CHAPTER 1

The Beginning Family Therapist

TAKING ON THE CHALLENGE

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

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

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

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

Most beginning therapists experience a host of anxious feelings when they start clinical work (Skovholt & Rønnestad, 2003). They are aware of their inadequacies more than their strengths, and need help to learn how to acquire the skills, knowledge, and sense of competency necessary to do good clinical work.

Many therapists complete the didactic part of their training with a sense of mastery and competence. After all, by the time they enter graduate school, the life of a student is very familiar, and they are accustomed to academic achievement in their course work. Academic accomplishments, however, do not necessarily translate easily into therapeutic competence. Faculty and students are left wondering how best to impart and acquire, respectively, the skills basic to clinical work.

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

"What am I supposed to say to the client?"
"How do I handle situation *X*?"
"What should happen after I complete the intake form?"
"Can clients tell I'm new at this and feeling completely inadequate and overwhelmed?"
"How do I keep all the information from the session clear and how do I know what is most important?"
"If I don't use a powerful intervention or technique during the first couple of sessions, am I a failure?"
"I know I should have a theory for this case, but I just don't understand how to apply information from my theories class to this acting-out adolescent and her hostile mother."

What students need is a way to develop their skills as therapists as they begin their clinical work. This book provides practical "how to"

guidelines on essential therapeutic skills from thorough assessment to careful treatment planning, from the nuts and bolts of specific interventions to the nuances of establishing therapeutic relationships and troubleshooting when treatment gets "stuck."

Reflecting the trend toward integrative approaches in family therapy, mental health, and the medical field, we stress a biopsychosocial view of assessment and treatment. This perspective provides the clinician with an effective and comprehensive framework for addressing the broad issues that clients can present in therapy. Thus, while family interaction remains a focus of attention herein, our goal is to prepare beginning therapists to integrate information and skills from other areas as well to best meet the needs of diverse client families.

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

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

Indeed, research on biological etiologies of mental illness and psychopharmacology suggests that therapists must be conversant with more than "talk therapies." A growing focus on treatment teams and multidisciplinary treatment approaches means that therapists must increasingly attend to the biological component of the biopsychosocial model and learn to collaborate with other healthcare professionals. A knowledge base in medication management and the ability to consult with physicians is one aspect of this multidisciplinary approach.

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

GETTING STARTED

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

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

Learning the art and science of doing therapy is a challenging task, particularly when first seeing clients. Beginning therapists frequently experience feelings of inadequacy and insecurity about their clinical abilities (e.g., Bischoff & Barton, 2002; Bischoff, Barton, Thober, & Hawley, 2002; Watkins, 2012; Woodside, Oberman, Cole, & Carruth, 2007). They fear that they will not be able to help their clients because of their inexperience. They may even fear that they will directly harm their clients or cause their conditions to deteriorate because of clinical mistakes. A few doubt their talent and ability as therapists to the extent that they seriously question whether to remain in the field.

Therapists and supervisors alike need to see confidence issues from a developmental perspective (Bischoff & Barton, 2002). Given their lack of clinical experience, it is only natural that beginning therapists question their competence. In fact, as supervisors, we worry more about beginning therapists who seem extremely confident in their abilities. These individuals underestimate the complexity and difficulty of learning to do therapy well.

MANAGING ANXIETY AND ISSUES OF CONFIDENCE

How does the beginning therapist deal with a lack of confidence, or with feeling overwhelmed and anxious? First, therapists must recognize that these feelings are completely normal. Learning to do something as complicated as therapy can be difficult, especially in the beginning. Paradoxically, the more one learns about how to do therapy, the more one realizes how much one doesn't know. This paradox can feed an individual's insecurity about being a therapist. In fact, it is not uncommon for students to question whether they have what it takes to be a therapist (Watkins, 2012). Beginning therapists may interpret feelings of being overwhelmed as a possible sign that they are not cut out

to be therapists, which only serves to fuel their anxiety and insecurity. Although the intensity of these feelings and the ways of coping will vary from therapist to therapist, every beginning therapist struggles to some degree with these feelings.

Second, beginning therapists need to share their insecurities with other therapists and supervisors. Unfortunately, it is fear of being incompetent or a failure that prevents beginning therapists from sharing their struggles with others. When a therapist does take the risk and shares his or her fears with peers, others will typically disclose similar worries. This disclosure helps the beginning therapist to accept that these struggles are developmentally appropriate rather than a sign of being unsuited for the profession (Bischoff et al., 2002). Supervisors can also provide reassurance that anxiety and lack of confidence are expected and normal at this stage of development.

Third, it is crucial to realize that the therapist–client relationship is inherently therapeutic. A therapist doesn't need to *do* something for clients to have a positive experience. This is very reassuring to most beginning therapists because they generally have confidence in their relational skills. When beginning therapists are instructed as to the importance of joining and empathically listening to their clients, most therapists are relieved, feeling "I can do that!"

Fourth, beginning therapists need to recognize that their early experiences in seeing clients often involve a steep learning curve, like any other new job. In the first few months, you will be doing a number of things for the first time. It is natural to be anxious doing something the first time because you are uncertain if you are doing it right. However, you will feel more confident doing something once you have done it multiple times. For example, you will be less anxious doing an intake with a family if you have two or three intakes "under your belt." It takes time, however, to gain enough experience so that many situations become familiar.

Finally, beginning therapists should examine if distorted cognitions or unrealistic expectations are contributing to their fears or struggles with confidence. Beginning therapists can struggle with perfectionistic tendencies or critical self-talk (Hill, Sullivan, Knox, & Schlosser, 2007), which may need to be challenged. Theo was hard on himself as a beginning therapist, and even questioned if it was ethical for him to treat many of his clients given his inexperience. He frequently thought that his clients would be better served by working with more experienced therapists. However, one day Theo recognized that the experienced therapists he thought his clients should be working with were once beginning therapists too. The only pathway to becoming an experienced therapist was to go through the learning process that he was going through. It was reassuring for him to know that even famous

therapists like Salvador Minuchin or Virginia Satir were inexperienced therapists at one time too. A good battery of constructive thoughts and images goes a long way toward soothing beginners' jitters.

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

Fortunately, therapists don't need to complete 5,000–7,000 hours of work to see a notable improvement in their confidence. Even in the first year of seeing clients, beginning therapists will see their confidence increase (Bischoff & Barton, 2002). The intense feelings of anxiety and being overwhelmed that are common in the beginning generally subside after 1–3 months of seeing clients. Beginning therapists also become less fearful that they will do something to directly harm their clients, although they continue to struggle with feelings of being ineffective or unhelpful.

When therapists have reached about 500–700 hours of clinical experience, they have achieved another milestone in therapist confidence. By this point in time, therapists have experienced enough clinical successes that they are beginning to develop some initial confidence in their abilities to help clients. At this level of experience, beginning therapists generally report greater ability in conceptualizing cases. They often know what needs to be changed, yet are sometimes unsure of how to intervene to bring about that change.

Most therapists will have confidence in their overall abilities by the time they have had 1,000–1,500 hours of clinical experience. At this point, they are better at conceptualizing cases and have also developed a repertoire of effective interventions. Of course, therapists can still experience periodic doubts about their abilities, particularly when struggling with difficult cases or issues. Issues of confidence may also reemerge if therapists start working with new and unfamiliar populations. However, most therapists at this stage are no longer plagued by significant doubts about their clinical ability.

STAGES OF THERAPIST DEVELOPMENT

McCollum (1990) notes that therapists trained in individual therapy generally go through three stages of development when learning to do family therapy. In the first stage, they focus on acquiring the skills necessary to work with families. In the second stage, they learn to apply systemic theory to their clinical work, and in the third, "self of the therapist" stage, they focus on more personal issues in relationship to

their clinical work, such as exploring how their family-of-origin experiences affect their work with families.

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

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

Stage One: Learning Essential Skills

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

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

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

Stage Two: Learning to Conceptualize Cases

Beginning therapists soon recognize that the therapeutic relationship is a necessary but not always sufficient ingredient for change. They no longer are content simply to be with their clients; they realize that some clients need concrete ideas or suggestions for change. At the same time,

therapists also become aware that to be effective, interventions must be rooted in a clear understanding of family dynamics. As a result, therapists soon move into a second stage, where emphasis is placed on conceptualizing what is happening in their cases.

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

> "How do I know what is the most important information to attend to in a case?"
> "My clients keep coming in with a different problem each week. How do I figure out what to focus on?"
> "I know I should have a theory for this case, but I'm not sure what theory would 'work' here."
> "I thought I knew what we should be working on last week, but now I'm confused again."
> "I know I should be focusing on the process, but I feel like I'm stuck in the content."

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

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

Stage Three: The Therapist-as-Self

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

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

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

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

OBSESSING ABOUT CLINICAL WORK

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

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

Thinking (or even obsessing) about clients is something that tends to subside with time and experience. Most experienced therapists report thinking very little about their clients outside the therapy hour. One reason for this change is that the therapist gradually gains a greater sense of clinical mastery by virtue of experience. In addition, therapists learn to balance objectivity and emotional involvement with clients. In a sense, therapists learn how to construct an emotional boundary (Skovholt & Rønnestad, 2003). If the boundary becomes too diffuse, the therapist may be overwhelmed and inducted into the family system. If it is too rigid, he or she may lack the empathy necessary to adequately understand the issues and join with the family. The former problem is characteristic of beginning therapists, who, with time, learn to better regulate this boundary.

DEALING WITH BURNOUT

At first glance, one would not anticipate that someone who is just beginning a career as a family therapist would experience feelings of

burnout. Yet many beginning therapists experience some degree of burnout during their clinical training. It is not uncommon for individuals struggling with burnout even to question whether they want to continue their careers as therapists. The potential for burnout among beginning therapists exists because of several factors.

First, learning to do therapy can be demanding. As noted above, beginning therapists may be constantly thinking about their clients, making it difficult to get a mental break from their clinical work. Also, worrying about one's competence as a beginning therapist can diminish some of the enjoyment of doing therapy (Edwards & Patterson, 2012).

Second, therapists have other stressors outside of their clinical work. For example, you may have other classes, comprehensive exams, or a master's or doctoral thesis to complete as part of your training program. You may need to work to pay for school or living expenses, or may have a family or partner who needs your time and energy. You may experience considerable stress from trying to successfully meet all these commitments.

Third, the courses or clinical work may raise personal issues for you as you learn to do therapy. Insights gained from clinical training inevitably lead student therapists to reexamine their own lives and families. Although this process can become the catalyst for significant personal growth, it can also place one more additional demand on the beginning therapist.

In order to avoid burnout, practicing good self-care is essential (Norcross & Guy, 2007). For example, you need to build in time for "recharging your batteries." Individuals who are faced with extreme time demands often put off taking personal time to do this. Taking time for yourself seems counterintuitive when faced with an overwhelming number of tasks to accomplish, but the time lost is often made up by being able to work with renewed energy and efficiency. Ironically, many therapists are willing to give this advice to their clients but have difficulty following it themselves.

Being willing to set limits is another important tool to avoid burnout. Beginning therapists often report setting their client schedule based largely on the convenience of their clients. In some cases, beginning therapists come in 5 days a week even though their caseload requires only 3 or 4 days. As therapists gain experience, they often will become more willing to set some limits on their availability, giving them some protected time for themselves.

You also need a strong social support network. Many of us owe our families a great deal of credit for the emotional and financial support they provided during our training. Being with family and friends

outside the field will allow you to temporarily escape the demands of being a beginning therapist. Yet, you also need support from those within the field who understand the unique stressors that come with being a therapist. You will find that connecting and obtaining support from your peers within your program is invaluable (Edwards & Patterson, 2012). Both experienced and inexperienced therapists need colleagues with whom they can share clinical experiences to avoid burnout.

CONCLUSION

This chapter has identified some of the common challenges that beginning therapists encounter early in their careers. While dealing with these challenges, it's important to keep the "big picture" in mind and recall the benefits of being a therapist. Learning to do therapy can be a strong catalyst for personal growth. What one learns about helping other families can be applied to one's own life and family, making it more enriching. As a therapist, you will be privileged to witness deeply moving moments of courage and compassion on the part of your clients. It is rewarding to see individuals create more fulfilling lives, knowing that we contributed in part to this growth or change. Often the clients whom we struggle the most to help are the ones who give us the greatest sense of fulfillment when they actually do succeed in changing. As you move through the rough spots, it can be helpful to keep the following "reminders" at hand:

1. *Becoming a therapist takes time.* This is an opportunity for you to be a learner; you are not expected to be an expert. Becoming an effective therapist takes several years of training.
2. *Make sure you take care of yourself.* Use constructive means for stress reduction. Develop resources for support from other students, peers, and colleagues.
3. *Self-doubts are normal.* Be patient with yourself, focus on the positive, and pay attention to the developmental tasks of becoming a therapist.
4. *Use the skills that brought you to the field.* While you are learning lots of new theory and material, continue to pay attention to your intuition, your desire to work with others, and your natural abilities.

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