Family-of-Origin Work and Family Therapy Skills Training: Both–And*

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Since the inception of field, theoreticians and teachers of family therapy have advocated for either problem-solving, skill-based training, or transgenerational training that emphasizes the therapist's own family-of-origin work. This article proposes an end to these polarized positions and argues for both–and, that is, a model of training that integrates the trainee's own family-of-origin work with live supervision and skills training. A family-of-origin curriculum designed for this purpose is described.

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THE different schools of family therapy take distinct stands on what constitutes appropriate family therapy training.

For the optimal development of a new family therapist, some trainers emphasize problem solving, live supervision, and skills training, while other trainers emphasize transgenerational patterns, personal therapy, and family-of-origin work. Leading the problem-solving school, Haley (8) soundly rejected the notion that therapists in training need guidance or therapy around how their own personal issues influence their behavior as a therapist:

> Training a student therapist can be conceived of as providing him with a rich philosophical life and helping him grow as an individual. Or it can be conceived of as teaching specific skills. . . . The task is to teach therapy as a skill. [pp. 173; 179]

Haley further recommended against attending any training program that does focus on the personal issues of the therapist:

> One should avoid institutions where the emphasis is placed on the personality and personal problems of the therapist rather than on skills to bring about change. . . . When the focus is placed on the student's personal life, usually the teachers do not know how to teach how to do therapy. . . . A person's personal life is too important to be tampered with by teachers. [p. 187]

This position was consistent with Haley's early reaction against psychoanalysis,

its historical fixation, and its preoccupation with self-examination, transference, and countertransference. Haley made an extremely important contribution to the field of family therapy when he showed that therapists can help families change problems rapidly by focusing on restoring appropriate hierarchy and interrupting dysfunctional behavioral sequences in the here-and-now. Like his approach to therapy, Haley's approach to training is to help trainees acquire the requisite skills to solve the problems presented in therapy.[1]

As a transgenerational therapist, Bowen (4), on the other hand, organized his theory and his training around the personal family-of-origin work of the therapist. He himself set the stage for therapists studying their own families when he boldly presented his own family-of-origin work at a conference in Philadelphia in 1967. Soon after, he described how a seminar of residents and their spouses who focused on their own family-of-origin issues made more progress in training than did residents in seminars on psychotherapy theory or technique (5):

> [I]t became clear that it was precisely those residents who had done best in the effort with their parental families who were also doing best in their clinical work. The residents provided some clues. Some said that family theory was just another psychiatric theory when they first heard about it. After they could see it work in their own families, it became live and real. Others said it was the experience with their own families that made it possible to better understand and relate to families in the psychiatric clinic. Still others said it was possible to help families avoid doing things that were nonproductive and

hurtful when you had the very same experience with your own family. [pp. 531–532]

Bowen's contribution to family therapy emphasized the importance of the therapist maintaining a differentiated position with patients. To do so, Bowen came to believe that the most powerful training ground for the therapist is work with his or her own family.

Other pioneers in family therapy also took stands on this issue. The Palo Alto group (21), like Haley, focused on problem solving in therapy and skill-building in training. Whitaker (see 22), on the other hand, used stories of his own family-of-origin work in his symbolic, experiential therapy. At least by example, he favored personal family work in the training of family therapists. Wynne (23), coming out of a psychoanalytic tradition, in an early article on what he then termed "exploratory family therapy," also advocated therapists' working on their own family issues. The field has been polarized on this issue since its inception.

Family therapy is now well-enough established to examine some of its early tenets, tenets that were extreme reactions necessary to balance the deficiencies in mental health treatment approaches of the day. While we examine training models for the 1990s, other family therapists have recently argued to reclaim the individual within the family (17), and to recognize the importance of biology to individual and family systems (3, 24). What once was anathema to family therapy is now being reconsidered from a systems point of view. Many second-, third-, and fourth-generation family therapists work from integrative theoretical models that include both transgenerational and problem-solving approaches, such as that proposed by Stanton and Landau-Stanton (11, 12, 18–20). With these moves toward integration and more comprehensive treatment models, the extreme either/or positions about what is

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[1] In a discussion with Judith Landau-Stanton in the fall of 1990, Haley reaffirmed his position opposing family-of-origin work as part of family therapy training. He said he still fears that including family-of-origin training could seduce family therapists into overfocusing on historical material rather than resolving the current dilemmas of their patients.

needed to train new family therapists no longer seem practical or appropriate. Family therapists need *both* theory and skill training in family therapy *and* attention to the development of the "person of the therapist" (1), especially around family issues. The University of Rochester training program offers one approach to bridge and integrate these training strategies.

INTEGRATION OF FAMILY-OF-ORIGIN WORK AND FAMILY THERAPY SKILLS TRAINING

In the early years of the University of Rochester Family Therapy Training Program, from 1983–85, the positions that our trainers took reflected the conflict in the field. As we were building our model and developing our training curriculum, some of our trainers routinely used a family-of-origin approach with trainees and argued for it to be included in formal coursework. Others argued equally as strongly that family-of-origin work was unnecessary, perhaps destructive, and could take away from the strength of our theoretical seminars and live-supervision groups. The major concerns of those opposed to its inclusion were: (a) that trainees would be vulnerable to scrutiny by other trainees, and (b) that it would be difficult to maintain a clear distinction between family-of-origin work and personal therapy. Perhaps because we actively were building an integrated theoretical model for psychotherapy, the argument was eventually won by those who wanted a training model that included attention to the family-of-origin issues of the trainee. This outcome was consistent with the original goals of the training program: to train postgraduate mental health professionals in a systems-oriented therapy model that integrates structural, strategic, transgenerational, transitional, and experiential approaches. Our current curriculum is summarized in Table 1 to illustrate the

TABLE 1

University of Rochester Postgraduate Family Therapy Training Program (FTTP) Curriculum

3-Year Core Curriculum:
  Seminar 1—an overview of the field of family therapy
  Seminar 2—the Rochester Integrated Model of Family Therapy
  Clinical Externships in years 1, 2, & 3—a choice of 3½- or 6½-hour live supervision groups
Electives:
  Individual supervision
  Clinical practicum
  Seminar 3—Advanced theory seminar
  Ethics in family therapy seminar
  Family assessment and diagnosis: observation of externships
  Family-of-origin seminar
  Families in film
  Seminar on family systems and school systems
  Family systems medicine seminar
  Gender issues in family therapy seminar
  Professional seminar series—a topical series including:
    Seminars on AIDS and the family, a family approach to alcohol and drug abuse treatment, immigration and cultural transition, medical family therapy, minorities and cultural diversity, and the self of the therapist
Training for Graduates of FTTP
  Advanced family-of-origin seminar
  Consultation
  Supervision of supervision seminar and clinical training

place of the family-of-origin courses in the overall family therapy training.

No one has regretted the outcome of that conflict. In fact, the most vocal opponent of this approach now very much enjoys teaching our family-of-origin course for senior trainees, assured that the course is designed in such a way as to obviate or at least minimize the major concerns. Two formats have evolved in the University of Rochester program to integrate family-of-origin training into the core clinical training that centers on live supervision: one in which the trainee's genogram and selected family-of-origin issues are discussed in the live supervision groups, the other in which

family-of-origin reading and presentations are the centerpiece of a seminar.

Formats for Integrating Family-of-Origin Work

Live Supervision Groups

We begin the training year in these groups by having the trainee establish professional and personal goals for the training year in the group. The personal goals help the trainers understand the developmental challenges facing the trainee in his or her own life. Then, we include trainees' family-of-origin presentations in the early phase of live-supervision, extern groups.

The 45–60 minute presentations use genograms (16) and transitional maps (10) to illustrate transgenerational patterns, current themes, and issues that might be relevant to the trainee's role as therapist. Trainees are encouraged to present only what they feel might be useful to them, and not to present any material they prefer not to present.[2] These presentations begin an ongoing process of integration of personal issues of the therapist with skill-building in the live-supervision groups.

These initial presentations also serve to build the cohesion that is important to a well-functioning training therapy team. They give the supervisor invaluable information about likely "triggers" for the therapist in sessions. In addition, they give the trainees information that allows them to support each other personally and makes their feedback about their colleagues' clinical work better. The trainee presenting his or her own family has the opportunity to examine the family's multi-generational patterns, define any changes he or she wishes to make in the future, and notice

how any of these issues have an impact on his or her role as therapist. For example:

Jeanne was an experienced school psychologist who came to family therapy training to "add to" her already developed, individually oriented counseling skills. Jeanne was bright, energetic, and warm with her patients. In her job, she saw a lot of troubled adolescents. She was sensitized to drug and alcohol problems and depression in teens. In Jeanne's own genogram presentation early in externship, several themes emerged, particularly Jeanne's own struggles for independence in adolescence and transgenerational patterns of tragic loss and imprisonment, most poignantly exemplified by her parents' internment in German concentration camps during World War II.

Jeanne's first case in externship would have been a challenge for the most seasoned therapist. And, as happens not infrequently, many of its themes seemed to have some overlap with themes in Jeanne's own family. The client, a joint referral from a physician at a clinic and a nurse at a homeless shelter, was a 42-year-old man dying of cirrhosis secondary to alcoholism. The especially dedicated nurse in the shelter had counseled this man daily until he gave up drinking and drugs. She, and the man's psychosocially sensitive physician, encouraged him to make contact with his adolescent children, two daughters and a son, who were being raised together in foster care. In the process of this counseling, the patient, Mr. Smith, told the nurse that he had committed many crimes in his youth in partnership with his now dead uncle who had raised him. Soon after this confession, the referral came in from the nurse who said she felt she was "in over my head." Mr. Smith accepted the referral because of his desire to reconnect with his children, and perhaps because of his desire to make peace with himself before his death.

In the first session, Jeanne seemed overwhelmed both by the extent of the nurse's involvement and by the difficulty in finding a way to engage this crusty, crotchety man. Jeanne had no trouble connecting with the three very attractive teenagers who were his

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[2] On occasion, the trainee has opted to wait until later in the year to present because of an acute stress in his or her life at the time of the early presentations.

children. The supervision team wondered how the issues of loss in this case might emerge for Jeanne. In the early stages, training focused on several issues: 1) helping Jeanne to connect with the nurse, use her as an ally, and clarify her role in the treatment inside and outside therapy sessions; 2) finding parts of Jeanne she typically did not use as a therapist to help her join and connect with this nonverbal man with the cynical exterior; 3) clarifying our legal responsibilities about this man's crimes; and 4) discussing the problems and strengths of the family to formulate strategies in helping the patient make amends and make it less likely for this transgenerational pattern to be passed down to his children.

The treatment of this case was multi-faceted, but the one area with which Jeanne seemed to have the most difficulty was in discussing Mr. Smith's feelings about his illness and his impending death. Jeanne felt the family was "not ready" to discuss these issues. She did not initiate discussion of this pressing matter, and had difficulty following through on questions about this topic when they were phoned in from the observation room. On the surface, Mr Smith was reluctant; so together they colluded not to discuss it. To the team, Mr. Smith seemed as if, with support, he might be ready, even anxious, to have an opportunity to discuss his health. Mr. Smith's daughters definitely were interested in the opportunity to discuss this subject.

The supervisor for this case tried several skill-oriented approaches to helping Jeanne, including: developing more questions to enhance our understanding of his stated goals for therapy, practicing slowing down the pacing of the session and matching his language, and role-playing to desensitize her to discussing the toxic issues of the case in the safety of the training group. These skills were important, but did not seem to be enough. Jeanne still avoided the issue of Mr. Smith's dying in spite of her intellectual understanding of its importance. She seemed to freeze whenever the topic arose. At best, she discouraged him from expressing his despair by telling him, "Don't give up the fight."

At this point we began to explore in more depth the possible overlapping issues, or triggers, in her family of origin. As we've found with many trainees when they are unable to respond to skill-focused training, family-of-origin issues were clearly blocking Jeanne's ability to learn. It took a while for her to clarify what this patient stimulated in her. She first discussed how she felt frustrated with what seemed to her as his welcoming his own death. The supervisor then raised the issue of her parents both being concentration camp survivors and asked if that could be related. With a heavy sigh, Jeanne described how much her parents had had to fight to survive, and how difficult it was for her to listen to someone who seemed to be "giving up."

With support from the supervisor and the team, Jeanne was able to clarify her own distress. She was then able to make good use of the skills she had practiced to stay with the intensity and uncertainty of Mr. Smith's situation: not seeking premature closure through giving him advice or making suggestions, avoiding pressing the family to change too quickly, and maintaining a position of "not knowing" rather than closing off his story by responding as if she understood. Once the relevant family-of-origin blocks were identified, Jeanne was able to do excellent work discussing illness and death with Mr. Smith and his daughters.[3]

This training example is nothing new for therapists oriented toward family-of-origin issues. Identifying and working with such personal "triggers" is the bread-and-butter of their training models. Transgenerational therapists such as Kramer (9) and Duhl (6) have written about their training models that focus on identifying such patterns for the training therapist. Traditionally this is not a part of training

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[3] This, and other examples in this article are actual training cases camouflaged to protect trainees' and patients' identities. The trainees mentioned have given permission for the essence of their stories to be shared. Susan McDaniel was the seminar leader.

in the problem-solving, family therapies. However, informal canvassing reveals that more and more trainers are moving toward an integrated approach such as the one described here.

Trainers using live supervision models have the opportunity to witness at first hand signs of personal issues interfering with therapist functioning. Observing the trainee over time and across cases allows for a relative baseline of performance to be established for the trainee. Any deviation from the usual functioning then may be seen as a warning signal that a trainee's family-of-origin or current family issues may be getting stimulated. Of course, the other possibility is that the case is calling for skills as yet undeveloped in the trainee. Sometimes, both are true. We find trainees usually are wrestling with a blend of skill development and family-of-origin issues: family-of-origin strengths often are reflected in the therapy skills with which trainees are the strongest, and family-of-origin problems often are reflected in certain skill deficits. Very occasionally, a trainee becomes overwhelmed by personal family issues stimulated by working on a particular case. In this situation, the trainer holds a private meeting with the trainee to advise him or her to seek therapy. Table 2 summarizes some of the signs that personal or family-of-origin issues may be acutely affecting the trainee's ability to function in a session.

The most telling signs of trainee stress we have come to call "The Family-of-Origin Freeze." Here a trainee is conducting a session in a rather routine way and, seemingly abruptly, becomes rigid, sometimes pale, and begins to flounder. This experience is immediately noticeable and typically leads members of the observing team to comment: "I wonder what's going on with my colleague." Another symptom that may signal that a patient is stimulating unresolved personal issues for a trainee occurs when a therapist is tracking a particular topic with a patient and suddenly changes the subject. Or, similarly, when a topic is discussed in pre-session planning and the trainee seems unable to initiate or stay with conversation about this topic when in the session itself. These symptoms occurred in the early stages of Jeanne's sessions when the team discussed the need to allow Mr. Smith to discuss his impending death. Jeanne avoided intensity at this stage of the treatment. Inappropriately pushing intensity also may signal trainees' trying in effect to encourage the family to do what they, the trainees, need to do for themselves. (And this may or may not be what the family needs to do as well.) Finally, especially for well-organized trainees, forgetting to ask about out-of-session tasks may signal a personal problem being stimulated for the trainee.

As mentioned earlier, all these signs and symptoms can occur when a trainee experiences a therapy session that demands skills that are as yet undeveloped. These problems also may occur as a result of a power struggle between the trainer and the trainee around how to handle a case; sometimes it seems to be a power struggle isomorphic to one occurring in the treatment family (13). Similarly, the development of trainee difficulties may signal unspoken conflicts in the patient family. The creativity and skill of the trainer lies in assessing which of these explanations is primary, and which might lead to the quickest and most effective growth for the trainee and the treatment family. Typi-

TABLE 2

*Signs and Signals of Personal Issues Interfering
with Therapist Functioning*

Shutting down and tightening up
Rapid and noticeable change in nonverbal behavior
Sudden subject change
Pushing or avoiding intensity inappropriately
Forgetting out-of-session tasks

cally, family-of-origin issues need to be addressed when other avenues for teaching, such as pre-session planning, telephone call-ins during a session, and role-playing needed skills, fail.

The Family-of-Origin Seminar

Clinically oriented externships leave only minimal time for dealing with these family-of-origin issues. Most extern time is spent on planning, assessing, and seeing cases, and on practicing the skills required to be successful with them. Because of this, we added an elective family-of-origin course to our curriculum to allow trainees to become better acquainted with transgenerational literature, and to have more time to focus on family-of-origin issues that have an impact on them as therapists. As described earlier, we began these courses tentatively some 6 years ago, once we had agreed on a program to attend directly to the person of the therapist and to the family-of-origin concerns in our externships. At that time, we wanted to experiment with the effect on extern functioning of more curriculum time to read and discuss transgenerational theory, and more time to apply this reading to the trainees' own families, without giving up our focus on skill-building in the live-supervision groups.

We quickly discovered that the course was very useful in many ways, and we now strongly encourage trainees to take the course. Beginning trainees typically apply their new learning to themselves and their own families. Training itself can have a major effect on trainees' personal lives. This seminar offers trainees a format and structure to apply the material with some guidance. As Guerin and Fogarty (7) and other transgenerational trainers have argued, we found that the seminar helped to humanize the experience of family therapy and family therapy training; it helped further the development of the self of the trainee; and it helped emphasize the inherent richness, strength, and diversity in

families. For extern-group trainees who had recurrent difficulties with patients and needed more time spent on family-of-origin issues than the setting allowed, we now had options other than the trainer spending extra time with the trainee outside of the extern group or referring the trainee for personal psychotherapy when it was not indicated.

The course was soon heavily subscribed by our trainees, and we have consistently run one, sometimes two, groups of 8–12 trainees since the first family-of-origin seminar began. Verbal feedback and anonymous formative evaluations at the end of the course by the trainees have been uniformly positive. Table 3 summarizes trainee ratings of trainer effectiveness in the course. Comments offered by trainees have been similar in kind to those reported by Bahr (2), who allowed family science undergraduate students to construct their own genograms and family chronologies to fulfill a course requirement. Students appreciate the structured opportunity to learn more about their own families.

Many different formats for such groups are plausible, and some variation exists in our training program depending on which trainer teaches the course. First, each trainee establishes goals for the course. A list of these goals appears in Table 4.

Remaining seminars include a discussion of the readings for that week, followed by 2–3 trainees each presenting for 45–50 minutes, depending on the size of the group. The size of the group then determines the length of the session. (Eight trainees meet for 15 2-hour sessions, or 12 trainees for 15 3-hour sessions, spread over a 30-week academic year.) This affords the trainees opportunity to read and discuss many of the primary works of Bowen, Kerr, Fogarty, Guerin, Friedman, Framo, Nagy, Paul, Williamson, and others. They also have an opportunity to present their own families on three occa-

TABLE 3

Trainee Ratings of Trainer Effectiveness in Teaching Family-of-Origin Seminars in 1988–1990*

	1	2	3	4	N/A	Total
Therapist awareness of self	0	0	3	18	4	25
Family therapy theory	0	0	5	17		22
Family therapy techniques	0	0	4	13	5	22

Key: 1 = needs improvement; 2 = adequate; 3 = good; 4 = excellent; N/A = not applicable

* Twenty-six of 48 trainees in 5 seminar groups returned evaluations at the end of the course, listing their goals for the seminar, whether they achieved these goals, and rating the trainer who led the seminar. In-depth verbal feedback from all 48 class participants at their last seminar was completely consistent with this sample of written evaluations. On the questionnaires, several trainees left items blank, or selected a score of 3.5 rather than 3 (Good) or 4 (Excellent). The latter evaluations were lumped with those who endorsed 3 (Good). Also, 4 trainees rated "Therapist's awareness of self" as "not applicable." In reading the qualitative portion of these trainees' evaluations, they rated the course very highly and felt it improved their own self-awareness. They seem to have misunderstood this item as relating to the seminar leader's own sense of self.

sions, with 8–10 weeks between each presentation, in order to work on areas of interest between times. Each trainee writes a paper for the course, as well as giving a presentation, to record the work they did and to present the material in written as well as verbal form. Like all other courses in the Family Therapy Training Program, students receive a "Pass" for this course if they complete the assignments. No grades are assigned to papers or presentations.

The personal presentations are framed as an "appetizer," an opportunity to apply the concepts they are reading about, which only begins what is likely to be a life-long, in-depth process. While the family-of-origin course may be therapeutic to the trainees, it is not therapy, and a clear distinction is made and maintained throughout the course. Many trainees do an amazing amount of personal work with their families, but the limited time for presentations serves to keep the initiative fully in the trainee's hands. The trainer's input is to maintain a safe and appropriate atmosphere, suggest the next small step that might be considered, and facilitate the group's discussion with the trainee. Occasionally, as in the live-supervision groups, a strong recommendation is made that a trainee seek psychotherapy for some issue or crisis that emerges as a result of the

course. Other trainees sometimes follow up by going into family-of-origin therapy because of their own desire to do more intensive work than the structure and time constraints of the course allow.[4]

The trainees are almost universally enthusiastic about their experience. Not surprisingly, this experience gives them greater respect and empathy for the struggles of their patient families. It also seems to increase their understanding of the concepts and skills they are learning in the live-supervision groups, regardless of whether these be transgenerational, structural, strategic, transitional, or experiential skills. Personal experience with the material seems to provide a different kind of learning, which extends and deepens the conceptual, perceptual, and executive skills typically taught in structural, strategic, and systemic training programs.

Each trainee's story, like those of our patients, is touching and powerful. A brief description of one person's work in this

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[4] To avoid conflict of interest, therapy is not provided for trainees by the staff of the Training Program or in the Clinic in which we work. Trainees are referred out to our family-oriented colleagues, including graduates of our program who practice in the community.

TABLE 4

Trainee Goals for Family-of-Origin (FOO)
Seminars: 1988–1990

Goals for Training*	No. of Trainees
Learn more about own family (roles, themes, myths, scripts)	18
Identify FOO issues and their impact on my role as therapist (e.g., with regard to "stuckness")	13
Apply new knowledge to future relationships with own family (increase differentiation)	11
Learn more about myself	7
Expand theoretical framework, integrate theory	6
Review family strengths and stuck points	4
Learn from others' genograms and share own material	3
Identify transgenerational patterns to allow for choice of interventions	2
Continue professional growth	2
Gain better insight into counter-transference	2
Observe Family-of-Origin work with others	2
Learn about cut-offs in families	2
Explore the sibling bond	2 .
Balance involvement with patients and own family	2
Learn about other families' dynamics	2

* Each trainee was asked to list three goals. Of the 91 goals listed by the 26 trainees, 78 (86%) were listed by two or more people and are presented in this Table. The remaining 27 goals were individualized and ranged from "Review intergenerational transmission of father/son cut-offs" to "Move away from protecting dependent people." All 26 trainees stated that they successfully met all their goals.

course may give a flavor for what many trainees experience:

Zanna was a psychologist born in South Africa, and married to a South African psychologist many years her senior who had emigrated years ago to this country. Zanna was a skilled child therapist, who had come to desire family therapy skills to "better help

the parents" of the children she was treating. She quickly converted to systems theory, and couldn't seem to get enough training to satisfy her desire to learn. She brought this same enthusiasm to her participation in the family-of-origin course.

Zanna had many difficult issues in her own family; she and her current family traveled back and forth to South Africa every year to see family and to re-immerse themselves in South African culture. Zanna's family had a history of emigrating and returning to South Africa. Her father had emigrated to the U.S. 50 years prior, married Zanna's mother who was American, and returned to South Africa. One of Zanna's maternal uncles and many cousins had also emigrated to this country. Early in her presentations, Zanna labeled emigration and "living in two worlds" as an important theme in her life.

Another theme revolved around illness and grief. Zanna's mother had been hospitalized with a severe, chronic illness when Zanna was 7. She died when Zanna was 20, and was hospitalized for the entire 13 years in between. Zanna and her brothers and sister spent every day after school in the hospital visiting with their mother who was bedridden. Learning about her mother as a person rather than a patient—her life before her illness—became an important goal for Zanna during the course. She also developed an interest in studying siblings and improving her relationships with her own siblings, which had been understandably strained by the experience with their mother.

Most notable in Zanna's work was the improved quality of her connection with her elderly father. Early in the course, she wrote to him in South Africa asking questions about his life and that of her mother. He began a series of letters, the first of which was 20 typed pages, giving her a history of his own experiences from childhood on. As with many older parents, he was ripe for the opportunity to share this information with his daughter. She got much more than she expected from this exercise.

Also unexpectedly, Zanna's letters to her siblings, two of whom she was cut off from,

produced responses both positive and angry. With difficulty she was able to continue the connection and begin to work through the issues behind the cut-offs (primarily grief around her mother's death and a history of competitive sibling relationships in families deprived of financial and emotional resources). To her surprise, her letters resulted in two parties given by her extended family that reunited members who had long been cut-off themselves. She received pictures of these occasions, and invitations to events scheduled to occur at her next visit.

This work directly affected Zanna's skills in her extern cases in several visible ways: she became more facile in the use of genograms for family assessment; she became more organized and "in charge" of her sessions; her ability to connect with fathers was markedly improved; and she was able to identify and help her patients work on intensely fused or cut-off relationships. She became especially skilled around issues of cultural transition and immigration, assisting one family in resolving the intense suicidal tendency of a young refugee by reconnecting him with his roots.

The family-of-origin course provides motivated trainees (like Zanna) with motivated families an opportunity to accomplish important goals in improving their relationships. Teaching these trainees is a privilege and a moving experience. Obviously, not all trainees are so motivated, and not all families are so receptive. Resistant trainees are relatively easy to teach: they are told to take it very slowly and only take on tasks that they themselves want to and believe will be helpful. (Of course the very resistant trainees do not sign up for the course.) The more difficult trainees are those that experience some crisis as a result of exploring their own families of origin.

RISKS AND DILEMMAS OF FAMILY-OF-ORIGIN PRESENTATIONS

All trainees come to psychotherapy training hoping to understand themselves and their own families better. Focusing explicitly on the interface between a trainee's professional role and his or her personal life can stimulate strong feelings, and lead to powerful and unexpected experiences. It is important to forewarn trainees that merely presenting a genogram to a group can be a surprisingly emotional experience.

Unresolved Personal Issues

Recent important deaths can be especially painful to discuss. One trainee whose sister had died 6 months previously could not bring herself to draw her genogram on the board because her grief was so acute. She was encouraged not to draw her genogram at this time, but to discuss the issues she felt were relevant to her work at a later time. In another situation, a trainer surprised himself when presenting his own genogram as a demonstration. He found himself crying when he diagrammed his mother's death that had occurred 2 years prior to the presentation. In both cases, these issues clearly had a potential impact on these individuals' functioning as therapists. However, all trainees need to be told to discuss only those issues they wish to discuss, patterns they feel are relevant to their work. Many trainees are quite open, but all trainees need to have permission to be cautious and private about that which feels too difficult to discuss.

For trainees who obviously have secrets or intense conflicts that are likely to interfere with being effective therapists, we recommend that they see a therapist for support and as an adjunct to their training. A list of good therapists for trainees is also important when a trainee uncovers unexpected, important information about his or her own family:

Dan was a senior supervisor in his agency, a solid clinician with sensitivity and insight who was well-respected by his colleagues. Early in a family-of-origin group, Dan stated that he felt stressed by his work and wanted

to go very slowly in the group. He was supported in this strategy, and even restrained when he began to get excited about what he was learning and wanted to push himself to begin many projects to learn more about his family.

The primary issue of concern was the death 6 years ago of his father. He was the oldest of eight children, and his father's favorite. He was not at home when his father died, and he expressed much frustration about how his mother and especially his siblings had dealt (or not dealt) with his father's death. Dan described trying to discuss his father's death in his family's presence, and the silence that came over the room. His impression was that he had grieved, but that his family had not. I encouraged him to go very slowly in this area, to look at how the family had handled other, more remote deaths, and to begin to ask his mother and the siblings to whom he felt closest a few factual questions about his father's death, avoiding pressuring them to discuss their feelings about the loss.

This approach with his siblings quickly yielded important new information about his father's death: his father had committed suicide. The rest of the family knew this fact, but had protected their brother from it. Dan was thrown into an acute crisis around finding out about this secret. The trainer quickly recommended that he and his wife see a therapist to help him work through this experience. He continued and made good use of the group, while dealing with the intensity of what had emerged in the more appropriate context of therapy.

This kind of intense experience does occur occasionally in these groups. The trainer needs to prepare the group ahead of time by advising trainees to consider carefully what they wish to work on. The trainer also offers to act as a referral resource for any trainees who need or wish to enter therapy themselves as a result of their presentations. Crises, when handled with care, and appropriate referral, when indicated, become a pivotal training experience for both the trainee and for the group

that is supporting and learning from the trainee.

Confidentiality

Partially because what emerges is somewhat unpredictable to the trainee, issues around confidentiality are very important. It is best for trainees who work together outside the training context not to be in groups together in training. If they are, it is important to discuss their dual relationship openly, and suggest that this should influence what they choose to present and what they choose to work on. Of course these presentations can improve people's working relationships because of their increased empathy and understanding of each others' lives. However, when private information emerges, the chance that it may damage a working relationship makes this situation potentially destructive.

Confidentiality should be stressed at the beginning, middle, and end of these courses. Trainees need to be able to trust that their own issues will not be discussed outside the group. Trainees should also be warned to keep their genograms carefully stored, so they can share them with family members when they choose to, rather than because someone stumbles on the information. The same is true of videotapes. Many of our trainees elect to videotape their presentations so they can review them for information they may have missed during the pressure of the presentation. One trainee, early in a group, came home to find that her pre-school son had asked his grandmother who was babysitting, "Do you want to see Mommy on TV?" He proceeded to show her mother a recent family-of-origin presentation. The trainee was quite upset about this occurrence since she had just begun to discuss and plan for how to deal with stresses and strains between herself and her mother. As it turned out, the mother had only watched a few minutes, which served to pique her curiosity and increase her desire to help the

trainee learn more about the family. As with any family information, family-of-origin work can be powerful and deserves to be handled in an educational setting with sensitivity, care, and caution.

SEQUENTIAL VERSUS INTEGRATED FAMILY THERAPY TRAINING

Several authors, like the first author of this article, have stated that trainees benefit from learning multiple approaches to family therapy, and that these approaches follow a natural learning sequence from structural, to strategic, to transgenerational (13). At that time, we believed that the directive approach of structural supervision made the most sense for anxious, beginning therapists, and that "once a supervisee has been trained to apply theoretical principles by the use of a repertoire of techniques, it is important for that supervisee to work directly at integrating the "self" experience with these therapy techniques" (22, p. 498). McCollum (14) recently recommended integrative training, but also believes that the natural sequence of this learning is from structural-strategic therapy skills, to theory, and finally to Bowenian coaching around person-of-the-therapist issues once skill and theory tasks are accomplished.

Certainly, all beginning therapists are anxious and need to learn both theory and skills to help them function effectively as therapists. However, we no longer believe that person-of-the-therapist issues need to be held in abeyance until the trainee's performance anxiety is decreased. An approach that integrates skills, theory, and the personal issues of the therapist from the *beginning* can offer a rich and efficient avenue for training family therapists. To be sure, one area may receive more or less emphasis depending on the needs of the trainee. Some trainees may benefit from a more intensive family-of-origin seminar

with live supervision in the first year. Other trainees may need a reading course early, or time to increase assessment skills from viewing behind the mirror. Different trainees need different emphases in their training. All trainees, however, may benefit from exposure to an approach that integrates these different methods of learning family therapy from the beginning.

CONCLUSION

This article recommends that training programs consciously offer trainees a focus on skills and on the development of the self-of-the-therapist. The University of Rochester program offers one model for this inegration. With the shift in the family therapy field toward integrative models, more dialogue among trainers who focus exclusively on problem solving or other systemic approaches, or exclusively on transgenerational issues, and trainers who are involved in integrative approaches may help all of us to improve the training of new family therapists.

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