

# COUNSELOR'S CORNER

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*As was stated in the last Counselor's corner, as a matter of policy, we will announce the population for which the column is best suited. This column is directed to **Counseling Professionals**.*

**T**he most recent Professional Training Series held in Philadelphia at Chestnut Hill College was very successful. Participants commented on the quality of the presentations, the sense of community, and the clinical insights gained. The training was divided into two parts, Level I and II. This column is based on a dialogue between one of the two leaders of the Level II training, and a participant.

Level II began with Dr. Scott Browning delivering an opening lecture on Stepfamily Therapy. This was followed by a therapy session observed through a one-way mirror with Dr. Patricia Papernow seeing the standardized patient family. Four well-trained graduate students had gone through substantial preparation with a consultant, Dr. Rachel Kabasakalian-McKay, in order to present as a fully believable patient family. Dr. Papernow completed the session and then reentered the group in order to discuss the session that Papernow examined the opening session. Hearing her discuss the inner process that had accompanied the session was most informative and exciting. The afternoon involved Dr. Papernow presenting a lecture, and ended with a case consul-

tation generated and strongly informed by the participants.

The second day began with a panel discussion. Then a therapy session with Dr. Browning working with the same created family, followed by discussion of the session with the family themselves out of character. The final afternoon was composed of a second complex case presented by a participant. At the conclusion of the two days, Dr. Kay Pasley, an authority on research involving stepfamilies, came and addressed the participants on the intersection of research finding and clinical issues.

What became evident from the experience was that Level II became a more complete training experience than either trainers or participants had expected. The lectures served to highlight didactic information that was of interest. While the live therapy sessions created an experiential/clinical piece, which was designed to be the hallmark of the Level II training. The surprise component was the rewarding group process that emerged. Dr. Papernow's extraordinary comfort in keeping participants involved in the process created a collegial respect that is rare in a training setting.

Although there were a great many of issues raised during the Level II training, the following three points-of-interest flowed directly from the therapy sessions.

In working with the family, assumptions were made about

Continued on page 4

## STEPFAMILIES/DELINQUENCY RISKS

Continued from page 1

come to be involved in delinquency. One path is through early involvement in antisocial behaviors that then continue into adulthood, and one's family experiences are believed to be of primary importance here. The second path is through engaging in deviant behaviors around age 14 that dissipate by adulthood. In this pattern, one's peers are more influential than is one's family.

Findings from their study showed that being in a stepfamily rather than residing with to be biological parents more than doubled the risk of juvenile delinquent behavior. This was not surprising given the findings in earlier studies. However, when they looked more carefully to determine what protected children from delinquency, the picture became more complex. For example, their results showed that having good peer relations at age 10 (rather than being rejected by one's peers) was a protective factor against police arrest (the measure of delinquent behavior) at age 17 for boys in all types of families (two-parent, biological; stepfamily; single-parent family). Unique to boys in stepfamilies was the protective effect of the family's ability to solve problems, which reduced the odds of arrest by about half. Importantly, family problem-solving did not protect chil-

dren in either single-parent families or two-parent, bio-families from these negative outcomes. In fact, for boys in single-parent families, problem-solving increased their risk for delinquency because of the over-emotional involvement between mothers and sons that was common in these families. Their findings also confirmed characteristics, including the structure of the family, exerted the greatest effect on the early onset of delinquency rather than affecting delinquency initiated after age 14.

These findings have several implications for professionals working with stepfamilies in reducing the risk of children's engagement in delinquent behaviors. First, all else being equal, all young males regardless of their family structures need assistance in developing and maintaining positive relationships with their peers. For boys in stepfamilies who have yet to reach adolescence, prevention and intervention strategies need to be directed toward developing problem-solving skills. In this way, the quality of the step-parent-stepchild relationship is likely enhanced as is the child's ability to make better choices about whether to engage in certain behaviors. □

## COUNSELOR'S CORNER

Continued from page 3

the young adult who was suddenly a member of a stepfamily. Initially, the position taken was to assist the adult child in continuing what was perceived as a natural launching from the stepfamily. The particulars of this character helped the collective of trainers and participants to realize that this young child needs to be able to integrate into her new stepfamily. This important step appeared contrary to developmental theory for a young adult, but was necessary in order for her to feel a solidarity with her father and the new stepparent. Completing this process was the necessary first step in later being comfortable in moving away from the stepfamily. In our effort as therapists to respect the developmental stage of a young adult, we might forget that the developmental process may have slowed for a reason. An adult child might be inclined to gain a sense of safety in the stepfamily that appears to the stepparent as a regression. As clinicians, great care must be taken in addressing the topic. Our helping to move an adult child out of the new stepfamily might be more based on our concern for parental friction, or some generic idea of launching, rather than flowing directly from the needs of the young adult.

A second clinical issue was the reinforcement of the principles of *respect for multiple realities* and how it impacts on the therapist's unconscious *parallel processes* during interviews with stepfamilies. Respect for multiple realities in stepfamily counseling is particularly important because in early stepfamily development the individuals usually have limited understanding of the other family members.

As the workshop participants discussed their reactions to the standardized patient family interview, the themes of inclusion-exclusion and the acceptance of the intimate outsider were explored. They were explored as responses to the clinical material witnessed and as shared personal responses to the workshop participants real-life experiences. The interview with the standardized patient family and subsequent shared group reactions allowed a deep level of acceptance and trust to be established within the training group. This allowed for an experiential, as we as, didactically understanding of the effectiveness of appropriate therapeutic intervention in stepfamily counseling – an unanticipated but most favorable benefit of the Level II training. Instructors and participants agree that the recognition of the intensity of this duality of experience, cognition was a major criteria for the success of the training.

A third component of the training-group process was the workshop participants' chance to experience two instructors working as therapists with the standardized patient family and then as leaders in their workshop group. The workshop leaders created role-models of openness, acceptance, and respect for differences that empowered the workshop participants to trust in their leadership. This facilitated openness within the participants' group. This significant level of trust came from an open, non-defensive discussion of the leaders' strengths and weakness in their therapy session with the standardized patient family. It demonstrated a healthy co-parenting attitude that permeated the workshop experience. The emotional well-being of the stepfamily is significantly

enhanced by the establishment of a solid foundation of trust in the step couple. The participants had close to real-life stepfamily experience of positive sharing of parental power.

For this workshop participant, the positive impact of the training had direct impact on clinical practice. While acting as a workshop leader at a Women's Health Day Conference the week after the training a sense of confidence and empowerment was noted in his manner of presentation. A qualitative difference in how he perceived his leadership role in the discussion that followed the presentation and the content issues were addressed was clear.

The next Level II Training will be offered at the SAA Professional Training Workshops in Alameda, California in April 1998. The group will be limited in size to a maximum of twelve participants. □

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