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THE INVISIBLE MIRROR: IN-HOME FAMILY THERAPY AND SUPERVISION

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Home-based family therapy intervention programs, designed as a preventive strategy for multi-problem, at-risk families, are a rapidly growing phenomenon in mental health agencies. However, a review of the literature reveals little information on clinical supervision, which is a major component of home-based family intervention. The purpose of this article is to provide an alternative supervisory approach, in-home supervision, for training therapists who do home-based intervention.

Programs providing home-based family therapy to prevent institutional placement of at-risk children or adolescents are growing rapidly in the United States (Kaplan, 1986; Maluccio, Fein, & Olmstead, 1986; Norman, 1985). Generally, high satisfaction with services and equally high (80% to 90%) rates of placement prevention have been reported throughout these programs (Frawley, 1986; Reid, Kagan, & Schlosberg, 1988).

A recent review of the literature reveals that although numerous articles describe the family at risk (Fossum & Mason, 1986; Fraser, Pecora, & Haapala, 1988), assessment strategies (Hartman, 1978; Kagan & Schlosberg, 1989; McGoldrick & Gerson, 1985), and therapeutic interventions (Breit, In, & Wilner, 1983; Kagan, 1983; Pittman, 1987; Tomm, 1987, 1988), literature on clinical supervision, which is a major component of home-based intervention, is sparse.

Liddle, Breunlin, and Schwartz (1988) indicate that over 200 papers and chapters in books on family therapy training and supervision are in print. The approaches to supervision presented in these materials range from oral presentations based on notes and analyses of videotaped sessions to inviting the family to the office for "live" supervision. However, since home-based programs are a recent phenomenon in the mental health field, it is not surprising that there is an absence of literature on issues pertinent to the supervision of therapists who work with families in the home (Clark, Zalis, & Sacco, 1982; Pegg & Manocchio, 1982; Zarski & Zygmond, 1989). The purpose of the present article is to address this limitation by providing an alternative supervisory approach for training novice therapists working in the home with families at risk. The

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approach integrates elements of an individual developmental model within a systems framework. The two models are entirely compatible.

DEVELOPMENT OF THE IN-HOME APPROACH

The development of the in-home approach to supervision, as it is presently practiced, has progressed through several stages. In the first stage, supervision involved a modified team approach in which clinicians met together once a week with a supervisor to discuss their cases. In the second stage, that is, live supervision, families were invited to the office where the primary therapist conducted the session, and the supervisor and other team members observed behind a mirror (Liddle et al., 1988). Interventions such as the Greek chorus, which developed as part of the Brief Therapy project (Papp, 1983), were also used. In the third stage, now in effect, the supervisor and team members accompany the primary therapist to the home for "home-based supervision of home-based therapy."

Families referred for home-based intervention are at risk of having a child or adolescent placed in a residential or psychiatric facility. Treatment is family crisis intervention, which is provided in the family's home and is usually limited to a maximum involvement of 12 weeks. Therapists are masters level clinicians with little or moderate training in systems theory or family therapy techniques.

THEORETICAL BACKGROUND

Stoltenberg and Delworth's (1987) work on therapist development provides a model within which to view home-based supervision.

Basing their model upon a theory of individual development, Stoltenberg and Delworth suggest that therapy trainees move through four stages of development ranging from neophyte to master therapist. Progress through each of these stages is based upon trainee development in both person-centered structures and professional activities.

Person-centered structures include self- and other-awareness, motivation, and autonomy. For example, the beginning level therapist is typically lacking in self-awareness, anxious relative to expectations of the supervisor, dependent on the supervisor for direction, and motivated more by a fear of failure than by a desire to succeed. Level two supervisees are beginning to think systemically. Their self-awareness has increased, and they begin to display more risk-taking behavior. Level three trainees exhibit a more differentiated interpersonal orientation in that they are aware of personal issues that are triggered by problems presented by family members, such as divorce, physical or sexual abuse, but are able to maintain a degree of separateness so that the triggers do not adversely affect the therapy. Level four trainees understand the strengths and limitations of family therapy and are insightful relative to personal strengths and limitations. These trainees have integrated the standards of AAMFT with their self-identity, and they can alter their mental structures to fit new experiences or environments.

Professional activities include, among other things, intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics.

Stoltenberg and Delworth (1987) also identify optimum supervisory environments that facilitate trainee progression through the four developmental stages. At stage one, a supervisor uses structure, support, and exemplification. Supervisory sessions are devoted to formulating hypotheses that examine a family's level of resistance to change as well as how this pattern of resistance is related to the family's current crisis. For example, the trainee is assisted in identifying primary resistance patterns such as denial ("There's no problem"), blaming ("It's Joe's fault"), or labeling ("He's hyperactive"). After

identifying a pattern of resistance, the trainee may hypothesize that a family is using denial in order to avoid dealing with a long history of violence in the family.

Stage two focuses on therapy tasks, flexibility, and enactments. In one case, the supervisor assisted the trainee in developing a set of triadic questions to explore the role of an ex-spouse in maintaining a child's school-related problems (Tomm, 1988). Following this intervention, the father realized that his role as a noncustodial parent with his son mirrored his own father's postdivorce behavior. The therapist then conducted several sessions with a focus on a co-parenting relationship with the result that the child's school behavior improved.

In stage three supervision involves less structure and more autonomy, with an emphasis on the pragmatic implications of adopting a family-oriented view. The supervisor's input at this stage focuses on how to help the trainee use family issues in a way that engages the parents as co-therapists while expanding the family's perspectives.

Stage four centers on peer and collegial relationships, and discussions in the supervisory sessions might focus on the trainee's use of ritual, metaphor, or paradoxical interventions with the family. In one case involving an Afro-American family, each family session was initiated by having all members call upon significant ancestors to help them in their present crisis with an acting-out adolescent.

Although Stoltenberg and Delworth's (1987) stage development model traditionally has been used for training office-based therapists, combining the model with in-home supervision has allowed us to accomplish three objectives: (a) to facilitate therapist growth; (b) to teach novice level therapists who work in the home to think systemically; and (c) to address difficult therapeutic concerns through a variety of supervisory interventions.

Therapist growth is promoted by emphasizing the self-in-context (Minuchin & Fishman, 1981). While Stoltenberg and Delworth's (1987) model provides guidelines for understanding the personal and historical aspects of the individual therapist, in-home supervision allows the supervisor to view the therapist in the context of the family and their home environment. For example, in the early stages of training, therapists are particularly inclined to become overinvolved with family members and overwhelmed by the number and severity of problems, such as children who have been physically or sexually abused and homes that lack adequate ventilation and are roach infested. The supervisor can observe the way in which a trainee joins this family and discover aspects of trainee self- and other-awareness that would never be exhibited in an office-based therapy.

By focusing on a novice trainee's typical responses, which range from emotional pain through fright, the supervisor can focus on two elements in the joining process—the family's emotional impact on the therapist and the impact of this response on the family. By helping a therapist recognize the therapeutic implications of these responses, the supervisor can prevent the possibility of a family's perception of rejection and premature withdrawal from treatment (Kagan & Schlosberg, 1989).

In-home supervision also allows for the creation of an optimal learning situation in which a supervisor can encourage a therapist's autonomy in the context of a structured learning environment. The in-home supervisor can take advantage of the home environment to observe the interaction between therapist and family and intervene to change the interaction through the therapist. For example, a therapist may learn about the key systemic concept of boundaries as a result of becoming enmeshed within the system of the family in crisis. By creating a hierarchy of influence (supervisor, therapist, family), the supervisor can centralize and challenge the therapist to challenge the family. Changing the therapist's transactions with the family contributes to a change in the boundary between therapist and family, with a resulting increase in therapist autonomy.

The decision to adopt an in-home approach to supervision was precipitated by feedback from therapists, such as, "The family is not the same when I see them in their home" and "It is one thing to talk about poor living conditions, and another thing to do therapy in those homes."

The term "invisible mirror" was selected to address the critical differences inherent in a home versus office supervisory environment. The use of the "invisible mirror" provides an expanded context for learning about therapy, training, and supervision. Liddle (1988a) suggests that a trainee's work setting has a major influence on the trainee's learning capacities in supervision. For example, both daily interactions with colleagues and feedback from clients are viewed as positive contributors to a trainee's effectiveness in therapy (Liddle, 1988a). However, therapists who work in the home usually have minimal involvement with other agency therapists. Moreover, given the intensity of treatment (approximately 12 weeks duration), there is little opportunity for feedback from family members. In addition, these therapists have no clear identity in the mental health field (Clark et al., 1982).

During the initial stages of supervision, the in-home supervisor can address these issues by emphasizing the idea of competence (Liddle, 1988b; Liddle & Saba, 1985) and building upon the strengths and competencies of the trainee while encouraging the development of theoretical and therapeutic resources. By working with the trainee to develop an appropriate ritual at the conclusion of treatment, the supervisor can create a context for the development of a therapist's self-esteem and a family's resourcefulness.

IMPLEMENTATION

Negotiating transitions is the central theme throughout the supervisory process. Families experience a transition when a stressor impacts on the system, requiring a response outside the system's usual repertoire. Similarly, therapists receiving in-home supervision experience several transitions while facilitating the involvement of the supervisor and team with the family in therapy.

Skillful negotiation of four transition points is crucial to the effectiveness of in-home supervision. (See Figure 1). The four transition points include: (a) the session preceding in-home supervision; (b) the entry of supervisor and team into the home; (c) the exit of the supervisor and team following the session; and (d) the home-based session following the in-home supervision. Therefore, it is important to incorporate the timing of the in-home session into the overall treatment plan of the family. Families receiving home-based intervention enter therapy in crisis, the crisis centering on a child or adolescent at risk of placement outside the home in a residential or psychiatric facility. The initial goal of therapy is crisis stabilization. Since this objective must precede family reorganization, in-home supervision appears to have its greatest value if used during the middle phase of treatment, usually somewhere between the fourth and eighth week of treatment since the majority of home-based programs limit the service to 12 weeks. It is during this period that the trainee has joined with the family, specific goals have been established, and family patterns contributing to the dysfunction have been recognized and confirmed.

Key issues related to these transition points are presented in Figure 2. For example, common among these high-risk, multiproblem families are complex situations involving overt coalitions that blur generational boundaries. For example, a grandparent or a significant other, such as an uncle, aunt, or sibling, may be living in the home as a means of meeting financial obligations. If unemployed, this person might take on the role of child caretaker while the parent(s) work.

Any of these configurations may contribute to the intense conflict that creates the at-risk situation. In preparing the family for in-home supervision, a novice therapist

Figure 1
In-Home Supervision Transition Points

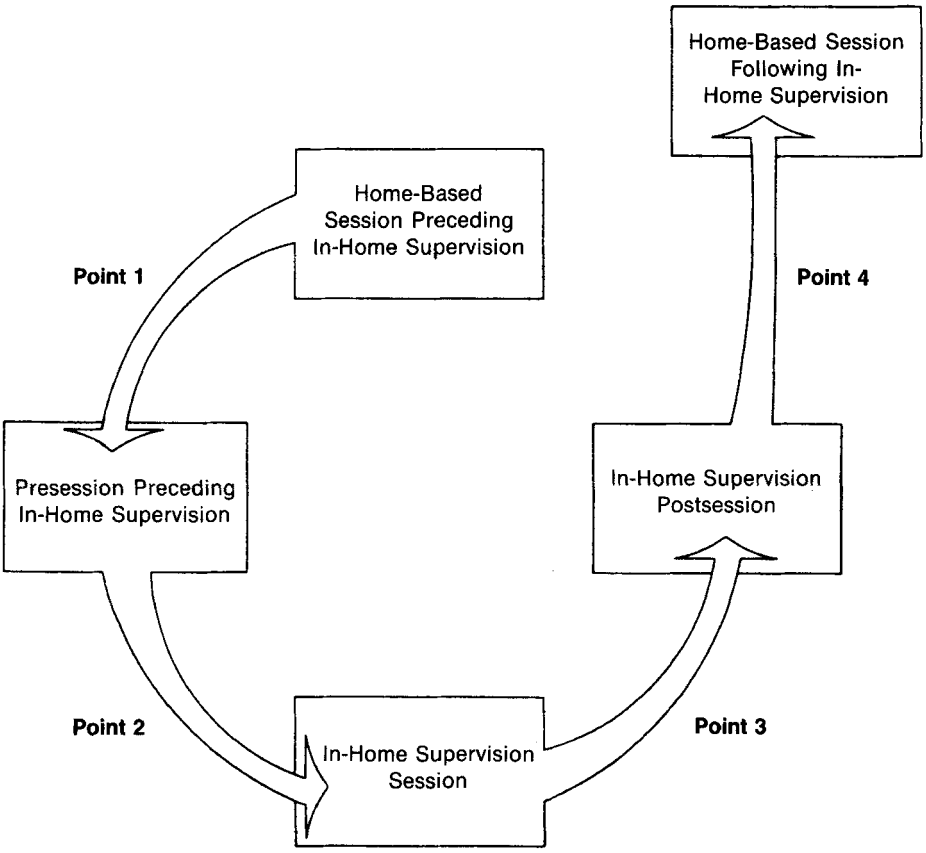

Figure 2
Major Issues Related to Transition Points

Transition Point	Therapeutic Issues
1	—Supervisor's Role Identity
	—Preparing Family For In-Home Supervision
	—Creating Context for Change
2	—Facilitating Entrance into Home
	—Positioning Supervisor/Team/Family
	—Beginning The Session
3	—Facilitating Exit
	—Establishing Closure
	—Connecting with Supervisor and Team Members
4	—Processing Family's Reactions to In-Home Supervision
	—Re-engaging Family in Therapy
	—Promoting Change

who does not understand the function of these coalitions may align with an overinvolved significant other, only to weaken further the parental subsystem. Embedded in this transition phase is the therapist's role identity and the desire to create a context for change. The supervisor, through the use of support, helps the therapist work with the family if there is initial resentment at the intrusion, fear of the consequences, or a sense of helplessness to do anything but agree to the in-home supervision (Clark et. al., 1982).

By incorporating systemic concepts such as boundaries and alignments into the learning process, the supervisor can enable the supervisee to challenge the pattern of significant other overinvolvement, thereby completing the transition to the presession stage of the supervisory process. For example, the supervisor might work with a beginning level therapist to help the therapist develop a healthy coalition with the parent or work to discontinue the troublesome coalition. In either case, the therapist can be instructed in how to "notice aloud" a critical aspect of the interaction and then follow with a simple task assignment. Such instructions may continue until a sequence is disrupted and a clear boundary is established between parent and grandparent.

In describing in-home supervision relative to the stage-specific framework, it is important to consider the following: the family's ability and readiness to work toward positive change, the developmental process of the individual therapist, the supervisor, the supervisory relationship, and the functioning of the home-based team as a unit.

Presession

The purpose of the presession (Montalvo, 1973) is to establish direction for the session. Goals for the presession include: (a) defining an overall strategy for the session, (b) determining the format for the team during the session (Liddle, 1988a), and (c) clarifying session-specific goals for the family and the therapy team.

In defining the overall strategy for the session, the home-based treatment plan may serve as a helpful tool. The home-based team and supervisor will have previously targeted two or three patterns of interaction within the family system which have sabotaged positive change. In that the in-home supervision session is inherently likely to unsettle the family system on some level, the session presents a positive opportunity for change.

Determining the format for the home-based team in the presession centers on clarifying the "rules" of the session. Will the team take a break during the session? What will be the hierarchy of communication during the session? Does the team need to develop a signal that indicates a family member has escalated to a critical level? Which team member will assume what role or function during the session?

During the presession, the home-based team and the supervisor will establish a goal for the session. To increase the odds of achieving that goal and, at the same time, model clear boundaries for the family system, it is important that the hierarchical nature of supervision be mutually understood by the supervisees and the supervisor (Zarski & Zygmond, 1989). During the presession, session, and postsession, the supervisor has leverage in creating an atmosphere that focuses on the process and content of the session rather than on evaluative aspects. A goal of the supervisor will be to foster competence in the team members and offer an experience that expands their maneuverability as facilitators of change within the family system.

The Session

Since families receiving home-based intervention may have developed resistance patterns of denial, blaming, or fragility, it is important for the supervisor, trainee, and team to consider two major issues regarding during-session interventions. The first is therapeutic maneuverability: How does the home-based team gain leverage on the family's turf? The second addresses boundaries. Because unclear boundaries are consis-

tently characteristic of high-risk, crisis-oriented families (Kagan & Schlosberg, 1989), the in-home supervision experience and the family's environment must be utilized to define boundaries within the family system.

Of course, boundary work has begun before the in-home supervision session. A home-based team may have a written policy that the team will not enter the home unless the family is willing to remove or secure any potentially violent weapons. If a home is infested with roaches, the team may provide money for an exterminator, but not enter the home until the extermination has taken place. The balance seems to be in joining with the family by using what the family presents, yet setting appropriate limits regarding danger and risk.

In typical live supervision settings, the supervisor may never meet the family. In bringing the supervisor and other team members not working directly with the family into the home, the direct service team will need to anticipate who will introduce the supervisor and team members to the family members. Introductions are an important vehicle in joining, empowering, and including family members. During the introductions and throughout the session, team members will attempt to join with the family, matching the family's language and respecting the family rules. Home-based intervention offers a rich opportunity to use and metaphorically or concretely restructure the family's environment.

After introductions, it may be helpful for the team to guide the family in establishing rules for the session. For example, what will the family do if the phone rings or someone comes to the door? During the session, the team may implement creative ways to use space in the home, to have simultaneous interactions with appropriate subsystems, or to use the kitchen table as the central location during the session if the therapists have come to learn that major family decisions happen at the kitchen table.

It is important that the supervisor maintain the flexibility to move around during the session. Unlike live supervision with the one-way mirror, the family members may hear the supervisor communicate an intervention to a therapist. Consistent with Liddle's (1988a) stage-specific model of supervision, the supervisor's decision to intervene will be based on several factors: urgency or the importance of the intervention and consequence if the intervention is not carried out; if a therapist enters into a power struggle with a family member; or if the therapist seems to have been inducted into the family system. The concreteness or difficulty of the intervention will depend on the development and learning style of the therapist.

Home-based team members often view in-home supervision as an opportunity rich in resources—the family's environment and the feedback from the supervisor and the team. One home-based family included a rigidly enmeshed system of a mother and four teenagers. During a session, the supervisor noted pictures of children who had been mentioned only briefly during previous treatment or in the social history. By incorporating these foster children, who had been abruptly removed from the home years ago, into a family sculpture, it became evident that the mother needed to grieve for the loss of these children she had nurtured before she could begin to look at supporting the growth and independence of her teenagers.

Postsession

The drive back to the office can provide a break before the postsession during which the supervisor can collect his or her thoughts. In the postsession, the supervisor will meet with the team and facilitate discussion addressing whether or not the team did what it set out to do. If not, why not? Did the therapist implement the supervisor's directives? If so, how well were they implemented? Did the interventions have the desired effect? It will be important not to cover too much in the postsession *and to* summarize concisely.

Ideally, the postsession will provide a sense of closure for the team. In considering the continuum of the family's growth and the therapist's developmental process, the supervisor will strive to connect the session to the overall process of the family and the team members' development.

CASE STUDY

The Johnson family was referred for home-based intervention by the County Juvenile Court due to physical abuse of the younger siblings by Tim, age 15. The father, Tom, was a long-distance truck driver and was only home on the weekends. It appeared that the mother, Louise, could not control Tim. It was evident to the Court that if the fighting continued to escalate between the siblings, someone would be seriously injured and Tim would be removed from the home.

Treatment Issues

All four children, Tim (15), Amy (14), Don (12), and Dennis (11), had been adopted by the Johnsons. Tim had been adopted shortly after birth. Amy, Don, and Dennis were siblings and had been adopted four years prior to home-based involvement. They were victims of severe neglect and sexual abuse in their birth family.

The home-based team assigned to the family consisted of a masters level therapist and a bachelors level case manager. The team referred to this family as the "Basement Family." Louise and the children spent their waking hours in the basement, and the children were only permitted in their bedrooms at bedtime. After school, they entered the house through the basement door, sat down at small desks, and looked to Louise for instructions. Their time was spent in one large room, and they asked permission to go to the bathroom. Clearly, the lack of boundaries and the rigid family rules needed to be addressed.

Other treatment goals included empowering Louise as a parent, strengthening the marital relationship (Tom actively participated in treatment by calling the team collect, completing homework while on the road, and attending occasional Saturday sessions), and exploring the blocks that prohibited the parents from letting these adolescents begin to "grow up." The family seemed to be stuck in a dangerous paradox—the more rigid and controlling the family rules were, the more violent Tim became, which caused the parents to become even more rigid.

In-Home Supervision

Home-based intervention continued for approximately 14 weeks. The in-home session was held during Week 6. During the two-week assessment period, the following were presented as integral aspects of treatment: videotaping, the in-home session, and the fact that the supervisor was a part of the team.

Presession

The in-home session included Louise, the four adolescents, the therapist, case manager, and the supervisor. During the presession, the "rules" for the session were established: the team would take a break during the session, the session would be held in the basement, the supervisor would not communicate directly with the family after the introductions, and she would move around the room to offer interventions to the team.

Considering the readiness of the family, the team strategized that a series of family sculptures would be implemented with the following treatment goals: (a) to reinforce appropriate boundaries; (b) to empower Louise to be in charge of the children; and (c) to take Amy out of the caretaker role that tended to set her up for abuse and encouraged

her younger brothers not to have their own voices in the family. The process of the sculptures would unsettle the rigid after-school routine, enable the family to experience and practice different communication patterns, and increase the therapeutic maneuverability of the therapist.

The supervisor suggested that the therapist direct the sculptures and guide Louise throughout the session. The case manager had a positive relationship with the adolescents and moved among them, encouraging them to participate and using the alter-ego technique when necessary.

In-Home Session

Louise met the team at the door. The children arrived from school 15 minutes later. The therapist introduced the supervisor to Louise and reviewed the structure of the session with Louise while the case manager set up the videocamera.

When the children arrived from school and were settled at their desks, the team was careful to respect Louise's need for routine. The therapist encouraged Louise briefly to review the structure of the session with her sons and daughter. The first sculpture included Louise, Tom, Tim, and three foster children—six years ago. Louise positioned herself surrounded by the children. Two dolls and a football symbolized the foster children, and it seemed that Louise demonstrated intense tenderness and protectiveness with these symbols. At this point, the supervisor directed the therapist to encourage Louise to process what it was like to hold the dolls and the football. Louise immediately became teary, stroked the football, said she missed the children, and refused to talk about it. With this information, a key hypothesis was formed by the team; unless Louise could grieve for the sudden loss of these foster children, she might not be able to encourage the growth and independence of her adolescents.

During the sculpture, Louise and Tim seemed to be the primary caretakers of the foster children, which reinforced the treatment hypothesis that Tim felt invaded when Amy, Don, and Dennis were adopted.

The second sculpture depicted four years ago when Amy, Don, and Dennis entered the home. At this point during the session, Tim began to deflect and become angry. The supervisor encouraged the case manager to stand beside Tim and quietly process his feelings as the therapist continued the sculpture with the rest of the family. It was very difficult for the family to continue with any goal or activity when Tim began to show anger. (In a later session, Louise remarked that it helped her to see how quickly Tim settled down.) It appeared that Tim was relieved at not being in charge.

The third sculpture symbolized the family in the present. Amy immediately triangulated herself into any interaction and "talked for" her younger brothers. The supervisor directed the case manager to turn Amy's back to the family and have Amy listen to family members' voices. The supervisor invited the therapist to stay with the discomfort and struggle and support Louise in giving Amy "permission" to be 14 years old. The younger boys became more verbal as the session progressed.

During the short break, the team agreed that the family seemed invested in the session and ready to break into dyads. The supervisor supported the team for their work in the session.

When the session resumed, the therapist asked Louise to sit knee to knee with Tim and talk to him briefly about how he felt when the other three were adopted. She also spent time knee to knee with Amy and was encouraged to talk to her daughter about any special advice she would like to offer her daughter as she is growing up. During these enactments, the case manager processed the observations and feelings of the other children. In closing, the supervisor asked the therapist to place Louise at the far end of the basement to "think about her own personal things" while the four siblings briefly processed the session with the team. When Louise joined the group, she reported that

she had "daydreamed" and that she felt more energy than usual. In "one voice," the team offered positive feedback to the family for their hard work and encouraged them to write in their journals feelings that surfaced from the session rather than act out with each other. Since the session had been intense, the team scheduled a follow-up session for the next day. In leaving, the supervisor thanked Louise and each family member for their hospitality.

Postsession

The postsession took place in two segments. The first was during the hour ride back to the agency. The team reported feeling excited rather than stuck with the family. The team felt the goals established in the presession had been accomplished on some level. The supervisor reinforced the team for scheduling an immediate follow-up session since the ripple effect from the session could be intense.

The second part of the postsession took place a few days later when the supervisor and team reviewed the videotape of the session. The therapist and case manager were offered feedback by the supervisor and team members. This postsession was structured on two levels: strategizing future treatment with this family and challenging the entire team to generalize what they had learned from the session to families in general. In addition, the supervisor pointed out the deliberate use of a soft voice as she delivered interventions to the team during the in-home session. It seems that if the supervisor uses a voice that is on the same level as or louder than the team's, the family may tend to look to the supervisor as the primary therapist and the team would be undermined.

Closing

In the following weeks, Louise wrote long letters to the foster children that she had loved and lost. Tom and Louise designed a specific behavioral contract with Tim that resulted in a few days in the detention center and a return home.

The team closed treatment with a family ritual. Soon after the closing ritual, the therapist, case manager, and supervisor each received a thank you note and an afghan that Louise had made herself.

SUMMARY

In summary, the in-home approach to supervision is offered as an alternative supervisory approach for training therapists working with high-risk families in their home environment. This approach to supervision holds the view that supervising home-based family therapists is more difficult and complex than supervising traditional outpatient family therapists. The approach is presented as an attempt to respond to Framo's (1979) call for family therapy trainers to update their methods in the context of contemporary changes in the delivery of services.

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