12.7. Mini-steps of setting clear rules and consequences.

Second, the counselor markers for this step were poorly defined. The two counselors had to be shown the strategies or mini-steps involved in helping the parents operationalize specific rules and consequences. The seven strategies shown in Figure 12.7 were developed from observed mistakes made by the counselors and from focus group interviews with clients and counselors.

After the counselors were trained to implement these seven strategies successfully, analyses of later interviews with the same families revealed that the rules and consequences were enforced. In addition, parents reported that a clear road map of rules and consequences enabled them to be more effective as parents.

In sum, an intensive analysis of videotaped treatment sessions and focus group interviews enabled me to create and fine-tune the 15-step family-based model. The idealized models and the final revised performance model revealed the steps themselves, but its broader application revealed the strategies or mini-steps needed to achieve each major procedural step. At the end of Phase III, the 15-step family-based model emerged. Figure 12.8 illustrates not only the 15 procedural steps, but the mini-steps or specific strategies that can be used to generate change within each step.

Phase IV: Consolidating the Theoretical Yield

In this section, I summarize some of the major ideas that emerged to expand my thinking about treatment with difficult adolescents. I highlight key moments of discovery throughout the three previous phases that shaped the 15-step family-based treatment model. Of particular interest is the discovery of what I call "mini-steps"—that is, the strategies a counselor must engage in to accomplish a larger goal. For example, it was discovered that to restore nurturance and tenderness (Step 11), a counselor may have to employ as many as seven different strategies.

It is important to note that the concepts outlined here are not altogether new. Many of them originated from the three idealized models, which in turn were derived directly from the literature, as described earlier. Concepts such as engagement, parental empowerment, and relapse have been in the field for a long time. What is new is the way these concepts and the steps related to them are mapped out. The task analysis methodology allowed me to gain an in-depth clinical understanding of the "what, when, why, and how" of interactions between difficult adolescents and their families. The patterns and themes that were identified provided a much clearer road map of the com-

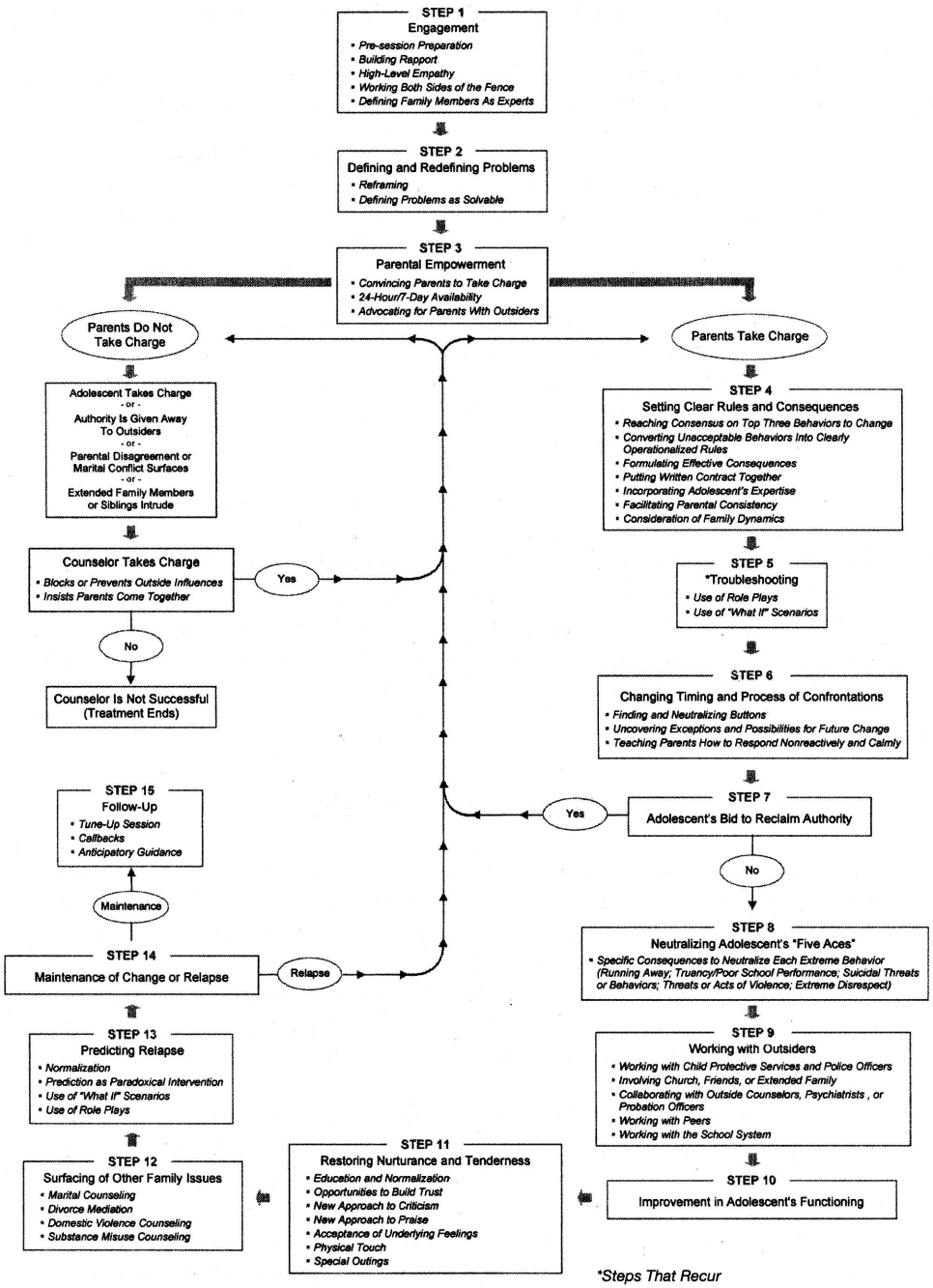

FIGURE 12.8. The 15-step family-based treatment model, with strategies or mini-steps for each step.

plex communications among counselor, parents, teenager, and outside systems. This bridged the gap between research and theory on the one hand, and direct practice on the other.

The key discoveries that reshaped my thought processes during this study centered around four areas: (1) relapse; (2) the "five aces"; (3) the hard and soft sides of hierarchy; and (4) rules, consequences, and troubleshooting. There were other discoveries, but these were the ones that stood out as facilitating substantial amounts of positive client change.

Relapse

From the focus group interviews and analyses of videotaped treatment sessions, exciting discoveries were made in the area of relapse. Each time an adolescent appeared to be doing better and the parents were hopeful, the adolescent would relapse the next week or soon thereafter. When this happened, the parents felt betrayed, angry, and even more hopeless than before. This often caused the teenager to shut down and become recalcitrant. At this point, the family would sometimes leave treatment or commit a series of no-shows.

The treatment model was clearly not working at this point, so I went back to the drawing board to determine what factors accounted for this anomaly. The second idealized model (Model 2/Stage 2) revealed that a teenager relapses following a period of normal functioning. The solution appeared to be to return to the techniques that worked earlier, and to reformulate clear rules and consequences to prevent a second relapse. However, this strategy often proved unsuccessful with the difficult families we worked with. They were too burned out, hopeless, and/or bitter to entertain the idea of refining their rules and consequences. New solutions had to be found.

An intensive analysis of the videotaped sessions in Phase III provided the clues needed to find these solutions. The examinations revealed a common pattern of intervention among the three counselors. In each case, the counselor failed to predict the relapse or prepare the parents for the possibility by discussing what they should do if it occurred. Every time an adolescent relapsed, the counselor appeared just as surprised and frustrated as the family did.

These common patterns led to the creation of Step 13 (predicting relapse) and the development of its mini-steps (normalizing, prediction, and the use of role plays and "what if" scenarios). First, the counselors were trained to normalize the behavior by explaining to the parents that relapse is common and often expected. Most parents understood this rationale, and this helped to decrease the bitterness and hopelessness they felt with a future relapse occurred. In addition, counselors were trained to predict relapse each time the adolescent began to function normally, as a paradoxical intervention to prevent the relapse from actually happening. When a relapse was predict-

ed, the motivation of the teenager and the family to rally together to prove the counselor wrong frequently increased. Finally, counselors were taught to use troubleshooting strategies (role plays and "what if" scenarios) to anticipate all possible occurrences in the event of a relapse.

After the counselors learned these new strategies, more sessions were videotaped and more focus group interviews were conducted. Analysis revealed that the clients' reactions to future relapses were much less negative and destructive. The parents seemed to take the relapses in stride and to work with the counselor to get back on track as quickly as possible. In addition, the parents reported in the focus group interviews that the troubleshooting strategies allowed them to feel prepared so that they were not caught off guard when relapse occurred.

Future research in this area will need to test these mini-steps with a broader population before these findings can be generalized. An outcome measure will have to be developed or located that is sensitive enough to pick up changes in the results of these relapse prevention steps. One specific hypothesis to be tested will be to determine whether relapse prediction immediately following normal adolescent functioning prevents future relapse and allows parents to feel less hopeless and more willing to prevent future relapses. This is a good example of how specific theories about the smaller scale steps involved in change can be generated from process research and tested through outcome research.

The "Five Aces"

The findings regarding the "five aces" were among the most exciting theoretical yields of the study. As the study broadened in Phase III to include other counselors and clients, I began to notice a very interesting pattern: Whenever the parents tried to restore their authority, the difficult adolescent would use an extreme behavior to induce the return of his or her authority from the parents. This use of extreme behaviors initially defeated the counselors in this study, because it was very difficult to come up with effective consequences. The entire process reminded me of a savvy poker player who always has a hidden ace up a sleeve to defeat an opponent at the precise moment the opponent thinks he or she has won. In the same way, adolescents seem to use their own "aces" to defeat parents and counselors any time the adults seem to be winning.

A developmental timeline illustrates how the concept of the "five aces" evolved and how both observational and self-report methods led to this theory.

1. The videotaped treatment sessions revealed a pattern of extreme behaviors by difficult adolescents that neutralized parents' and counselors' effectiveness.

2. The following four extreme behaviors seemed to produce the neutralizing effect on the parents' and counselors' authority: running away, suicidal threats or behavior, truancy/poor school performance, and threats or acts of violence.

3. A closer analysis of the videotaped treatment sessions demonstrated that the adolescents initiated one or more of these extreme behaviors following the parents' attempts to implement predetermined consequences or change their confrontational style. When the rules and consequences were effective and the teenagers were unsuccessful in controlling the mood and direction of arguments, the authority shifted to the parents.

4. As the parents became stronger, the teenagers' typical methods of regaining their authority (yelling, refusing to comply, nagging, inducing guilt, etc.) were no longer effective. The teenagers would then pull out one of their "aces" to counter earlier defeats and regain authority. Parents and counselors appeared not to know what to do to stop these behaviors.

5. If the adolescents were successful, they kept using the "aces" until the parent and the counselor gave up and things went back to the status quo. The parents would then hand their authority over to an outside source (institution, police, extended family), and treatment would often end unsuccessfully.

6. The family-based model was revised to include Step 7 (adolescent's bid to reclaim authority) and arrows to illustrate what happened if the parents and counselor failed to stop a teenager's "ace(s)." The word "aces" was chosen to describe these extreme behaviors because of the similarity to a poker player's actions (see above).

7. Focus group interviews with parents revealed a fifth "ace," disrespect. Some parents report that disrespect often pushed their buttons to a greater degree than all the other aces combined. In turn, this caused the parents to lose control of their tempers and of their rational thought processes. Parents then reacted out of emotion and were unable to maintain consistency or follow through on predetermined rules and consequences.

8. The family-based model was revised again to include this fifth "ace" of disrespect.

9. The literature was revisited to discover methods and techniques that were effective in neutralizing extreme behaviors. The writings of Haley (1980), Schiff and Belson (1988), Price (1996), and Keim (1996) provided helpful suggestions.

10. A menu of strategies or consequences was developed for effectively neutralizing each "ace."

11. The team of counselors was given this menu and trained in the use of these strategies. Counselors then implemented these strategies with parents and teenagers during Step 8.

12. Videotapes of and focus group interviews about these interventions were then analyzed and compared to the final revised performance model.

13. Anomalies were discovered (i.e., times when these interventions failed or were not effective).

In sum, this timeline demonstrates the iterative process involved in operationalizing theory within actual practice. As new discoveries were made, I (as the researcher) had to take the patience and time necessary to explain anomalies at any point during the treatment process. The answers to these questions led to more questions. For example, a discovery of how the parents were defeated through extreme behaviors led to questions on how to stop these behaviors. In turn, these questions led me back to the literature in search of answers. These answers led to the implementation of mini-steps designed to neutralize a specific extreme behavior. A videotape analysis of these mini-steps led to more questions and changes. In addition, collaboration with clients through self-report interviews led to new information and the creation of the fifth "ace," disrespect. Each of these discoveries led to a further refinement of essential concepts and gave counselors a better road map to follow.

The Hard Side versus the Soft Side of Hierarchy

An intensive analysis of Haley's and Schiff's work during Phase II did not result in the discovery of the soft side of hierarchy. Jim Keim's (1996) writing appeared to be the only place in the literature where the concept was described, but details were not provided about its implementation. For example, Keim (1996) wrote about initiating soothing sequences of communication, physical touch, and special outings; however, it was not made clear how or when to implement these interventions in the overall treatment process. Despite this lack of specification, it appeared that these principles were essential contributors to the probability of treatment success. Constant negative communication patterns between parents and difficult teenagers created a dearth of softness, and softness was needed for permanent change to take place. As a result, I decided that it was important to try to implement these procedures somewhere in the overall treatment process. For this to occur, three main questions had to be answered:

1. Where and when should the concept of restoring nurturance and tenderness be implemented within the overall treatment process? In other words, what is the optimal timing of this intervention, and what are the parental characteristics that influence this timing?
2. What are all the mini-steps or strategies that can be used to successfully implement the step of restoring nurturance and tenderness?
3. Once these strategies are discovered, how can they be operationalized in such a way that they can be implemented in a step-by-step fashion?

Below is a summary of the developmental process through which these three questions were answered. The specific points within this developmental timeline where the three questions were answered are highlighted.

1. After reading Keim's (1996) work, I decided to implement this concept during Phase III of the project.
2. The team of counselors was trained on how to restore tenderness and nurturance. The supervisor discussed the mini-steps of physical touch, initiating special parent–teenager outings, and creating soothing sequences or nurturing communication patterns between parent and child. However, since these steps were still in the developmental stage, the supervisor asked the counselors to use their creativity and intuition in implementing each step and the timing as to when they should be introduced. The team was told to videotape every session in which this intervention was used.
3. Videotapes and focus group interviews were analyzed and compared to the three idealized models and the final revised performance model. Anomalies or failed sessions were carefully scrutinized for patterns and themes.
4. Results from the analysis revealed the answer to the first question (i.e., when and where should restoring nurturance and tenderness be implemented, and what client characteristics influence this decision? It was discovered that if an adolescent exhibited one or more extreme behaviors (one of the "five aces") or the problem was chronic, the counselor had to stop these behaviors first before trying to introduce the concept of nurturance. Videotapes revealed parental hostility whenever nurturance was introduced before the extreme behavioral problems were solved. In addition, parent self-reports supported this finding: Parents ($n = 9$) stated that they and the counselors would have to "stop the bleeding" by stopping the problem behavior before they would have the time or energy to consider the issue of softness. Parents ($n = 22$) also reported that they first had to establish trust and confidence in their counselors' ability to help them. Such confidence was in part established when a counselor could design a consequence to stop an extreme behavior when others had tried and failed. When they were armed with this confidence and trust, the parents were more willing to take the risk of opening their hearts up again and being soft.
5. Based on this information, the step of restoring nurturance and tenderness was placed as Step 11 of the 15-step model. That is, it should generally occur after the "five aces" have been neutralized and the teenager is functioning without behavior problems.
6. Focus group interviews partially answered the second question (i.e., what mini-steps or strategies can be used to successfully implement nurturance?). Many of the teenagers interviewed ($n = 37$) reported that they needed an opportunity to regain lost trust. Without trust, resentment and bitter-

ness set in, and there was little hope for nurturance. In addition, some of these teenagers (n = 17) reported that the potential for nurturance was blocked when parents constantly criticizes them or failed to understand how they felt.

7. Based on this information, the following new mini-steps were adopted and implemented: opportunities to build trust; a new approach to criticism; a new approach to praise; and acceptance of underlying feelings. An analysis of videotapes employing these interventions helped to refine and operationalize these mini-steps. These results helped answer the third question (i.e., once these strategies are discovered, how can they be operationalized in such a way that they can be implemented in a step-by-step fashion?).

8. The strategies of special outings and physical touch were implemented, and the videotapes of these interventions were closely scrutinized. Sessions that did not work provided the necessary clues needed to implement these strategies successfully. For example, videotape analysis revealed that special outing sessions were unsuccessful when a counselor failed to get a parent and teenager to set a specific date and time, and when the counselor also failed to troubleshoot all the things that could go wrong. After these problem variables were identified, counselors were shown how to incorporate specifics and troubleshooting to increase the probability of success.

9. An analysis of videotapes revealed that soothing sequences of communication were conversations where a parent, *not* the child, controlled the mood, topic, and direction of the discussion. These discussions also did not contain elements of criticism or attacks on the teenager's character, but rather elements of praise, acceptance, positive rewards, special outings, acceptance of feelings, opportunities to build trust, and/or signs of good physical touch. Failed sessions that revealed for this intervention to be successful, a counselor must first engage in careful preparation. The counselor must then show the parent how to deliver soothing communication sequences properly through the use of "dry runs" or role plays. These discoveries were invaluable. Finally, it was decided not to describe this intervention as a "strategy" per se, but as a means of implementing and pulling together the other strategies.

In sum, this process is a good example of how a relatively new theoretical concept can be field-tested and operationalized by means of process research. Using task analysis methodology, I studied counseling sessions intensively for clues on how and when to implement the particular interventions involved in restoring nurturance and tenderness. In addition, the interventions were operationally defined. This example also demonstrates how clients can collaborate with researchers to direct them to new areas of investigation and strategies that are custom-designed for their needs.

Rules, Consequences, and Troubleshooting

Another important discovery was the correlation between the successful implementation of rules and consequences and the use or nonuse of troubleshooting. In cases where troubleshooting was employed, the parents had a greater degree of success in implementing rules and consequences. In the cases where troubleshooting was not used, the adolescents did something unexpected that often rendered the rule or consequence ineffective. After these patterns were observed, I looked for potential variables within the videotapes to explain these occurrences. Throughout this analysis, I asked myself the following question: "What factors could account for this pattern?"

The answer to this question was revealed when tapes of sessions that employed troubleshooting were compared with tapes of sessions that did not employ it. The following developmental timeline describes how the answers to this question were revealed:

1. The comparison of videotapes with and without troubleshooting revealed the following important discrepancies. The tapes without troubleshooting showed the implementation of rules and consequences without the preparation of role plays or "what if" scenarios. When this happened, rules and consequences were often ineffective, as the teenagers were able either to push their parents' "buttons" so as to make them lose control of their emotions, or to outmaneuver them by thinking two steps ahead. For example, if a consequence was grounding on the weekend for missing school, a teenager would get up early and be out the door before the parent woke up to enforce this consequence. Unexpected behaviors like this were preplanned by teenagers to throw their parents off track and render the consequences ineffective.

2. Tapes using the troubleshooting techniques of role play and "what if" scenarios were analyzed. The tapes showed that parents who used these strategies were able to deliver rules and consequences more effectively than those who had not used these interventions. Parents who had practiced their delivery through role plays did not allow their teenagers to control the mood of the discussion or to throw them off track. In addition, the teenagers would still try to outmaneuver the patients as before, but this time there was a Plan B in place if a particular rule was violated.

As stated earlier, difficult adolescents have both enhanced social perception abilities and the ability to push their parents' buttons. As a result, a comparative videotape analysis revealed the importance of troubleshooting in countering these special skills. The impact of troubleshooting and the timing of its use would have gone undetected without an intensive analysis and comparison of both successful and unsuccessful change episodes. As a result of

this analysis, it was decided to make troubleshooting Step 5 of the 15-step model, to stress its importance at this juncture. In addition, an analysis of successful change episodes led to the operationalization of the mini-steps of role plays and "what if" scenarios.

Phase V: Combining Process with Outcome Research

Once it was determined how the model worked, the final phase was to use outcome research to determine whether the model did work. In this section, I report the results of a 2-year pretest–posttest outcome study with 83 difficult adolescents and their families. The ways in which these results supported or disconfirmed the theoretical concepts that emerged from the process study are highlighted. Specifically, standardized outcome measures were used to obtain answers to the following five research questions:

1. At the end of treatment, did the parents show a significant change in negative attitudes toward their difficult teenagers?
2. At the end of treatment, did the results show a significant change in the parents' role, particularly in their ability to be in charge and maintain control over their teenager's problem behavior?
3. At the end of treatment, did both parents and teenagers show a significant change in the areas of affective responsiveness and affective involvement, or nurturance and tenderness?
4. At the end of treatment, did both parents and teenagers show a significant change in negative communication patterns?
5. At the end of treatment, did both parents and teenagers indicate satisfaction with the overall treatment process, even in cases where clients were involuntarily committed to treatment?

In sum, the standardized measures used were sensitive enough to test the effectiveness of four theoretical constructs from the 15-step model: (1) parents' ability to take charge; (2) changing the timing and process of confrontations; (3) parents' ability to neutralize behavior problems (the "five aces"); and (4) restoration of nurturance and tenderness. Other concepts, such as the changes in relapse and in rules, consequences, and troubleshooting still need to be tested. These were not tested here because I was unable to locate standardized measures that were theoretically congruent and sensitive enough to measure changes in these areas. It is important to note that most "measures are chosen because they are widely used and have become standard instruments, not because they provide the best test of the impact of a particular family treatment" (Anderson, 1988, p. 83). As a result, the outcome results in this study could only go as far as the sensitivity of the standardized measures used and the extent to which these were theoretically congruent with the concepts being evaluated.

Target Population Characteristics

Of the 83 families that participated in this study, 68.4% were European American, 18.4% were African American, 7.9% were Asian American, and 5.3% were Hispanic. Almost half the parents participating in the study were married (42.1%); 28.9% were divorced, 18.4% were single, and the remainder (10.6%) were either separated or divorced.

The families had an average of 2.9 children ($SD = 1.3$). Over two-thirds of the parents were employed (69.4%), with 19.4% being unemployed and 11.1% homemakers. Income levels were as follows: 20.8% of the families made less than $10,000; 29.2% earned between $10,000 and $20,000; 25% earned between $20,000 and $35,000; and 15.6% earned between $35,000 and $50,000. The remainder of the families (9.4%) earned more than $50,000.

As stated earlier, most of the adolescents treated were males (78.9%), with an average age of 15 years ($SD = 1.5$). The statistics on these adolescents' behavior problems and arrest records (see the description of clients in Phase III, above) indicate that they were indeed difficult and defiant.

Design and Measures

A nonexperimental pretest–posttest design was implemented. Parents and teenagers completed the Family Assessment Device (FAD) and the Client Satisfaction Inventory (CSI) separately and independently before treatment began and again after counseling ended. Some families completed treatment in 5 sessions and others within 10 sessions, with an average session length of 6.7 sessions. Only the parents completed the Index of Parental Attitudes (IPA). Responses from the pre and post program measures were evaluated to determine the level of change that occurred after the 15-step family-based treatment model was implemented. Descriptions of the scales used are presented below.

The FAD (Epstein, Baldwin, & Bishop, 1983) is a 60-item questionnaire designed to evaluate the overall health and pathology of a family, as well as changes in the family's organizational properties and in communication patterns that have been found to distinguish between healthy and unhealthy families. Family members are given a series of statements (e.g., "We are too self-centered," "Anything goes in our family") and asked whether or not they strongly agree, agree, disagree, or strongly disagree with each statement. The subscales of the FAD identify and distinguish among seven kay areas of family functioning: (1) Problem solving, (2) Communication, (3) Roles, (4) Af-

fective Responsiveness, (5) Affective Involvement, (6) Behavior Control, and (7) General Functioning.

The IPA (Hudson, 1992) is a 25-item questionnaire designed to measure the extent, severity, or magnitude of a parent's overall positive or negative attitude toward a teenager. If the overall pretest or average mean score is above 30, it suggests a clinically significant problem and indicates that the parent has an extremely negative attitude toward the teenager. In addition, there is an increased risk that the parent is experiencing extreme stress, with a clear possibility that some type of violence may be considered or used by the parent to deal with the problem. On this scale, a parent is given statements about his or her child or teenager (e.g., "I really enjoy my child," "I resent my child"), and is asked to respond whether each statement is true none of the time, very rarely, a little of the time, some of the time, a good part of the time, most of the time, or all of the time.

The CSI (McMurty, 1994) is a 25-item questionnaire designed to measure a client's overall satisfaction with treatment and his or her perception of how good or bad the services were in general. If the average mean score is below 30, it suggests a clinically significant problem in the client's perception of the quality of treatment; it indicates that the client is extremely unhappy with treatment or with the counselor's style and "bedside manner." Scores above 30 indicate the opposite. On this scale, a client is given statements about counseling or the counselor (e.g., "I feel much better now than when I first came here," "People here are only concerned about getting paid") and is asked to respond whether each statement is true none of the time, very rarely, a little of the time, some of the time, a good part of the time, most of the time, or all of the time.

Research Questions and Relevant Results

1. *At the end of treatment, did the parents show a significant change in negative attitudes toward their difficult teenagers?* The IPA results showed that parents reported a statistically significant change from pretest ($M = 33.01$) to posttest ($M = 23.17$) in negative attitudes toward their difficult teenagers ($t = 2.69$, $p \leq .05$). The pretest mean score of 33.01 indicated that before treatment the parents had extremely negative attitudes toward the teenagers. Following treatment, however, the mean score dropped below the cutoff of 30, suggesting a decreased risk that the parents were experiencing extreme stress or that violence would be used to deal with the teenagers' problem behavior. This indicates that the family-based model was effective in changing two key areas influencing overall parental attitudes: the timing and process of confrontations, and the restoration of nurturance and tenderness between parent and teenager. During the process study, it was discovered that parental attitudes were affected by these two areas. If the communication was mostly

negative, the attitudes of the parents would also be negative. In turn, these negative attitudes would severely limit the possibility of bringing nurturance back into the relationship. Parents often reported in focus groups that they loved their sons or daughters and that they did not like them any more. In sum, the significant change in posttest parental attitudes supports the hypothesis that changes in confrontational patterns and nurturance can have a positive effect on negative parent–teenager relationships.

2. *At the end of treatment, did the results show a significant change in the parents' role, particularly in their ability to be in charge and maintain control over their teenagers' problem behavior?* Table 12.1 and Figures 12.9 and 12.10 show that both parents and teenagers indeed reported significant changes in the parents' role, especially in their ability to resume authority and keep control over the teens' behavior. This was indicated by changes in scores on the FAD subscales of Roles, Behavior Control, and General Functioning.

The FAD Roles subscale focuses on whether a family has a clear set of rules and consequences, and whether parents clearly assign roles and tasks to the children. Examples of items on this subscale include "We discuss who is to do household chores," and "We make sure members meet their family responsibilities." The posttest mean scores of 1.96 for parents and 1.91 for teenagers indicated that the family-based model was effective in clarifying roles and hierarchy between parents and teenagers. This supports the notion that the parents were able to maintain and accept a position of authority following treatment. In turn, this supports the hypothesis that the family-based model was effective in putting the parents in charge and helping them to maintain this position of authority.

The FAD Behavior Control subscale measures how effective parents are in controlling problem behaviors and setting up rules and consequences. Ex-

TABLE 12.1. Results on the Family Assessment Device (FAD) Roles, Behavior Control, and General Functioning Subscales for Parents and Teenagers

FAD subscale	Pretest	Posttest	t
	Parents		
Roles	2.43	1.96	–3.06**
Behavior Control	1.86	1.56	–2.63*
General Functioning	2.36	1.85	–3.29**
	Teenagers		
Roles	2.64	1.91	–4.16**
Behavior Control	2.08	1.65	–2.76*
General Functioning	2.60	1.81	–4.68**

*$p \leq .05$; **$p \leq .01$.

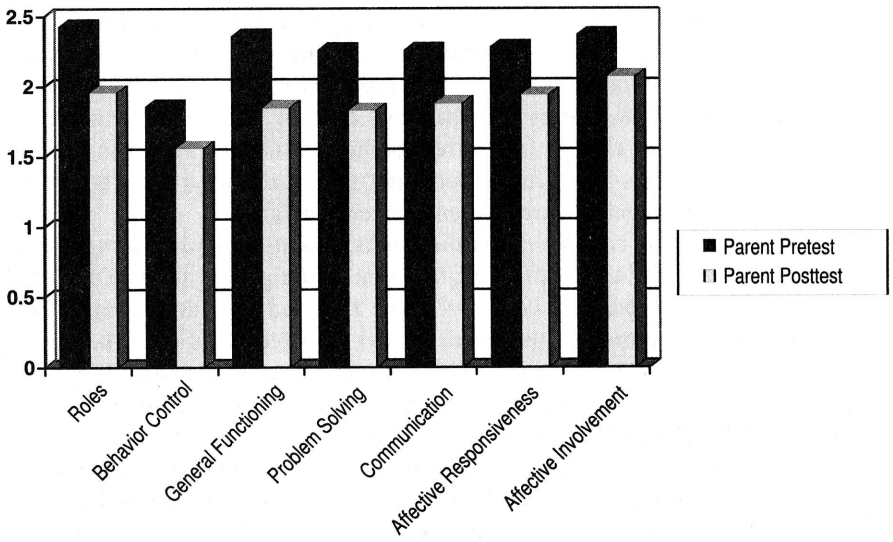

FIGURE 12.9. Results on all subscales of the Family Assessment Device (FAD) for parents at pretest and posttest.

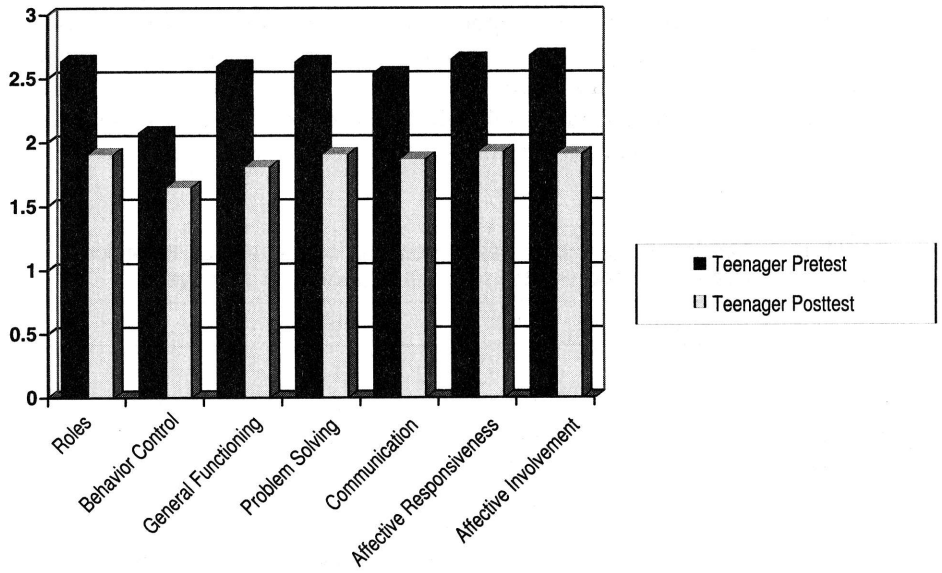

FIGURE 12.10. Results on all subscales of the Family Assessment Device (FAD) for teenagers at pretest and posttest.

amples of items on this subscale include "We have rules about hitting people," and "We have parents who control behavior problems." The posttest mean scores of 1.56 for parents and 1.65 for teenagers indicated that the parents were able to stop or control the problem behavior. In turn, this finding supported the hypothesis that the family-based model was effective in helping the parents to neutralize their teenagers' "aces" by controlling the particular behavior problems. This therefore supported the inclusion of Step 8 (neutralizing the adolescent's "five aces") in the model.

The FAD General Functioning subscale measures the overall health or pathology of a family. Examples of items on this subscale include "We don't get along well together," and "We cannot talk to each other about the sadness we feel." The posttest mean scores of 1.85 for parents and 1.81 for teenagers indicated that the overall health and general functioning of these families improved. A basic premise of the family-based model is that if the hierarchy is congruent and the parents are back in charge, the overall health of the family will improve. These results therefore supported the inclusion in the model of the general principle of putting the parents in charge of the adolescent's behavior.

3. *At the end of treatment, did both parents and teenagers show a significant change in the areas of affective responsiveness and affective involvement, or nurturance and tenderness?* Table 12.2 and Figures 12.9 and 12.10 show that both parents and teenagers reported significant changes in these areas, as indicated by changes in scores on the FAD subscales of Affective Responsiveness and Affective Involvement.

The FAD subscales of Affective Responsiveness and Affective Involvement measure whether or not family members show tenderness, concern, and affection for one another. Examples of items on these subscales include "We express tenderness," and "We cry openly." The posttest mean scores for parents and teenagers on both subscales indicated that both parents and

TABLE 12.2. Results on the Family Assessment Device (FAD) Affective Responsiveness and Affective Involvement Subscales for Parents and Teenagers

FAD subscale	Pretest	Posttest	*t*
	Parents		
Affective Responsiveness	2.28	1.94	–2.04*
Affective Involvement	2.37	2.07	–1.53*
	Teenagers		
Affective Responsiveness	2.65	1.98	–4.27**
Affective Involvement	2.68	1.91	–4.59**

*$p \leq .05$; **$p \leq .01$.

teenagers were able to show tenderness and nurturance, and to be more concerned for one another's welfare. In turn, this finding supported the hypothesis that the family-based model was effective in helping parents bring nurturance back into the relationship with their teens. It thereby supported the inclusion of Step 11 (restoring nurturance and tenderness) in the 15-step model.

4. *At the end of treatment, did both parents and teenagers report a significant change in negative communication patterns?* Table 12.3 and Figures 12.9 and 12.10 show that both parents and teenagers reported a significant change in this area, as indicated by changes in scores on the FAD subscale of Communication.

The FAD Communication subscale defines the quality of the exchange of information among family members. The focus is on whether or not verbal messages are clear in content and direct, in the sense that the person spoken to is the person for whom the message is intended. Examples of items on this subscale include "We are frank with each other," and "People come right out and say things instead of hinting at them." The posttest mean scores for both parents and teenagers indicated that after treatment there was improved communication in general, as well as a decrease in bitter and negative confrontations. This finding supported the hypothesis that the family-based model was effective in changing communication patterns; it thereby supported the inclusion of Step 6 (changing the timing and process of confrontations) in the model.

5. *At the end of treatment, did both parents and teenagers indicate satisfaction with the overall treatment process, even in cases where clients were involuntarily committed to treatment?* Within a 10-session framework, 88% of the parents and 83% of the teenagers reported on the CSI that they were satisfied with treatment. What makes these percentages *particularly significant* is the fact that a majority of clients came involuntarily to treatment (i.e., they did so only because they were required to do so by probation officers). This was a particularly surprising result, and it suggests that this model has a great deal of promise for the future. Counselors often ask parents to make a great deal of sacrifices to regain control of their households and take charge of their teens' problem behavior. Therefore, unless the clients are satisfied with treatment, there is no reason why they will make any sacrifices or listen to their counselors. In addition, if the clients are required to come to treatment, they will often enter the first session with a negative attitude and will resist any suggestions for change. This is especially true with difficult teenagers.

TABLE 12.3. Results on the Family Assessment Device (FAD) Communication Subscale for Parents and Teenagers

	Pretest	Posttest	*t*
Parents	2.26	1.88	–2.89**
Teenagers	2.54	1.87	–4.22**

**$p \leq .01$.

Some of the focus group interviews provided clues as to why client satisfaction was so high. Several parents ($n = 7$) reported that this treatment was different and better because it "got down to the business of giving [them] specific tools to solve the problems [they] came in to counseling for." Parents ($n = 5$) also said that "this kind of counseling was not just office work." The counselors were available 24 hours a day and came to where the problems were, whether this required home visits, school visits, or church visits. Teenagers ($n = 14$) reported that the counseling showed their parents how to talk to them differently and without yelling. They also liked the facts that clearly defined rules let them know what to expect, and that the rules had both negative *and* positive consequences. Finally, teenagers ($n = 37$) reported that they liked the fact that they had chances to earn back trust, and that their opinions and ideas were heard and even integrated into the contract.

In sum, these preliminary findings indicated that parents were satisfied with treatment because the model was clear-cut; because it provided specific tools and strategies; and because counselors were available on call 24 hours a day, not just for an hour a week in office sessions. Teenagers reported that they were satisfied because the model provided them with better methods of communication, clear rules and consequences, a voice, and opportunities to earn back trust. Further research is needed to tap into additional reasons why clients were satisfied with treatment. Answers to this question will provide valuable insight into the model's strengths and weaknesses.

BEYOND THE 21ST CENTURY: CONCLUSIONS AND FUTURE IMPLICATIONS

This chapter has demonstrated how process and outcome research can be used within a single study to operationalize key theoretical concepts and build a treatment model directly from clinical practice. Rather than beginning with hypothesis testing, this study moved toward hypothesis testing as the final step of a rigorous program of discovery process research. In this study, outcome measures supported the effectiveness of four theoretical constructs from the 15-step model: (1) parents' ability to take charge; (2) changing the timing and process of confrontations; (3) parents' ability to neutralize behavior problems (the "five aces"); and (4) restoration of nurturance and tenderness. In turn, these findings can lead to future task analysis investiga-

tions to find out why clients are so satisfied with this treatment model and which specific parts of these four theoretical constructs produce positive change. In this way, theory-building process research and verification outcome research are interdependent and complementary: Process research has directed outcome research, and now these results are directing researchers toward further process or task analysis research. The use of these two methods can lead to better research questions and a better and more refined definition of theoretical concepts within the 15-step family-based model.

Directions for Future Research

As stated earlier, it is my hope that readers will see this model as a work in progress and will use the research process described in this chapter to refine and develop the model further. The next logical step is to custom-fit the model to an even larger set of variables and possible scenarios. For example, suppose a counselor is presented with these variables and this particular scenario in practice:

> A 15-year-old male comes from a single-parent home. He belongs to a gang, uses drugs, and relapses before Step 13 in the model and before other family issues surface in Step 12. Given this scenario and these variables, what are the best treatment steps and options?

These types of exceptions to the overall model are common. Counselors will want custom-designed road maps for their particular cases and problems. One day in the future, a clinician may be able to sit down in front of a computer and type in a set of variables. After these variables are analyzed, an interactive computer disk will present the counselor with a customized set of procedures that fit the particular scenario and the set of variables presented. This kind of fine-tuning is needed in the future; indeed, it is expected in a society that wants positive change quickly and a health care system that demands it.

As we enter the 21st century, it seems timely for the field to reconsider and reassess its conceptual base by defining its treatment models through process and outcome research. We must struggle to conduct research that moves us closer to answering Frank's (1991) central question in his classic work *Persuasion and Healing*: "The question is not whether psychotherapy works; that goes without saying. Rather, the central question is, what are the central ingredients within a particular treatment method that account for its effectiveness with a particular population and clinical problem" (p. 6). To accomplish this goal, we must return to our roots of discovery-oriented research and to a collaboration between counselors and researchers.

A Return to Our Roots

In the 1950s, family therapy was born of discovery-oriented observations from behind a one-way mirror of family members sitting around a circle in the next room. Initially, the therapeutic goals and procedures, if any, were only vaguely specified. These observations, however, yielded rich theoretical concepts (e.g., metacommunication, family homeostasis, the double bind) and generated new research hypotheses and clinical enthusiasm. In the 1960s, these concepts were incorporated into a diversity of family counseling models (e.g., structural, Bowenian, Mental Research Institute, brief therapy). Family therapy teaching and theorizing flourished and were both conceptually interesting and provocative. From the 1970s to the present, however, family therapy has become disconnected from its discovery-oriented research base and has lost its original zest and focus. The field now either resembles a "flavor of the month club" by moving from one fad to the next, or relies on "who won" outcome studies that fail to move the field to the next step: finding out how a particular treatment works and why, with a particular population and presenting problem. Direct-practice counselors and students are hungry for answers to this question and want mini-steps to find their way within the complexity and multiple layers of a problem.

In addition, a split occurred during the 1970s between those who did research and those who did clinical work. This split is described by Haley (1978):

> In the 1950's it was taken for granted that a counselor and researcher were of the same species (although the counselor had a more second class status). . . . Today it seems more apparent that the research stance and the counselor stance are quite different. The researcher must explore and explain all the complex variables of every issue since he is an explorer of truth. The counselor stance is much different. He must use simple ideas that will accomplish his goals and not be distracted by the explorations into interesting aspects of life and the human mind. It seems evident that the creation of the researcher and the creation of the counselor are different enterprises. (pp. 73–74)

This split continues today. It must end if the gap between research and theory on the one hand, and practice on the other, is ever to be bridged.

In sum, we must ask ourselves this central question: "Is our field's current effort in model building working?" If the answer is no, then we must look for a time in the past when it was working, and must do more of what was done then. I believe that this time was in the 1950s and 1960s, with discovery-oriented research that employed a here-and-now process–outcome template. I hope that this chapter and this book represent a first step toward this future.

The Future of Counseling

At the Evolution of Psychotherapy Conference in 1995, Salvador Minuchin and Donald Meichenbaum gave a joint presentation to answer this question: "What is the future of counseling as we approach the 21st century?" They gave very different answers to this question, but their answers represent both the fears and hopes of many counselors about the future. I present these two different viewpoints here and show how this research chapter and model building may offer one possible solution to the dilemmas presented by each speaker.

Meichenbaum was the first to speak. He stated that the field of counseling will need to move to manualized treatment models whose effectiveness with specific populations (children, adolescents, adults) and treatment issues (anxiety disorders, depression, conduct problems, etc.) can be evaluated. These manualized treatments will have to be able to show documented strengths in order for counselors using them to be reimbursed by third-party payers. Meichenbaum envisioned a time in the 21st century when there will be computerized manuals or interactive disks in which counselors or actors will perform and demonstrate each essential strategy and technique. Family members can then take these disks home between sessions and practice each strategy between sessions. He called these disks "catalytic supplements." In addition, there may be a time when a counselor or client can go on the Internet or tune to a cable TV station and receive interactive supplements through a push of the button.

Minuchin then spoke and presented a different viewpoint. He stated that these manualized treatments will be unable to mirror or reflect all that transpires within a particular session. Manualization will also limit the intimacy of treatment and the therapeutic relationship between counselor and client. Finally, it will lead the counselor toward a rigid application of treatment—one that does not allow for the individual needs of the client or for novel situations and circumstances.

Meichenbaum and Minuchin thus presented different viewpoints, but both posed this central dilemma: How can we produce manualized treatments that do not sacrifice the intimacy of the therapeutic relationship, but are flexible enough to respond to a client's particular needs without stifling the innovation and creativity of the counselor? The 15-step family-based model attempts to accomplish this task in the following manner. First, the model offers treatment guidelines or a generalized template, rather than a rigid application of treatment steps. Even though the steps are numbered, they are done so only to give the counselor a sense of direction. Each chapter of this book provides numerous case examples and "what if" scenarios, to give the counselor as many options as possible within a particular procedural step or situation. For example, Chapter 7 provides the reader with three possible ways to introduce the topic of nurturance, depending on a particular family's characteristics. These different options emerged from the research study and are outlined to give the counselor flexibility.

Second, the intimacy and importance of the therapeutic relationship are never undermined, but are expanded and written about in almost every context. It is described as a separate step (Step 1, engagement), but it is also talked about within many other steps. For example, in chapter 8, I specifically talk about the importance of rapport and trust between counselors and clients and between counselors and outside systems. In this way, engagement is not presented as a one-time step, but as recurring throughout the treatment process.

Third, the model was not developed in a laboratory setting, but emerged from actual practice sessions and from collaboration with expert clinicians (Jay Haley and Neil Schiff), counselors, parents, and teenagers. Each time a new discovery was made, the concept was field-tested with a variety of counselors and clients. These sessions were then analyzed for anomalies. Moreover, clients were asked about their perceptions and feelings about a particular intervention or series of interventions; in turn, this feedback was used to refine the model further. In this way, the model was grounded in direct practice, and the principles reflected all the complexity and "curve balls" a difficult family could present. This gives the counselor information on how to respond to such a family's special needs, without stifling his or her innovation and creativity.

In sum, the 15-step family-based model represents an attempt to address the central dilemmas posed by Minuchin and the needs of the 21st century posed by Meichenbaum. I have already begun the process of experimenting with "catalytic supplements." For example, I have allowed parents to take home and read a draft version of Chapter 6, or have had them view videotapes of actors demonstrating ways to change the timing and direction of confrontations. Preliminary focus group interviews with parents indicate that these additions to treatment have been very helpful in clarifying specific strategies. It will always remain a challenge to juxtapose manualization and the complexity of the counselor–client relationship. However, as we enter the 21st century, we cannot afford to evade this challenge. Theory construction can no longer remain a back-room activity; it must be moved front and center, so that we can improve our methods for constructing testable theories.