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A REFLECTING TEAM APPROACH TO FAMILY THERAPY: A DELPHI STUDY

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Due to different conceptualizations and unclear theoretical guidelines, a reflecting team approach to family therapy has lacked conceptual and practical clarity. The purpose of this exploratory study was to outline the theory and practice of a reflecting team approach to family therapy. A Delphi technique was employed for panelists to consider the theoretical assumptions, techniques, how change occurs, major goals, when to use, and contraindications of a reflecting team approach. Analysis of data revealed where consensus was reached and a profile was formed to aid in further clarifying this approach.

Reflecting teams have quickly become a popular new approach in family therapy. Authors stress that reflecting team practice is unique and set apart from other types of therapy (Andersen, 1987; Hoffman, 1988; Lax, 1989; Miller & Lax, 1988), yet these same authors often omit critical detail in their discussions of the theory and practice of this approach. These omissions do not invalidate the importance of this approach to family therapy, yet it is often difficult to determine what a reflecting team approach is and how it is practiced. A reflecting team orientation to family therapy lacks a coherent theoretical body of knowledge to guide research and practice efforts.

It is common in the field of family therapy for practice techniques to outpace theory development (Nichols, 1984). However, since it is impossible to "not theorize" (Fisch, Weakland, & Segal, 1982, p. 7) and models are not theoretically neutral (Witkin, 1991), it is important to ascertain how theory guides a practice approach. Since family practitioners must clarify the tenets of theory and practice, the challenge is to make these assumptions explicit for researchers, clinicians, and educators (Alexander, 1988; Piercy & Sprenkle, 1988; Wynne, 1988). Only when theoretical assumptions are clearly demarcated can they be examined and refined (Nichols, 1984). The best family therapy practice models are those that are clearly and explicitly tied to theory and research (Sprenkle, 1976; Wynne, 1988).

For the survival of the field of family therapy, the theoretical assumptions of modalities must be articulated as assumptions continue to guide practice activities and enhance careful evaluation of the method (Alexander, 1988). Because practitioners and researchers

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are guided by their models of practice (Berger, 1986), this study sought to define the tenets of the theory and practice of a reflecting team approach to family therapy. With a clear understanding of how informed practitioners and scholars enact a reflecting team approach, researchers can begin to attend to the specific events that produce change during therapy.

Reflecting Teams

Andersen first outlined reflecting teams in his seminal 1987 article. In this article, he suggests that the assumptions of reflecting teams are:

1. The observer generates the distinctions called "reality," with many possible meanings constituting the many possible worlds.
2. When people share their views, each person receives different versions of "reality," and these enriched pictures form an "ecology of ideas."
3. People can only respond or participate in modes of relating that are available in their repertory.
4. Sharing different versions of the same world allows "stuck" systems to move away from their "standstill" position.

In addition to these theoretical assumptions, Andersen discusses some "working guidelines" that other authors further elaborate.

A reflecting team approach follows the assumption that information needs to be shared rather than withheld (Andersen, 1987, 1990; Lax, 1989; Miller & Lax, 1988). Adhering to this assumption, reflecting team members can share their thoughts and ideas with a family during sessions. Andersen (1987) states that when two or more people share their ideas, they can hear different perceptions of reality. Andersen (1987, 1990) argues that clients need to hear the differences among team members in order to enrich the clients' picture of the dilemma. Reflecting teams provide clients the opportunity to pause and incorporate a different view of their situation (Smith, Sells, & Clevenger, 1994). These enriched pictures of the family and its dilemma have become known as an "ecology of ideas" (Bogdan, 1984). Hoffman (1985) further stresses that practitioners should consider problems, not just the family, an ecology of ideas.

In reflecting team practice, multiple views of clients' dilemmas offer hope of obtaining fresh perspectives of the problematic situation (Andersen, 1987; Davidson, Lax, Lussardi, Miller, & Ratheau, 1988; Mittelmeier & Friedman, 1991). This discussion allows clients to understand that doubt and ambiguity can exist on a team and that there is no one correct solution to a situation (Reichelt & Christensen, 1990; Smith, Yoshioka, & Winton, 1992). Through these various perspectives, clients alter their perception of the problem which in turn facilitates change (Andersen, 1987; Lax, 1989; Mittelmeier & Friedman, 1991; Smith et al., 1992). Noting that clients can only participate in conversations to the extent of their repertoire of interactions and ideas, new distinctions offered by the team must be acceptable to family members to be considered useful (Andersen, 1987; Lax, 1989). If these ideas or distinctions are neither too familiar nor foreign to the family, the ideas may make a difference that leads to a change (Lax, 1989; Mittelmeier & Friedman, 1991).

Gottlieb and Gottlieb (1990) describe reflection as the open dialogue of therapists' reactions to the client system. They add that a reflecting team is one in which the therapists and family continually shift their ideas and perspectives by incorporating one another's information. Lax (1989) compares a reflecting team to kneading bread dough; conversations between family and team continually fold back on one another. These continual conversations allow new distinctions for members of a system (Lax, 1989).

Hoffman (1988) argues that reflecting teams make the family an active and vocal part of the thinking of the team. This contention supports the idea that families know better than anyone else what kind of information is useful and gives them the opportunity to accept or reject ideas received in therapy (Reichelt & Christensen, 1990). Additionally, in Andersen (1990), Hoffman warns that reflecting teams are not merely another new method or school of family therapy with similar theoretical assumptions. Instead, she argues that the reflecting team approach is a therapeutic stance. With this counsel in mind, readers of reflecting team literature are left with incomplete discussions of whether to include or discard aspects of theory for their research and practice.

The literature contains many, often differing, suggestions about the practice of reflecting teams. Authors suggest various room configurations, from the team remaining silent behind a one-way mirror until the family overhears their discussions (Andersen, 1987; Young et al., 1989) to keeping an imaginary boundary in the same room between the family and team (Davidson et al., 1988; Smith, Jenkins, & Sells, 1995) to the therapist and client of the same gender speaking alone in the room while members of the other gender watch from behind the mirror (Miller & Lax, 1988). Additionally, the reflecting team has been described as composed of as few as one member (Wangberg, 1991) to as many as seven members (Young et al., 1989). Beyond the size of the team, the composition of the team is considered more important than the type of family seen or the severity of the presenting problem (Young et al., 1989). Some suggest that the reflecting team should be composed of only therapists and the family (Andersen, 1987); others suggest it be balanced by team members of both genders (Sells, Smith, Coe, Yoshioka, & Robbins, 1994; Smith et al., 1995) or by a combination of therapists, clients, and peers (Aderman & Russell, 1990). Although different guidelines exist, it is unclear how significant the differences between such groupings might be for future research and practice.

METHOD

The Delphi Technique

The Delphi technique, a method of gathering opinion from a panel of knowledgeable persons, was first defined in an article by Helmer and Rescher (1959). They maintained that resolving dilemmas called for the judgment of several experts when a convincing reason to select a particular plan of action did not exist. The RAND Corporation used the Delphi technique to find a more effective statistical method to use with individual opinions in defense decision making (Dalkey & Helmer, 1963). The objective of their research was to gain insight into the topic through input from a panel of knowledgeable informants (Linstone & Turoff, 1975).

The Delphi technique makes for effective use of group information (Dalkey, 1972) and can be used when there is no accepted theoretical body of knowledge to point to a single method or alternative (Helmer, 1967). Dalkey (1972), in a discussion of using Delphi over other types of group decision making, states that the advantages of the Delphi procedure include anonymity of participants, responding without coercion, and the ability to use statistical procedures on the gathered information. Sackman (1975) adds to this list, citing the major advantages as low cost, versatile application to any area where "experts" can be found, ease of administration, minimal investment of time and effort by the director and panelists, and the simplicity, popularity, and directness of the method.

The Delphi technique allows for a systematic and organized approach in uncovering information about reflecting teams. It also allows discourse that might otherwise have been logistically impossible (Figley & Nelson, 1990). This technique has been implemented in other areas of the field of family therapy (Avis, 1986; Figley & Nelson, 1989, 1990; Nelson & Figley, 1990; Stone Fish, 1985; Watson, 1985; Wheeler, 1985; Winkle, Piercy, & Hovestadt, 1981). Since the Delphi technique is more concerned with identifying issues and exploring minds than with setting down precise recommendations (Wheeler, 1985; Jenkins & Smith, 1994), this methodology would provide a beginning outline of experts' opinions of the theory and practice of reflecting teams. From this introductory delineation, further works can refine the tenets of theory and practice of reflecting teams.

Panel Selection

Following the delineation used by other family therapy Delphi studies (Avis, 1986; Stone Fish, 1985; Wheeler, 1985), the author attempted to operationalize the term *expert*. The panelists for this study were identified as experts by meeting at least one of the following criteria: (a) they had published at least one article, chapter, or book with the focus of the content in the article or chapter on a reflecting team approach to family therapy; (b) they had presented at least once at a state or national convention with the focus of the presentation on reflecting teams or with reflecting teams in the title of the presentation; (c) they had at least 5 years of clinical experience in family therapy, with at least 1 year spent in practicing a reflecting team approach to family therapy; and (d) they had been an editor of a family therapy journal within the previous 4 years.

In addition to operationalization, capturing the population of knowledgeable participants is often arduous. In this Delphi project, purposive sampling, a form of nonprobabilistic sampling, was used. This type of sampling allows the researcher to choose respondents who best meet the purposes of the study (Bailey, 1982) and may be unavoidable given the relative lack of development of this approach. A random sample of family therapists would not give an adequate knowledgeable sample because of the relative novelty of the practice approach. This type of nonprobabilistic sampling is considered appropriate for research designs that focus on generalizations to theory, rather than generalizations to populations (Bogdan & Biklen, 1982; Goetz & LeCompte, 1984; Yin, 1989).

To locate panelists who met the above criteria, the author carefully reviewed the published works on reflecting teams, listings of presenters at family therapy conventions, and family therapy journal editors. The author sent a letter to 29 panelists who met the above criteria describing the research study, requesting their participation, outlining time investment, and suggesting why his/her participation would be of value to the study. Sixteen (55%) of the family therapists originally contacted agreed to participate. Each panelist was requested to acknowledge his/her willingness to participate in the project and to nominate additional colleagues who met the criteria for inclusion in the study. Through this procedure, 10 additional nominees (91%) agreed to participate. Thus, a total of 26 participants comprised the study sample at the beginning of the Delphi study. Of the members who participated, all but 1 (a family therapy journal editor) met at least two of the criteria to take part in the investigation. Table 1 shows general demographics of panel members. Even though some of this data does not indicate expertise on reflecting teams, it is included to better understand the participants in the study.

Table 1
Profile of Panel Members Who Completed Delphi Questionnaire 2

Number of Publications	1.5	Age	46 yrs	
Number of Presentations	1.7	Race	White	21 (100%)
Clinical Experience	13.5 yrs	Sex	Female	9 (43%)
			Male	12 (57%)
Reflecting Team Experience	4 yrs	Marital Status	Married	18 (86%)
			Single	1 (5%)
			Living Together	2 (9%)
Supervision Experience	10 yrs			
Teaching Experience	5.7 yrs	Employment Context	Academic	5 (24%)
			Self	9 (43%)
			Community	7 (33%)
Consultation Experience	9.7 yrs			
Research Experience	6 yrs	Highest Degree	Doctorate	12 (57%)
			Master's	9 (43%)

Procedure

This study proceeded through a pilot stage to formulate and refine questions and two rounds or "waves" of questionnaires, Delphi Questionnaire 1 and Delphi Questionnaire 2. Rounds or waves refer to the number of times the questionnaire was mailed to the participants in the study. Each panelist was mailed a copy of Delphi Questionnaire 1 (DQ1) that contained six open-ended questions modeled after other theory and practice building studies in family therapy (Avis, 1986; Stone Fish, 1985; Wheeler, 1985). Each of the six questions formed categories to which the panelists were asked to respond. Twenty-one, or 81%, of the 26 panelists completed DQ1.

The researcher collected and read responses from participants to the questions on DQ1. These responses were edited for redundancy, then written as statements about reflecting team theory and practice. A 7-point Likert-type scale was then added to each of the reflecting team statements to enable panel members to agree or disagree. The original six categories, participants' statements, and the scales comprised Delphi Questionnaire 2 (DQ2). To assess whether responses from DQ1 were adequately represented by the statements on DQ2, one third of the original completed questionnaires were randomly selected. From the selected surveys, several responses from each of the six categories of questions were randomly chosen and checked by two independent raters for inclusion in the study. These independent raters were to check for representativeness of DQ1 items within the second questionnaire. DQ2 was then corrected to adjust for any disagreements in the ratings.

DQ2 was mailed to 22 panelists (1 panelist who was unable to complete DQ1 asked to be able to complete DQ2). Experts were asked to rate their degree of agreement or dis-

agreement with the 273 responses from DQ1 and fill out a demographic form and return it with their completed questionnaire. The final DQ2 was completed and returned by 21, or 95%, of the 22 participants.

After the panelists completed DQ2, the median and interquartile range was tabulated to show the central tendency and dispersion of the responses. Following the guidelines of other Delphi studies in the field of family therapy, and to assure high levels of agreement and consensus, only those items in DQ2 whose medians were less than or equal to 2 and whose interquartile ranges were less than or equal to 1.50 were accepted (Avis, 1986; Binning, Cochran, & Donatelli, 1972; Stone Fish, 1985; Wheeler, 1985; Winkle et al., 1981) as part of the ending reflecting team profile. A median score of 1 or 2 meant that the item was deemed "very important" or that panelists had "strong agreement" with the item being included in the study. Additionally, an interquartile range of less than 1.5 meant that a majority of the scores did not greatly differ from one another. The items that fell within these ranges are considered to be those that encouraged the most agreement among the panelists.

RESULTS

The results of this research are presented using tables with each item's median and interquartile range. A table is employed for each of the six categories or questions that appeared in the Delphi questionnaires. Panelists identified a total of 273 items in DQ1. Of the 273 items that were included in DQ2, 48 or 17.4% met the criteria for inclusion in the final reflecting team profile. This profile comprises a model for a reflecting team approach to family therapy.

DISCUSSION

Tables 2-7 and the discussion outline the major categories of responses endorsed in the final profile of a reflecting team approach to family therapy.

Theoretical Assumptions

Table 2 identifies the theoretical assumptions underlying a reflecting team approach to family therapy that were endorsed by the panel of experts. Twenty of these 82 items, or 24.4%, met the criteria for inclusion in the ending profile. The items deemed acceptable were focused on assumptions of reality and meaning. Panelists agreed that reality is negotiable and observer dependent. Additionally, language is used by families and therapists alike to construct reality and meaning socially. According to the study's participants, a reflecting team approach to family therapy starts with the epistemology of social constructivism. Several items in the ending profile endorse the idea of social constructivism in reflecting team practice: (a) meaning and reality are socially constructed, negotiable, and observer dependent; (b) there are multiple realities since language creates reality; (c) the observer cannot be separated from what is observed; (d) meaning is formed through people's use of language and dialogue; and (e) reality is created and altered in clinical sessions with clients. Since reality is socially constructed, panelists agreed that there is no one, true reality sought by members of the system. Instead, multiple realities are created in the session by both family and team members. Using the reflecting team approach, the therapist or treatment system joins with the client system in an attempt to co-create a different meaning

system.

The panelists also agreed on several assumptions that concern the use of language and narrative. The panelists stated that knowledge, meaning, and perception are mediated (construed), formed, and altered through language and dialogue. Panelists agreed that clients and team members bring narrative to therapy for the process of narrative exploration rather than traditional problem-solving goals of therapy.

Table 2
Assumptions Underlying a Reflecting Team Approach to Family Therapy

Med.	Intq. Range	Assumptions
1.0	.5	The observer cannot be separated from what is observed.
1.0	1.0	There are multiple paths to change.
1.0	1.0	Open conversations are preferable to secret deliberations.
1.0	1.0	Meaning and reality are socially constructed.
1.0	1.0	Knowledge, meaning, and perception are mediated (construed), formed, and altered through language and dialogue.
1.0	1.0	Therapy is not about finding the "truth" or about finding a solution to a problem or about changing a "pathological/dysfunctional" family system. Instead, it is about establishing an ongoing dialogue (conversation) between people (at least one of whom has a complaint) such that new ideas or stories emerge and/or "problems" come to seem less problematic.
1.0	1.0	Sharing different versions of the same world influences the family to create a wider view of their reality and offers the possibility of alternative approaches to their problem.
1.0	1.0	Therapy is a "conversation," not something done to a patient.
1.0	1.5	The therapist or treatment system joins with the client system to co-create a different meaning.
1.0	1.5	Reality is negotiable and observer dependent.
1.5	1.0	Change is the evolution of new meaning through dialogue.
1.5	1.0	Emphasis is on more useful positive/logical connotations rather than negative or pejorative ones.
2.0	1.0	Clients bring narrative to therapy that changes with the criss-crossing of ideas in therapy.
2.0	1.5	Multiple realities are created in the session.
2.0	1.5	Therapists need to attempt to be aware of and acknowledge their own (professional/clinical, personal, cultural) "pre-stories" they bring into the conversation.
2.0	1.0	Meaning and behavior are co-related.
2.0	1.0	The process is nonlinear and not focused on problem solving so much as narrative exploration.
2.0	1.0	Language creates reality.
2.0	1.0	Fundamental belief in people's ability to make choices/construct reality in their own best interest and toward health.
2.0	1.0	The family will find it useful to focus attention on the meaning(s) they associate with experiences and relationships.

Assumptions concerning "doing therapy" form another focus area from the endorsed items. The biggest shift occurs in that the therapist and team members have moved from a superior, hierarchical position "above" clients to a more collegial relationship. The panel-

ists agreed that therapy is not something "done to a patient," finding "truth" or a solution to a problem, or changing a "pathological" or "dysfunctional" family system. Instead, therapy is about establishing an ongoing dialogue or conversation between people (at least one of whom has a complaint) such that new ideas or stories emerge and/or "problems" come to seem less problematic. Team and family members share different versions of the same world, each influencing the other, creating a wider view of reality, and offering alternative approaches to the dilemma. Open conversations among all members of the therapeutic system are preferable to the once secret deliberations of therapy team meetings. With these open conversations, the emphasis is on more useful positive or logical connotations rather than negative or pejorative ones. Finally, panelists agreed in the fundamental belief in people's ability to make choices and construct reality in their own best interest.

The assumption that positive/logical connotation should be emphasized in reflecting team practice was endorsed in the ending profile. Positive connotation is continually mentioned as a fundamental guideline of reflecting team practice (Andersen, 1987; Lax, 1989; Miller & Lax, 1988). Although therapists have been cautioned about the use of positive connotation (Smith et al., 1995), this item was endorsed because it is believed that such practice can best facilitate an environment for change. However, considering the complexity of the cases which receive treatment, the endorsed items of "open conversations are preferred to secret deliberations" combined with an "emphasis on positive/logical connotations" may paralyze some reactions in the session. Team members may somehow limit themselves to only positive or logical discussions, when actually they are secretly considering other discussions about the family dilemma. Prior to this research effort, authors had outlined some assumptions for reflecting team practice (see Andersen, 1987; Miller & Lax, 1988; Young et al., 1989). Some of these assumptions were endorsed in this research effort under the category of assumptions of reflecting teams; other items were endorsed under the category of techniques or interventions of reflecting teams. The assumptions endorsed in the final profile and in the literature include: reality is negotiable and observer defined, emphasis is on more useful positive/logical connotations rather than negative or pejorative ones, and meaning and behavior are co-related.

Techniques or Interventions

The second category of items refers to the techniques or interventions identified as associated with a reflecting team approach to family therapy. Panelists identified a total of 83 techniques or interventions, of which 17 (20.5%) met the criteria for inclusion in the final profile (Table 3). The discussion of results will be organized according to the techniques or interventions discussed in the literature about reflecting teams. Panelists stated that the reflecting team approach has many different applications and can be used creatively by its members. The reflecting team model can be used as part of family team work, home-based work, supervision, and as a stance for the individual therapist in thinking out loud with clients. The panelists stated that this model incorporates sharing multiple perspectives and shifting talking and listening positions for all members of the therapeutic system. A "non-judgmental/curious stance/neutrality" [sic] is followed to prevent either the therapist or the reflecting team from becoming critical or judgmental. The reflecting process of sharing information back and forth between the team and the family also allows the therapy team members to watch and listen to their own process being described. This information provides additional feedback and another perspective for the team that may be different from the beliefs they held previously about themselves and the family.

All interventions in this approach reflect a sense of respectfulness and an effort to demystify the therapeutic process or relationship. The interventions are considered collaborative rather than imposed on a client. The panelists stressed that a sense of mutual exploration is communicated in this approach since the language used is respectful, free of jargon, tentative, and curious. It is a language of associations (i.e., stories, analogues, images) rather than of problem solving. This switch in language is significant because in reflecting team practice the therapist and team are no longer in the hierarchical position of searching to "fix" a problem situation presented by the family. In reflecting team practice, the team and family strive to share information and stories that may enable new perspectives and choices surrounding the dilemma. Through these stories and perspectives, it is hoped that the client will no longer view the situation as a problem. The acceptance of items that deal with language and dialogue may be influenced by the growing interest in

Table 3
Techniques or Interventions Associated with a Reflecting Team Approach

Med.	Intq. Range	Techniques or Interventions
1.0	1.0	The sharing of multiple perspectives.
1.0	1.0	The reflecting team can be used creatively by its members.
1.0	1.0	The composition of the reflecting team (RT) can be different, i.e., the RT can consist of other therapists, or therapists and other members of the treatment/client system.
1.0	1.0	Shifting talking and listening positions for all members of the therapeutic system.
1.0	1.0	Speculation rather than interpretation.
1.0	1.0	Respectful listening.
1.0	1.0	Reflecting teams have many applications – as family team, in home-based work, supervision, stance for individual therapist in thinking out loud.
1.0	1.0	Interventions are collaborative rather than "done to."
1.0	1.0	The reflecting team can be composed of only one person.
1.0	1.5	Communicating a sense of mutual exploration.
1.0	1.5	The language used is respectful, free of jargon, improvisational, tentative, curious, questioning, etc. It is the language of associations (stories, analogues, images) rather than of problem solving.
2.0	1.0	The reflecting process allows the therapy team members to watch and listen to their own process being described, which provides another perspective on themselves and each other.
2.0	1.0	Nonjudgmental/curious stance/neutrality – to prevent either the therapist or the reflecting team from becoming critical and judgmental.
2.0	1.0	Developing reflexivity.
2.0	1.5	All interventions reflect a sense of respectfulness and an effort to demystify the therapeutic process/relationship.
2.0	1.5	The therapist's/interviewer's questions follow the content that the client offers in a way that is "unusual enough" (Andersen, 1990) but not too unusual to be useful.
2.0	1.5	Important to limit reflection to under 10 minutes since it is easy to over-load families and hinder responses.

narrative-based and dialogue-based therapy approaches at the time of the study (Anderson & Goolishian, 1988; Hoffman, 1990; Mook, 1989; Parry, 1991; Smith, 1991; White & Epston, 1989). The members of the team work to develop reflexivity (undefined term endorsed in this study; for clarification see Hoffman, 1991) and use speculation rather than interpretation. The therapist's/interviewer's questions follow the content that the client offers in a way that is "unusual enough" for the client to notice a difference (Andersen, 1990) but not so unusual as to be inexplicable.

The panelists also reported that there are creative uses of this approach. The reflecting team can be composed of a team or only one person. This one item stressed an exception to the traditional sizes of a reflecting team mentioned in the literature. An article by Wangberg (1991) that does address a one-person reflecting team was published after the study began. The concept of a one-person reflecting team configuration complements the traditional idea of teams and co-therapists offering different options for practitioners. Though there is no evidence for this speculation, this item may have been approved by panelists in an effort to make a reflecting team approach more applicable to therapists who do not have the luxury of a team or co-therapist in their practice. Although items in the first round of the study captured the more traditionally accepted sizes of a reflecting team, two to five members, these items were not approved for the ending profile. Items outlining sizes of reflecting teams may not have been approved because members did not want to limit the arrangements available for reflecting team use. The lack of endorsement for any particular size of reflecting team makes many variations of reflecting team configurations available for practitioners. One configuration is not preferred over another.

Panelists agreed that the composition of the reflecting team can be different; that is, the reflecting team can consist of other therapists or therapists and other members of the treatment/client system. The members of the study stated that it was important to limit the "reflection" time to under 10 minutes since longer conversations might overload families and hinder their responses. No other limits were set on how often or seldom a team shares their thoughts, except that the sharing should not overload the family.

How Change Occurs

The third category of items refers to how change occurs using a reflecting team approach to family therapy (Table 4). Panelists identified a total of 25 items related to how change occurs using this approach, of which 4 or 16% met the criteria for inclusion in the final profile.

Items endorsed by the panelists on how change occurs centered on the team members "accepting the client," as well as offering new dialogue, lens (viewpoint), and narrative. Panelists agreed that reflecting conversation creates a dialogue whereby people are able to think, feel, describe, and understand their situation in slightly different ways. This dialogue allows the "stuck system" to "move on" (dissolve or re-define the problem) in its own idiosyncratic way. This finding is in agreement with Andersen's (1987) earlier statement that change occurs by families hearing something slightly different or being exposed to new information that was previously overlooked. The panelists postulate that when clients change their narrative, change in behavior follows, or the problem is no longer experienced as a problem. The panelists also added that multiviewpoints (lenses) offer an opportunity for shifts in meaning-making, meaning (constructs), positions and relationships, and actions. This endorsement is in agreement with previous authors (Davidson et al., 1988; Friedman & Fanger, 1991; Lax, 1989; Roberts, Caesar, Perryclear, & Phillips, 1989) who had re-

Table 4
How Change Occurs

Med.	Intq. Range	How Change Occurs
1.0	1.0	Reflecting conversation creates a dialogue whereby people are able to think, feel, describe, and understand their situation in slightly different ways. This allows the system to move on (dissolve or redefine the problem) in its own idiosyncratic way.
2.0	1.0	Clients change narrative and change in behavior follows, or the problem is no longer seen as a problem.
2.0	1.0	Acceptance of client system.
2.0	1.5	Multiperspectives (lenses) offer an opportunity for shifts in meaning-making, shifts in meaning (constructs), shifts in positions and relationships, shifts in actions.

Table 5
Major Goal

Med.	Intq. Range	Major Goal
2.0	1.0	The development of a new narrative which will include a behavioral change and, often, a sense of hope for the future. This is a qualitative shift in both clients' description or conceptualization of their current discourse and their interactions.
2.0	1.0	To create a holding context/conversation in which new, more useful, stories can emerge.

Table 6
When to Use a Reflecting Team

Med.	Intq. Range	When to Use this Approach
2.0	1.0	Reflecting team therapy is a useful training tool (as is reflecting team supervision) because it allows a number of therapists to be actively involved in a case (even more so than being a member of a supervision group or sharing cases with colleagues in the hall).

marked that change, or movement of the standstill system, occurs when family members, after obtaining new ideas or meanings, shift their view or perspective of the problem.

In response to the question of reflecting team members' involvement in family alterations, authors have begun to examine whether they are change agents in the therapy process (Davidson et al., 1988; Friedman & Fanger, 1991; Mittelmeier & Friedman, 1991; Roberts et al., 1989; Young et al., 1989). These authors state that they see themselves not as change agents but as people who provide a context in which conversations can occur. Some participants in the study stated their concerns about this inquiry about change, but the final profile did not include these concerns.

Major Goal

Panelists identified 26 goals in the first questionnaire, 2 or 7.7% of which met the criteria for inclusion in the final profile (Table 5). The fact that 92.3% of the items suggested in the earlier round were not endorsed might suggest overwhelming diversity in the goals for this approach. Of the endorsed items, the major focus from this section of the study was to facilitate change. According to the panelists, the major goal is change, which reflecting team practitioners seek in clients' behavior and/or dialogue. This change is expedited in two ways. The first way is to create an environment that offers a sense of hope accompanied with behavior change, and the second is to create a context in which more useful stories and descriptions can emerge from the dialogue. Panelists did not differentiate a useful story from one that is not useful.

A review of the literature and responses to this study suggest that authors often group "how change occurs" and "goals" of reflecting teams. The responses to these two areas often centered around the idea that the goal for a reflecting team approach is change, and change occurs by creating a broader and more embellished picture of the dilemma brought by the family (Andersen, 1987; Miller & Lax, 1988). However, in her discussion of the differences between reflecting teams and other traditional family therapy approaches, Hoffman (1991) states that there are no goals at all for a reflecting team approach, adding that this approach creates "loops in the dialogue" that allow families to create new stories in their quest for change.

When to Use

The fifth category of items refers to the use of a reflecting team approach to family therapy (Table 6). Of the 26 items identified for this category by panelists in DQ1, only 1 or 3.8% met the criteria for inclusion in the final profile.

The one use endorsed states that reflecting team therapy is a useful training tool, as is reflecting team supervision, because it allows a number of therapists to be actively involved in a case (even more so than being a member of a supervision group or informally sharing cases with colleagues). This endorsement is congruent with previous authors who have suggested the use of this approach for training (Young et al., 1989) and for group supervision (Prest, Darden, & Keller, 1990). The experts endorsed reflecting teams as a training tool and not as an approach for particular types of cases or families. Possibly, experts thought it was apparent that reflecting teams would be used in family therapy sessions; therefore, they did not clearly delineate areas of use for this approach. Even though panelists mentioned many items in the first round of the study that described possible uses of reflecting teams, these items were not endorsed in the ending profile. Prior to this study, reflecting teams were considered useful when families were experiencing a crisis (i.e., times of violence, loss, or grief) or upon the clients' request (Kassis & Matthews, 1987), with clients who were resistant to other kinds of interventions (Davidson et al., 1988), with

couples who displayed an exceptionally disruptive level of conflict in sessions (Miller & Lax, 1988), and with cases involving young children (Lax, 1989). Some authors have suggested that the reflecting team approach can be used with a range of families in a variety of work contexts (Roberts et al., 1989; Young et al., 1989).

Additionally, some authors report that they used the reflecting team approach near the beginning of therapy (Davidson et al., 1988; Roberts et al., 1989) or in later sessions to open possible topics of discussion (Roberts, et al., 1989). Roberts et al. (1989) added that the reflecting team can be used in one-time consultations, ongoing therapy, and larger system interventions. Davidson et al. (1988) used the team for initial interviews to generate a wider range of information than conventional methods and to provide supervision and live consultation on cases.

This lack of endorsement for particular uses of reflecting teams may be consistent with the idea that this approach is more a treatment philosophy than a technique. Even if reflecting teams are a philosophy, clinicians need carefully to consider when the use of this philosophy would prove beneficial or detrimental.

Contraindications

The sixth category of items refers to the contraindications of using a reflecting team approach to family therapy (Table 7). Panelists identified a total of 31 items yet only endorsed 4 or 12.9% for inclusion in the final profile.

Table 7
Contraindications

Med.	Intq. Range	Contraindications
1.0	0.0	When it is not offered in the spirit of being possibly useful or is forced or insisted upon.
1.0	1.0	When the family members or therapist do not believe such an approach would be helpful.
1.0	1.0	When team members are highly judgmental and critical and rely on static labels of behaviors.
2.0	1.0	When it is not guided by dialogue between family and therapist.

The theme from the four items approved for the final profile of contraindications of a reflecting team approach follows the idea of an "attitude" or a philosophy of the reflecting team approach. One contraindication of this approach is when it is not offered in the spirit of being possibly useful or is forced or insisted upon. The approach is also contraindicated when the family members or therapist do not believe such an approach would be helpful and when team members are highly judgmental and critical and rely on static labels of behaviors. It was agreed that another contraindication is when a reflecting team approach is not guided by dialogue between family and therapist.

Prior to this study, the literature on contraindications to the use of reflecting teams was sparse. Roberts et al. (1989) caution against using the reflecting team in consecutive sessions since team members may no longer offer new, unique conversations. Also, the team is considered counterproductive when the problem is deemed by the family or the team as one

of a relatively low intensity (Kassis & Matthews, 1987).

Young et al. (1989) question potential disadvantages of using a reflecting team approach to family therapy. Although not stating any disadvantages, they question the potential confusion about who is responsible for the outcome of therapy as well as the possibility that the therapist may not feel in control of the sessions' content and process. They add that further exploration needs to address these concerns.

Additional Responses from Reflecting Team "Experts"

Several additional responses to the research merit discussion. The first is a response from a member who decided not to participate in the study. In this letter he/she states:

> . . . I have come to understand this whole process is a not-on-before-hand determined relationship between two or more persons who talk together in order to search for the not yet seen and the not yet understood in relation to something that usually is defined as problematic. This is mostly a not-on-before-hand determined relationship where talking and language become the core. There is therefore not a reflecting team approach. There are rather several and different approaches. The work is based on the idea that what one thinks and understands emerges from what one talks about, and what one talks about is tied to how one talks about it. In other words there is not theory "behind", but what happens can be understood differently depending on which perspective one chooses as a background for understanding. Research might therefore be a certain way to talk about (and thereby let understanding emerge) a phenomenon, f.i. the reflecting team. The perspective for my participating in a reflecting process is that one can only reach *meanings* about what happens in a reflecting process and *meanings* how this description can be understood. In my perspective are such meanings very person-bounded, not at least to the language that person who creates meanings is *in* . . .

Even though early writing on reflecting teams began to outline the theory and practice of a reflecting team approach, this person was unwilling to formalize this process any further through this study. At first glance, this letter appears to challenge the utility of this project; however, articulation and refinement of the theoretical assumptions that guide reflecting teams would benefit the field of family therapy. Additionally, the comment that there is "not a reflecting team approach" was also agreed upon by members in this study. Participants concurred that there are numerous practice techniques associated with reflecting teams.

The following are additional responses from people who had various reactions to the project. The first letter is from a member who did not want to participate yet later joined in the study. He/she stated: "I looked over your questionnaire and realized that I couldn't answer the questions because I think what I do is influenced by the reflecting team approach of Tom Andersen but is not the same . . . ."

He/she later added in a second letter:

> I have filled in your questionnaire as best I could, by indicating agreements where possible. However, some of the boxes I left blank because I didn't agree with what they represented. Tom Andersen's Reflecting Team language, some because they weren't in the spirit of the Reflecting Team, some because they were self-evident, and some because they were so broad that they could apply to any kind of therapy. I kind of gave up by the ending sections.

> Part of the problem is that you specified "Reflecting Team," as if that were the identifying format for an approach that Harry Goolishian suggested Tom call "Reflecting Process." If you have used that as your focus, I think I would have agreed with more of the statements you included.
>
> Another difficulty is that the Reflecting Team is easy to "do" without having any grasp of the subtler shift in stance that is involved. Some Milan style therapists are using it, but in their hands it ends up producing a version of positive connotation or positive reframing, which straitjackets the conversation in a strategic fashion.
>
> One aim you accomplished, although you may not have started out to do this: your questionnaire shows the descriptive language that is being used to define the Reflecting Team concept is unrelievedly vague, abstract, confusing, elliptical, and so general as to be without meaning. I don't exempt my own contributions. For that realization I sincerely thank you . . .

The final response is from a telephone conversation with a panelist who eventually dropped out of the study before completing the first Delphi questionnaire.

> . . . I am having trouble answering the first two questions in the study. I am inclined to just put "see Andersen's article" for these questions . . . Also, the way these questions are written causes me to wonder if this was like a take-home test . . . The questions could be improved to tell experts to list their assumptions they follow when using a reflecting team approach . . . In conclusion, should I give credit to Andersen if I list his assumptions? . . .

Each of these responses needs to be considered as additional information that may have impacted this research project. It is apparent from these responses that some panelists understand the phrases "a reflecting team approach," "reflecting process," and "reflecting teams" quite differently. This problem of communication is a limitation of this study. Even though terms were used from the existing literature, there appear to be multitudes of meanings associated with each of these "reflecting team" headings. Additionally, as is apparent from the responses received, the seminal work of Andersen (1987) shapes much of reflecting team work and cannot be overlooked. It was not uncommon for participants to state "see Andersen's work" as their answer to some of the questions. Although this may have been a convenient answer, it did not offer the type of content needed to refine the tenets of this approach further.

Delimitations of Study

Certainly, one limitation of this study would be the difficulty in operationalizing the term *expert*. Although every attempt was made to include knowledgeable and experienced individuals, it is conceivable that the panelists did not have the necessary expertise to offer helpful data for this study. Although many of the most prolific writers on the topic did participate, it is possible that the lack of participation by others may have skewed the final profile. Also, this study may have been limited by the panelists who chose not to participate in the study. Dalkey (1969), in defending the Delphi procedure, suggests that the limitation of obtaining "experts" may be seen as less consequential in that these "less" knowledgeable participants often provide valuable information that leads to reaching the desired results.

Another consideration is the use of independent raters to check for representativeness of the data. Although these raters did not have any specific knowledge about this topic, the author made sure that all items they selected were captured in the study. The raters' lack of

knowledge on the topic could be seen as a limitation since they may not have understood that an item was adequately captured. Although this study followed the guidelines of other Delphi studies, the reliability procedures of family therapy Delphi studies should be better articulated.

As is evident from the correspondence, the wording used in this research effort profoundly impacted certain participants. While some members spoke of the "vague" wording used in the reflecting team literature, others may have been mistaken about an "item" definition yet continued with the project. This type of miscommunication may have seriously influenced the results. Based on the final profile of reflecting teams, it is not surprising that "item wording" or "narrative" would be a concern for participants. Perhaps future efforts can overcome these difficulties of wording and authorship in researching reflecting teams.

Other members seemed to struggle with the concept of "reflecting teams." These members may have been influenced by the choice of words used to describe this approach. Even though Andersen (1987) refers to this technique as "a reflecting team approach," some members struggled with this as the correct way to describe, and therefore research, the topic.

Andersen's impact on reflecting teams (or reflecting process) is extremely significant. Panelists in this study noted that they had a difficult time separating their thoughts from his original work on the subject. As noted earlier, some authors did not offer carefully considered answers to the areas of investigation; they merely referred to Andersen's works. This uncritical acceptance appears to go against the idea of diversity endorsed in this study.

Finally, the sheer volume of items to consider was a limitation. Other Delphi studies have divided the questionnaire response sets in order not to overwhelm participants (Figley & Nelson, 1989). This may have been a more effective way to encourage full consideration of each and every item. Additionally, it is hard to know if any panelists actually practice reflecting teams as outlined in the final profile. Including all items endorsed in the final profile in a reflecting team approach might be difficult. With this in mind, practitioners are warned to consider these results as an exploratory means of examining reflecting team practice. As noted by Jenkins and Smith (1994), a Delphi study should be viewed as a beginning statement and not as a definitive work. The final profile should not be seen as the only standard for reflecting teams but as a means to prompt further clarification of this appealing approach.

CONCLUSIONS

The purpose of this exploratory study was to develop a profile of a reflecting team approach to family therapy. Using a Delphi technique, experts agreed upon the items in a final profile for the theory and practice of a reflecting team approach to family therapy. Of the 273 items identified in the original round of the study, the panelists agreed on 48 or 18% of the items for the ending profile. This ending profile is not the final word on reflecting teams; rather, the results from this study offer a beginning step toward considering the important tenets of the theory and practice of reflecting teams.

According to the panelists, a reflecting team approach is a fundamental or qualitative shift in family therapy. Constructivist practice and reflecting teams are considered a new way of thinking about clinical work and therefore a new way of doing therapy. Reflecting teams are not merely a new technique to use in a "grab bag" of therapy tricks to try with

clients; they are considered a new philosophy of treatment. If family therapists begin to use reflecting teams as merely another strategy with clients, the essence of reflecting teams is lost. The endorsement of constructivist assumptions makes this approach a fundamental shift away from traditional, positivist family therapy.

Several items from the first round of the study that included what the literature had outlined as assumptions of reflecting teams were not endorsed in the final profile. One such item was the idea that systems are an ecology of ideas (Andersen, 1987). Because of the discussion of problems and therapy as involving multiple perspectives and views, panelists may have felt that this idea had already been captured in the final profile.

Additionally, the ideas that "there is no issue of right; only an issue of fit" and "sharing information rather than withholding" were not endorsed, even though they are included in Andersen's seminal work. Throughout the literature, authors (Davidson et al., 1988; Young et al., 1989) have considered the sharing of information a fundamental assumption of reflecting team practice. This was one of the original assumptions that encouraged the therapeutic team to become a vocal part of the discussion of the family. The panelists' lack of endorsement is consistent with an article by Storm (1992), in which Braulio Montalvo cautions against a "smorgasbord of ideas" in therapy that results in confusion for the family. However, taken to an extreme, the neglect of this assumption puts the reflecting team back as a traditional therapeutic team behind the one-way mirror. This type of practice does not allow teams to share the multitude of ideas and struggles with the family.

The assumption that "problems generate systems" was never included by the panelists. Even though this assumption has been previously discussed (Hoffman, 1985, 1988; Lax, 1989; Miller & Lax, 1988), because it was not included in any of the rounds of the study, it could not be endorsed in the final profile. It is unclear why some of these previously held assumptions about reflecting teams were either omitted or not endorsed in the final profile. As stated earlier, these omissions may have been due to the large number of items in the study. Possibly future research on reflecting teams can address these items.

Since the continuation of dialogue and creation of context for the development of narrative and stories is a primary focus for reflecting teams, clear guidelines need to be delineated as to what these terms mean. It cannot be assumed that practitioners adopting a reflecting team approach are knowledgeable in implementing narrative-based techniques. In addition, researchers need to begin to test the role of "development of narrative" in the outcomes of this approach. The panelists did not differentiate how the team members would be able to assess their ability to be "guided by dialogue" or how they would judge their critical attributes. Of particular importance to the panelists was the idea that families be given the chance to accept or reject the concept of having a reflecting team for their therapeutic services. Clients could reject the active participation of a team in their discussion; however, since a reflecting team approach is considered a philosophy, they would have a much harder time rejecting the ideology that guides their therapist.

Future research needs to address which of these items are considered most pivotal in reflecting team work. The question arises, "Must a practitioner use each and every one of these endorsed items in order to enact a reflecting team?" It seems absurd to decree that all items be initiated in order actually to execute a reflecting team approach. Moreover, if diversity of practice is considered an element of reflecting teams, future efforts need to discern just how diverse practice can get and still be a part of this approach. Since treatment interventions associated with reflecting teams are still in the formative stages, continued development is urged.

It should be noted that because of continual lack of conceptual clarity, reflecting teams may remain a faddish practice technique. Meaningful research may never occur on reflecting teams as long as there is no agreement on the assumptions that comprise its theory base. In the absence of conceptual clarity and research, one cannot promote the use of this family therapy approach. In order to further the research on reflecting teams, educators can begin to teach both beginning and experienced students about reflecting teams. Educators are warned to be careful about teaching this as "truth" since there is such great diversity and murkiness among authors on this approach. Through this educational process, researchers can gain knowledge to test the effectiveness of a reflecting team approach as contrasted to other family therapy schools of thought.

Clinicians must also become aware of the possible ethical dilemmas generated with a reflecting team approach. The endorsed tenet of "not being judgmental or critical" with clients may seem to put reflecting team clinicians at odds with societal guidelines for handling incidents such as violence and abuse. Undoubtedly, reflecting team practitioners need to deal with such critical issues. The difficulty may arise in balancing this confrontation with the idea of "not being judgmental."

The jargon of reflecting teams needs to be much more specific and clear. One panel member's description of much of the terminology used with reflecting teams as vague, abstract, and without meaning is worth reiterating. Because reflecting teams were created to demystify the therapeutic process, the confusing language often used is especially unfortunate. However, with continued refinement, this new approach appears to offer much of value to the field of family therapy.

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