HOW MARRIAGE AND FAMILY THERAPISTS ARRIVED AT THEIR THEORETICAL ORIENTATION: A QUALITATIVE STUDY

A DISSERTATION

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BY

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DEDICATION

This work is dedicated to my great grandmother, born Anna Zedar in the 1890's, who was not allowed to continue her education after the 6th grade solely because of her gender. She longed to continue and her teachers unsuccessfully begged her father to let her continue because she was one of the most gifted students they had. She continued her quest for knowledge and continuously was caught reading instead of tending the family's cows. She continued her quest even after leaving Yugoslavia as a mail order bride, going through Ellis Island, and as I have been personally told by my great aunt (her daughter), she became one of those radical suffragettes and voted in the first election women were allowed to vote in despite never learning to speak English. This forward thinking woman speaks to me of her dedication and motivation that all humans be full citizens with equal access to all the resources available and has been the foremost motivating force for me to complete this degree and to never stop my education.

So this is for you, Anna. Thank you for your courage, your refusal to give up, and all the years of your life that you dedicated to the betterment of us all.

ABSTRACT

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The purpose of this study was to explore with licensed practicing marriage and family therapists (MFTs) how they formulated and arrived at their theoretical orientations. The participants were 20 licensed practicing MFTs seeing more than 10 clients a week for more than five years. Semi-structured, audiotaped interviews were the source of the data for this phenomenological qualitative study. After careful and triangulated data analysis, two themes emerged. A theme of an initial theoretical orientation was revealed first with a progressive process, as more experience and practice were gained, to a theme of convergence to a personal practice model, a process where personal and professional experiences merge with theoretical orientation until congruence occurs. These two themes are illustrated with quotations. Conclusions of this study, as well as the implications for therapists and for training, continuing education, and academic programs, are made along with the limitations of this study. Recommendations for future research are also discussed, especially regarding the person of the therapist.

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CHAPTER I

INTRODUCTION

Since the 1960s, the number of psychotherapy approaches and techniques has grown over 600 % (Garfield & Bergen, 1994) with estimates of more than 200 therapy models and 400 techniques (Karasu, 1986; Miller, Duncan, & Hubble, 1997).

This rapid proliferation of therapy models has both advantages (sign of rapid growth) and disadvantages (theoretical fragmentation) in the field of psychotherapy. Like other psychotherapists, the marriage and family therapist (MFT) is faced with a vast variety of frameworks and orientations from which to practice. Much of the research to date on theoretical orientations has used a quantitative methodology, asking the respondent to choose one theory from a forced-choice list, to identify all applicable theories from a list, or self-ascribe one.

With so many practice orientations to choose from, how does a clinician select and develop a personalized theoretical approach? How have practicing clinicians developed their own theoretical orientation? Previous research has had difficulties in gathering pertinent descriptions of a clinician's theoretical orientation, especially with the development of integrative approaches (Poznanski & McLennan, 1998).

It may be useful to attempt to examine this issue by changing from a quantitative methodology to a qualitative one, using a phenomenological approach. Such an approach attempts to make the invisible visible and searches for the essence, a linguistic

construction of the phenomenon, not a discovery and sets the stage where the answer to a question lies not in a hypothesis but in the interactional relationship between the participants and the researcher and is found through the interpersonal connectedness and the shared language (Morrissette, 1999). This research process is more than just questions and answers. It is a collaborative process between the participant and interviewee that provides the aesthetically rich narratives that allow the essence of the phenomenon to unfold.

Statement of the Problem

A wide search of multiple databases, of peer reviewed journal articles and dissertations available yielded no research that focused on the process by which marriage and family therapists (MFTs) selected and arrived at their current theoretical orientation. Understanding how practicing MFTs arrived at their theoretical orientations could be of benefit to therapist training programs, licensing boards, professional organizations, university curricula, and family therapy supervisors as well as therapists themselves.

Statement of the Purpose

The purpose of this study was to explore with licensed practicing MFTs how they arrived at their theoretical orientations. Purposive and snowball sampling were used to gather a sample large enough for the results to be of practical significance.

Research Question

This phenomenological study was guided by the following question:

How do practicing marriage and family therapists arrive at their personal theoretical orientation?

Research Design

Qualitative methodology using a phenomenological approach was utilized for this research. The focus of phenomenological methodology is on how people describe and make sense of their experiences (Patton, 2002). This approach fits with the purpose of this research, to arrive at the essence of the phenomenon (Creswell, 1998). A semi-structured, audiotaped, face-to-face interview was the source for data collection and took place in the participant's natural setting of choice (Sprenkle & Moon, 1996). The data were analyzed for recurring themes.

Definitions

The following definitions were used for the purpose of this research.

1. Practicing MFTs- licensed therapists who identify themselves as marriage and family therapists, average ten or more sessions a week, hold either a master's or doctorate in marriage and family therapy, and have practiced for more than five years.
2. Theoretical orientation- is a consistent theory of human behavior, psychopathology/behavior disorder, psychotherapy, and the mechanisms of therapeutic change (Norcross, 1985).

Assumptions

The following assumptions underlie this research:

1. Therapists have a theoretical orientation.
2. Therapists can articulate how they arrived at their theoretical orientation.

3. Education in marriage and family therapy theories will influence their theoretical orientation.

Delimitations

This study was delimited by several factors:

1. The participants were from the Dallas/Fort Worth (DFW) area.
2. Only MFTs were invited to participate.
3. Each participant saw clients an average of at least 10 hours a week.
4. Each participant was professionally licensed and had been practicing five years or more.
5. Only those MFTs who agreed to be audiotaped were interviewed.

The Researcher as Person

The researcher is an integral part of the data collection and analysis in a phenomenological qualitative study. The researcher herself is a licensed practicing MFT. In order not to compromise her study, this researcher's goal was to bracket her preconceptions so as not to inject hypotheses, questions, or personal experience in the data collection and analysis as Creswell (1998) and feminist scholarship require (Dahl & Boss, 2005). This was done in an attempt to allow the participants' meanings to emerge freely (Rosenblatt & Fischer, 1993) and to enable the researcher to "understand the social actor's frame of reference" (Dahl & Boss, p. 63). This was accomplished by interviewing herself and becoming the first participant before collecting any participants' data in order to bracket her experience and not compromise her study (Creswell).

Summary

The number of therapy models and techniques has grown tremendously since 1960. All this choice leads to the question of how therapists choose their theoretical orientations. The purpose of this study was to explore with licensed practicing MFTs how they arrived at their theoretical orientations utilizing a phenomenological qualitative methodology. Definitions, assumptions and delimitations were addressed as well as the importance of the researcher's role.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter contains the results of two separate reviews of the literature. One review was done before the study and one after the data were analyzed in order not to compromise the results of this study. No relevant research was located in the family therapy field concerning how marriage and family therapists arrive at their theoretical orientation and the review of literature was expanded to include psychology. There are four areas of research that appeared relevant: theoretical orientation, theoretical orientations of MFTs, common factors among theoretical orientations, and the theoretical orientations of psychotherapists.

Theoretical Orientation

Most, if not all, mental health training programs are grounded in theory. Licensing boards, professional associations, and accreditation institutions are foundationally built on theory, as are continuing education programs. Theoretical orientation has been defined by Norcross (1985) as a consistent theory of human behavior, psychopathology/behavior disorder, psychotherapy, and the mechanisms of therapeutic change. Norcross goes on to say that "theories are provisional attempts to explain complex issues and should not be presented as scientific fact" (p. 16). Yet effective therapy cannot proceed without a guiding model. Theories are the models that

provide the conceptual basis for therapists to understand their clients and make clinical decisions (Sexton, Ridley, & Kleiner, 2004).

Theoretical Orientation of MFTs

A 1984 random survey of 396 American Association for Marriage and Family Therapy (AAMFT) clinical and associate members from Texas was done to find which MFT model was the most prevalent (Quinn & Davidson). The respondents were asked to describe their theoretical orientation and to rank each one checked. The forced-choice list consisted of: a.) communication (Satir), b.) strategic (MRI), c.) structural (Minuchin), d.) experiential (Whitaker), e.) behavioral (Patterson), f.) intergenerational (Bowen), g.) psychodynamic (Kernberg), h.) functional (Alexander), and i.) other (any not listed). The survey results found the most frequent MFT model to be Satir communication (85%, when combining all the rankings), followed by strategic approach (66%), and then structural (62%). The category of other was chosen by 26.2% of the respondents and was included in the rankings. Of the 396 AAMFT members, 55.9% had been members for more than five years leaving 44.1% being clinical or associate members for less than five years.

In a survey of 1,334 counselors from 123 Family Service of America agencies, Cantoni & Cantoni (1990) asked their participants to indicate from a list what interventions were used in the last four months using a 6 point Likert scale with 0 = never to 5 = all the time. The interventions were listed below the theory from which they were derived. The survey contained eleven groups of counseling and psychotherapy theories and 71 interventions. Each theory had at least five interventions listed. Two theories had

as many as nine. Interestingly, joining was listed as an intervention under the family therapy theories. Nearly all (99%) of the participants chose more than one theory and 60% reported some use of all 11 theories. Less than 1% indicated use of five theories or less. The three most used theories were, listed in ordinal ranking, family therapy theories, problem-solving theories, and ego psychology theories. Information about the years of experience each clinician had was not asked.

In 1998 Bor, Mallandain, and Veterec surveyed 495 members of the United Kingdom Association of Family Therapy asking eight questions concerning their practices. They were asked to list the three approaches that most informed their practice. Of the 123 approaches reported, the Milan approach was reported as most used (43%), with psychodynamic next (27%), followed by structural (21%). No data were collected on individual length of practice. However, 34% did indicate no professional qualification in family therapy although 70% had at least a graduate degree. Six percent of the respondents were family therapy students and 8% had only a bachelor's degree.

In 2002, the AAMFT contracted with a research firm to survey by phone 534 of their currently practicing clinical members. Each group was represented by at least a 70% response rate. After attrition, 282 surveys were completed. The average years of experience was reported as 19.7 years in the mental health field with an average 16.4 years in MFT. Each participant was asked to describe in a word or two their primary treatment modality for intervention. Of the 19 models identified, MFTs most frequently identified cognitive-behavioral (27.3%), multisystemic (10.6%), and solution-focused approaches (8.2%) and 25.3% other theoretical orientations not listed (Northey, 2002).

Utilizing the internet, Wood (2003) developed an online questionnaire accessed through a website to assess the participants' level of affiliation to 17 models of therapy. A forced-choice five-point Likert scale was used, asking how often they used a particular concept. AAMFT members were notified of the website as were many state associations. Various academic family therapy departments with AAMFT ties were also notified of the website. There were 156 participants from around the country that completed the survey. The majority of the participants (58%) identified themselves as either a clinical or associate AAMFT member. A little over one-third (37.5%) of the participants graduated with their professional degree by 1989, 28% graduated between 1990 and 1997, and 35% between 1998 and 2002 with 16% still in school (student AAMFT members). The results showed a preference for behavioral models focusing on communication and interpersonal exchanges (75%), followed by emotions, needs and developmental models based on the work of Nathan Ackerman, Don Jackson, Susan Johnson, Leslie Greenberg, Richard Schwartz, and Abraham Maslow (71%), experiential models of Satir and Whitaker (65%), and Michael White's narrative model (62%). It was also reported that reframing was the most frequently used intervention technique (Wood).

Common Factors Among Theoretical Orientations

Blow and Sprenkle (2001) using a Delphi approach, created a panel of 50 MFT professionals in an attempt to find common factors across MFT theories, following up on research in the MFT field on the integration of theories (Lebow, 1997) and Lambert's research on therapeutic efficacy that concluded "only 15% of therapeutic improvement could be accounted for by model/technique and different therapies may embody common

factors that are curative although not emphasized by the theory of change" (Lambert & Bergin, 1994, p. 161). The criteria for selection to the panel were based on extensive clinical experience, theoretical knowledge, or recommendation by another panelist. A 333-item seven-point Likert-scale questionnaire was created for the purposes of this study. Responses were categorized into four groups: client/therapeutic factors, relationship factors, model/technique factors, and placebo/expectancy factors. Only 35 members of the panel completed the two rounds comprising the study. The panel members ranked their top three MFT theories as integrative (32%), solution-focused (16%), and structural (11%). The limitations of the study were also discussed given that the findings are a result of consensus and that the panelists were predominantly middle class Caucasian men (Blow & Sprenkle). The four categories were further subdivided into 12 subcategories. This categorization was later further refined into the common factor categories of psychotherapy: the client, therapist effects, the therapeutic relationship, expectancy, and nonspecific treatment variables. Three additional common factor categories unique to MFT were added: relational conceptualization, the expanded direct treatment system, and the expanded therapeutic alliance (Sprenkle & Blow, 2004).

Sexton, Ridley, and Kleiner (2004), believing that a common factor approach was too simplistic, proposed a multilevel-process model of change. This model of change consists of two parts: a.) foundational principles of change and the multi-leveled change processes occurring between the therapeutic change mechanisms brought by the therapist, the change experiences of the client while undergoing treatment, and b.) the immediate relational interactions of the therapist and client. The authors recommended further

outcome research and continued development of comprehensive models of change (Sexton, Ridley, & Kleiner).

This scholarship has also led to the formation of *The Heart and Soul of Change* (Hubble, Duncan & Miller, 1999), an edited volume whose objective is to specify how psychotherapy can be operationalized in practice when informed by common factors. This offers readers transtheoretical and inclusive views to a complex process in order to advance the research into effective psychotherapy.

Theoretical Orientation of Psychologists

Norcross & Prochaska (1983) designed a study to compare the characteristics of practicing independent psychologists with those psychologists in the public sector. A five page questionnaire was completed by 210 full-time practicing psychologists randomly selected from the American Psychological Association (APA), Division 29, of which theoretical perspective was the focus of a section of questions. Of the 13 orientations listed, including other, eclecticism, where multiple theories are espoused, of was the most frequently selected (31.4%). No significant difference in theoretical perspective was found between the various theoretical orientations. The psychodynamic perspective was selected by 14.3%, followed by psychoanalysis with 11.4%. The average age of the participants was 47.2 years with an average of 13.6 years post-doctoral experience (Norcross & Prochaska).

The above study was repeated in 1989 using the same questionnaire but asking the participants to select a primary and a secondary theoretical perspective. Of the 143 randomly selected counseling psychologists from the APA, Division 17, one-third of the

respondents (47) identified themselves as primarily eclectic. The next most chosen theoretical perspective was psychodynamic, with only 13.7% (19) selecting it as their primary perspective. The remaining respondents' answers were spread over 13 other orientations by the respondents (Watkins, Lopez, Campbell, & Himmell, 1989). Eclecticism was the most frequently selected secondary perspective with 16.3%, followed by Rogerian as secondary for 14.1% of the participants. The average age of the clinicians was reported as 49 years with an average of 14.8 years of postdoctoral experience. Nearly all (95.7%) of the participants were Caucasian (Watkins, Lopez, Campbell, & Himmell).

A later study (1998) surveyed 132 randomly selected Australian counseling psychologists. Again, the participants were queried about their primary and secondary theoretical orientations. The participants self-ascribed their particular primary and secondary orientations and completed the Counsellor Theoretical Position Scale (CTPS) developed by the researchers (Poznanski & McLennan). Cognitive-Behavioral (34%) was most frequently self-ascribed, followed by Psychodynamic(26%), then Experiential (18%), and Family Systems (14%). Cognitive-Behavioral (34%) again ranked first as a secondary theoretical orientation with Family Systems following with 29%. It was concluded that their results indicated a trend toward integration (Poznanski & McLennan). The average age was 41.1 years with an average of 15.3 years of practice. The results of the CTPS indicated epistemological differences between the theoretical orientation groups.

A newer study from the same Australian researchers, blending both quantitative and qualitative methodologies, interviewed 103 psychologists following a Therapeutic

Practice Structured Interview Protocol (TPSIP) developed for the study and had the participants complete the NEO Five Factor Inventory (FFI), a self-report personality measure (Poznanski & McLennan, 2003). The participants, all located in Melbourne, Australia, were purposefully recruited according to which theoretical orientation they espoused, in as equal numbers as possible, from a psychodynamic orientation (31%), a cognitive-behavioral orientation (27%), a family-systemic orientation (23%), or an experiential orientation (18%) (Poznanski & McLennan). The average age of the participants was 43.8 years with an average length of experience at 12.5 years. Just over half (51%) of the participants were in private practice. The remaining participants worked within a community setting. Their results found that each of the four groups were associated with a different cluster of personality characteristics and that those psychologists with a family-systemic orientation were more likely than the other groups to be eclectic in their choice of therapeutic intervention and that these psychologists came from families where they assumed responsibility for other family members as children (Poznanski & McLennan). These researchers did caution about drawing inferences concerning the level of commitment to the assigned theoretical orientation due to the use of a cross-sectional study, but did emphasize that their results found that theoretical orientation appears to be "intimately associated with the person of the therapist" (Poznanski & McLennan, p. 226).

While the previously reviewed studies have focused on what theoretical orientation was espoused by their participants, one study took a different approach. The study (Vasco, Garcia-Marques & Dryden, 1993), done in Portugal to determine if the

mismatching between a professional's choice of theoretical orientation and their personal values had any effect on their career. They sent a set of three questionnaires to all the members of all the Portuguese psychotherapeutic professional associations and all the publicly listed independent practitioners (487). Only 140 respondents met the criteria for inclusion in the study as 25 responses were not usable. The average age of the participants was 37.4 years and the average length of experience was 8.2 years with a range from six months to 33 years. After analyzing the data, the respondents were grouped into 5 theoretical orientations: cognitive (61), psychodynamic (35), systemic (16), humanistic (15), and behavioral (13) and reported that the dissonance between a therapist's theoretical orientation and their personal values and philosophy was related to dissatisfaction, especially for behavioral and cognitive therapists, which increased the likelihood of inefficacy and the abandonment of psychology as a career (Vasco, Garcia-Marques & Dryden). The researchers also reported that therapists appear to do one of the following when dissonance occurs: they re-entrench their chosen orientation, they revise or enlarge their paradigm, they abandon their career, or they stay in a continuous state of crisis. The researchers found that eclecticism, the adoption of multiple theories, may reduce the chance of dissonance. They also encourage future therapists to reflect deeply on their choice of theoretical orientation due to the future affect it may have on their efficacy and personal satisfaction (Vasco, Garcia-Marques & Dryden).

Another source of research from the field of psychology is the qualitative and quantitative study utilizing a grounded theory approach with a modified cross-sectional design. This longitudinal study spanned two years between an initial interview and a

follow-up interview with three/fifths of the original participants (Skovholt & Ronnestad, 1992). One hundred therapists, purposely selected from various levels of expertise, participated in an hour long interview and completed a 23-item questionnaire developed for the study. The average age of the respondents was 42.4 years old with a range from 24 to 71. The authors' data analysis revealed eight stages of development and 20 themes along with a discussion of stagnation versus professional development. The stages of development start with a conventional stage, followed by a transition to professional training stage, imitation of experts stage, conditional autonomy stage, exploration stage, integration stage, individuation stage, and finally, an integrity stage (Skovholt & Ronnestad). The themes found, as presented in Chapter 10 of the authors' book, are as listed:

-Professional development is growth toward professional individuation,

-An external and rigidity orientation in role, working style and conceptualizing issues increases throughout training then declines continuously,

-As the professional matures, continuous professional reflection becomes the central development process,

-Beginning practitioners rely on external expertise, senior practitioners rely on internal expertise,

-Conceptual system and role-working style become increasingly congruent with one's personality and cognitive schema,

-Development is impacted by multiple sources which are experienced in both common and unique ways,

-Optimal professional development is a long slow and erratic process,

-Post training years are critical for optimal development,

-As the professional develops, there is a decline of pervasive anxiety,

-Interpersonal encounters are more influential than impersonal data,

-Clients are a continuous major source of influence and serve as primary teachers,

-Newer members of the field view professional elders and graduate training with strong affective reactions,

-External support is most important at the beginning of one's career and at transition points,

-Professional isolation becomes an important issue with increased experience and age,

-Modeling/imitation is a powerful and preferred early-but not later- learning method,

-There is a movement toward increased boundary clarity and responsibility differentiation,

-For the practitioner there is a realignment from a narcissistic position to a therapeutic position,

-Extensive experience with suffering produces heightened tolerance and acceptance of human suffering (Skovholt & Ronnestad, pp. 100-123).

Summary

A review of the literature found no recent or historic literature on the topic of how marriage and family therapists develop their theoretical orientation. The search did reveal

several quantitative studies concerning which theoretical orientations clinicians ascribe to or use, both for psychologists and MFTs. A subsequent search was performed following the analysis of the data which yielded studies concerning integrative therapies and the common traits and factors shared by most theoretical orientations. Also reviewed was a study that researched theoretical orientation dissonance and two studies that combined qualitative and quantitative methodologies. One study compared personality testing with the choice of theoretical orientation. The other study developed a comprehensive stage development of therapists along with extensive themes which are listed.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore with licensed practicing marriage and family therapists (MFTs) how they formulated and arrived at their theoretical orientations. Data were collected by audiotaping semi-structured, face-to-face interviews of MFTs and were analyzed for emerging and recurrent themes utilizing a phenomenological qualitative research design.

Participants

Participants were licensed therapists who identified themselves as MFTs, who provided 10 or more therapy sessions a week, and who had been practicing for more than five years with either a master's or doctoral degree in family therapy. Participants were recruited from the Dallas-Fort Worth metroplex area. This researcher interviewed 20 MFTs, meeting the above described criteria. This also meets the standard of a 5-25 sample size for a qualitative study (Kvale, 1996). Two participants did not complete the data collection process; therefore none of their data were used.

Protection of Human Participants

This study was reviewed and approved by the Institutional Review Board (IRB) for Texas Woman's University (Appendix F). Confidentiality was protected by assigning each qualified participant a consecutive code number beginning with 01 and the numbers were used on their demographic sheet (Appendix C) and interview protocol (Appendix

D) for identification. The code numbers were assigned from a Master List which was kept in a locked desk drawer in the researcher's private office. Each completed consent form was also kept in the same locked drawer as they were collected. A professional transcription service was contracted with to transcribe the audiotapes. A transcriber was assigned, completed the Human Subjects Protection Training and became part of the research team. Once the audiotapes were transcribed, the hard copies were saved to a flash drive and both were stored in a locked drawer when not in use. The researcher and the transcriptionist were the only ones who had access to the audiotapes which were also stored in a locked drawer after being transcribed.

In order to minimize any emotional risk, the participant controlled the pace of the interview and could stop the interview at any time, take a break, or end the interview if they deemed it necessary. The researcher/therapist, herself, was also alert for any continued signs of discomfort and was prepared to take a break or end the interview if any emotional discomfort was noticed. No emotional discomfort was reported by the participants and neither did the researcher observe any.

All the data obtained will be destroyed after five years except for the consent forms which will be sumitted to the IRB at the completion of the study. The flash drive files will also be deleted in five years.The hard copies of the transcripts, along with the master list, will be shredded at the time when the audiotapes are destroyed.

Instrumentation

An audiotaped interview of each participant was the vehicle for gathering the data. An interview protocol (Appendix D) was developed to ensure accuracy and was

used for the collection of field notes. The interview used two open-ended questions to gather the data.

Interview Question 1: What is your theoretical orientation?

Interview Question 2: Would you tell me the story of how you arrived at that?

The researcher, herself, was an integral part of the instrumentation, data collection and analysis. The research process was more than just questions and answers. It was a collaborative process between the participant and interviewee that provided the aesthetically rich narratives that allowed the essence of the phenomenon to unfold (Morrisette, 1999).

Collection of Data

In order not to compromise her own study, this researcher's goal was to bracket her preconceptions so as to not inject hypotheses, questions, or personal experience in the data collection and analysis (Creswell, 1998). This was done in an attempt to allow the participants' meanings to emerge freely (Rosenblatt & Fischer, 1993). Before beginning data collection, the researcher created a narrative description of her own theoretical orientation and how she arrived at that. She was heavily influenced by feminist family therapy theories and arrived at that through her first two practica. In a free flow response, this researcher asked herself the interview questions. This narrative of her own story was then set aside and bracketed to allow her participants' stories to be heard without the encumbrance of her own.

The proposed study was submitted for approval to the IRB. Once approval was granted, the proposal was then submitted to the graduate school for final approval. Upon

receipt of the graduate school approval, recruitment began. In order to avoid direct solicitation, fliers (Appendix A) were used to recruit participants and were mailed and hand delivered to area agencies, institutions, and offices where family services are offered. Handouts were personally passed at conferences, professional organization meetings, and other places where MFTs gather. Snowball sampling, a nonprobability sampling method where each participant was asked to suggest other qualified therapists and/or pass out the recruitment fliers, was a main source for recruitment in the study (Babbie, 1998).

Once a therapist, after seeing the recruitment flyer, made contact with the researcher directly, the researcher's first step was to confirm that the therapist met the study criteria. Once that was determined, the researcher answered any other questions and the therapist agreed to be a part of the study. An appointment for the interview was arranged at the setting and time of the participant's choice and a code number assigned. Upon arrival for the interview, this researcher introduced herself and prepared for the interview by arranging the equipment (tape recorder, pens, and interview forms). The consent form (Appendix B) was given to the potential participant to review. Once agreed to, the consent form was signed by the participant as directed by the interview protocol (Appendix D). The participant had the opportunity of requesting a summary of the results by providing contact information on the consent form. After being given another opportunity for any further questions or concerns, audiotaping began after a short test for audibility. The interview protocol was followed as outlined. The demographic sheet (Appendix C) was completed after the interview concluded. Participants were again

thanked for their time and assistance. A copy of the consent form and the researcher's business card were left with the participant along with additional fliers to pass along to their colleagues if they agreed to do so. The researcher maintained a professional stance throughout the interview. Field notes were also taken during and/or immediately after the interview on the interview protocol.

Pilot Study

In order to improve the credibility of this study, a pilot study was conducted. The first three interviews conducted served as the pilot study. This gave the researcher a chance to get feedback from these participants as well as to minimize any potential for errors and to make any necessary modifications. No major modifications were necessary but the pilot study did aid in the comfort of the researcher as data collector. In addition, the data collected from the pilot study was included in the data analysis.

Treatment of Data

A professional transcription service was contracted with to transcribe the audiotapes. Each audiotape was delivered to the transcriber personally by this researcher. When the transcript and the audiotape were returned, the researcher reviewed it for errors. At times the researcher replayed the audiotapes for clarity. Each transcript was then emailed as an attachment or mailed through the post office to the participant who was given a chance to review the transcript of the interview to aid in triangulation (Johnson & Waterfield, 2004; Patton, 2002), reciprocity (Lincoln, 1995), and confirmability (Lincoln & Guba, 1985). Each participant was given seven days to make any additional comments and/or corrections prior to data analysis. Several participants

did make minor adjustments, mainly grammatical and/or spelling. Several made no changes at all. Another widely used and effective method of triangulation (Johnson & Waterfield; Patton) was then employed. After the first five transcripts were reviewed by the participants and returned, transcripts #1, #3, and # 5 were sent to the panel of coders for thematic analysis. Two of the coders were doctoral students in family therapy, had completed the IRB Human Subjects Protection Training, and had successfully taken a doctoral qualitative research course. Both came highly recommended by their professors. The third coder was the major advisor for this study who has also completed the IRB Human Subjects Protection Training. The corresponding demographic information and participant's names were not released although the transcript did contain each participant's code. These analyses were compared with the researcher's coding for any discrepancies. All were in general agreement.

The qualitative data collected were analyzed following the guidelines recommended by Morrissette (1999). Each approved transcript was then read by the researcher after its return from the participant along with any field notes. Once all the data had been collected, the approved transcripts were thoroughly read by the researcher. The transcripts were then read again for content categories which were highlighted by the researcher. The researcher again reread the transcripts to hone and clarify the categories, first order thematic abstraction (Morrissette). The researcher, utilizing the cut and paste capability of her word processing software, pasted the highlighted statements into content categories. The remainder of the transcript was examined for any omissions and any other possible themes. Each complete intact transcript was again re-read and briefly

summarized to facilitate synthesis of the data as a whole, second order thematic cluster (Morrissette). A between persons analysis was conducted on the summarization leading to the emergent theme (Morrissette). After the completion of the analysis, as an additional method of triangulation, a subsequent review of literature was done.

Summary

The purpose of this qualitative phenomenological study was to explore how MFTs developed their theoretical orientations. Participants were practicing MFTs. Recruitment was attained through the use of fliers placed in local agencies, institutions, and offices where family services are offered.

Confidentiality was protected with the use of a coding system. Stringent guidelines were followed in order to protect the participant's confidentiality following the guidelines set by the IRB. All material will be destroyed after five years.

Data were gathered through audiotaped semi-structured interviews. Voluntary and snowball sampling techniques were employed to recruit participants. Once a pre-screening determined eligibility, an appointment was made for an interview. The interview consisted of two open-ended questions and was audio taped. The first three interviews conducted served as a pilot study. Data collection continued until 20 interviews were conducted.

Triangulation was achieved through allowing the participant an opportunity to review the transcript, having a qualified three member panel of coders review the first, third and fifth transcripts for comparison, and reviewing the literature again to find relevant research after the themes that emerged. Data analysis began with taking a hard

copy of the transcript, then cutting and pasting the interview statements into content categories. The data continued to be analyzed until no new themes emerged.

CHAPTER IV

RESULTS

The purpose of this study was to explore with licensed practicing marriage and family therapists (MFTs) how they formulated and arrived at their theoretical orientations. The chapter includes a description of the sample and the themes that emerged from the data analysis and concludes with a summary of the findings.

Characteristics of Participants

The participants were 20 MFTs who met the criteria for this study and volunteered to be interviewed. All were practicing licensed therapists. All the participants practiced in the Dallas-Fort Worth area except one participant who practices in Mexico City, Mexico but has close professional ties in the Dallas and Houston areas. The ratio of female to male was 3:1. The average age was 55.4 years and 17 identified themselves as Caucasians (C) with two African-Americans (AA) and one Hispanic (H). Concerning birth order (B/O), interestingly, one half (10) of the participants indicated they were the oldest with two being the only child. They averaged 1.55 children/stepchildren each and one fourth (5) had no children with one participant not responding. Relationship status (R/S) results were 14 married, four divorced, and two single.

Table 1
Participants' Personal Demographics

P#	Age	M-F	ETHNI	B/O	R/S	#/CHILH
1	50+	f	C	old	m	2 step
2	54	m	C	2nd	s	0
3	34	m	C	2nd	m	0
*5	54	f	C	old	m	2
6	64	m	C	old	m	1
7	69	m	C	old	m	1
*9	60	f	C	old	m	3
10	67	f	C	?	m	4
11	65+	f	C	y	m	2
12	57	f	C	old	d	2
13	66	f	C	only	d	4
14	57	f	AA	old	d	2
15	46	f	H	y	m	2
16	60	m	AA	only	d	n/a
17	62	f	C	2nd	m	3
18	51	f	C	old	m	1
19	58	f	C	old	m	0
20	49	f	C	old	m	2
21	32	f	C	y	m	0
22	53	f	C	2nd	s	0
	M=55.4	m=5 f=15	C=17 AA=2 H=1	old=10 2nd=4 y=3 on=2	m=14 s=2 d-4	M=1.55

****participant #4 and #8 did not complete interview process****

Of the 20 participants, nine held master's degrees (m) in family therapy (or equivalent) and 11 held Ph.D.s (p) in family therapy (or equivalent). More than half (13) of the participants held more than one of these professional licenses: Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Licensed Chemical Dependence Counselor (LCDC), Licensed Specialist in School Psychology (LSSP), and Advanced Practitioner of Nursing (APN).

Two-thirds (15) of the participants had other advanced degrees (+ Adv Degree) in addition to their advanced degree in family therapy. Several of the participants completed all the available MFT courses offered in their initial mental health degree and then in addition completed an advanced MFT degree or the equivalent. The participants averaged a total of 22.65 years since graduating with an advanced mental health degree with the least being seven years and averaged 15.75 years since completing their official MFT training.

As for where the participants received their professional training, 16 of the participants graduated from programs in the state of Texas with 13 of them from the north Texas area, eight from the Denton area (7- TWU and 1-UNT), three from Commerce, and 2 from Dallas, with the remaining three from Houston. Four of the participants graduated from programs out of state, one from the northeast area and three from universities in the Midwest. The most graduates from one university were six and spanned 10 years. Only one participant graduated from a CACREP accredited program however, five graduated from COAMMFTE accredited programs.

Table 2 Participants' Professional Demographics

P#	Ed Lvl	Lic(s)	Yrs pr	Yrs/MFT	+ Ad Degree
1	m	LPC/LMFT/LCSW	29	29	
2	p	LPC	17	4	Psy
3	p	LPC/LMFT	12	5	Ch/dev
*5	m	LPC/LMFT	7	7	
6	p*	LPC/LMFT	24	24	Seminary
7	p	LPC/LMFT	33	25	
*9	p	LPC	9	9	MAIS
10	m*	LPC/MFT/LCSW	26	26	Psy
11	m*	LPC/LMFT	34	27	Ch/dev
12	m*	LPC/MFT/LCSW	29	21	MSW
13	m	LPC/MFT/CD/Sup	20	20	
14	p	LCSW	34	2	Seminary
15	m	LMFT/Sup	23	23	
16	p	LMFT/Sup	32	9	MLA
17	m*	LPC/LMFT/Sup	29	19	Psy
18	p*	LPC/APN	7	7	Nursing
19	p*	LMFT/LSSP/Sup	31	22	Psy
20	m*	LMFT/LCSW	21	20	MSW
21	p	LMFT	10	4	Psy
22	p	LPC/LMFT/Sup	18	12	Psy
	m=9 p=11 * equiv		22.25	15.75	

*****participant #4 and #8 did not complete interview****

Regarding a description of the participants' practice, all but six participants worked with individuals, with only one participant leading groups (Appendix F). Three participants indicated that they worked only with couples. All but two participants worked with families, and four participants indicated that they worked in some other

format. Three participants indicated that they only worked with families and one participant indicated that 95 percent of their practice was with couples. The other participants indicated that their practices consisted of individual, family, couple, group, and other.

One half (10) of the participants indicated that they only worked in private practice setting (Appendix G). Four worked in a training agency setting only. One participant worked only in a school setting. Three participants indicated that they split their practice between the training agency, their private practice, and other settings, while two participants indicated that they split their practice between the training agency (85% or more) and their private practice (15% or less).

Eleven of the participants indicated that they were on managed-care panels and slightly more than half of the participants had an average of 15 sessions or fewer a week, but all had at least 10 sessions per week. Only four averaged more than 21 sessions per week. The average income was between $43,000 and $52,999.

Findings

All the participants related their stories with great energy, excitement and passion. Their individual professional theoretical journeys to the present moment were multi-leveled, personal, and experiential. The results of the data analysis emerged with two themes: a theme of an initial theoretical orientation was revealed first with a progressive process as more experience and practice was gained to a theme of convergence, a process where personal and professional experiences merge with theoretical orientation until

congruence occurs. These themes are termed: Initial Orientation and Convergence to a Personal Practice Orientation (Appendix G).

Theme #1: Initial Orientation

In response to "What is your theoretical orientation?" all but three participants named an orientation, The most named orientation in response to the first question was post modern (5) followed closely by systemic (4). Nineteen family therapy orientations were named and 13 psychological theories were mentioned. Only two participants (1-PhD and 1-Masters) described themselves eclectic.

Several of the participants recounted their journeys from one profession to another until they found family therapy as evidenced by this white female therapist narrative about how her training as a psychologist was too driven by pathology and did not work for her:

> I was trained as a traditional psychologist and fairly analytic and fairly detached and fairly expert position and fairly psychopathological. And I never found comfort. I never found that to be at least my own comfort therapy, comfort in a sense that it wasn't -- were those useful ideas when I sat down with them. No, they weren't useful things and so I was on a search really for things that might have comfort, sent me on a search. I really did not like the pathological idea of assessing [in my other training]...and trying to find out the pathology and fixing it...that never fit with me....It wasn't till I moved to Texas, started in graduate school, that I met Harry Goolishan. P19

This white male therapist also described his journey to family therapy and a fit while as a minister, he outgrew his church view:

> During the course of my studies in Louvain, I began to move more and more away from official church teaching I felt I couldn't, ahh, you know continue in church ministry teaching things that I no longer could be ascribe to. So, I eventually kind of ended up working myself out of church ministry, and so out of a job… It [systems] brought together all those past experiences for me, both on the level of theology, ahh, umm, counseling, umm, pastoral ministry, family of origin, all of those kinds of things… P6

Another African-American female therapist talks about how she outgrew her previous training in social work where she realized that it did not fit with what she was experiencing:

> I was working in, ah, the physical abuse component and then I, ah, was a trainer and then I worked with, ah, towards the end I worked with, ah, ah, young people who were, ah, growing up in foster care, and then finally worked with, ah, foster and adoptive parents, ah, along that line as a supervisor in that, ah, aspect of it. But I really got a chance to look at how sometimes people even move from that role even there as being, again, the victim to being, ah, you know, now, okay, I'm grown up and now I'm victimizing my child, so I really wanted to look more from, you know, just this particular act of aspect of it to a wider, broader picture and what other

kinds of things come into play and how do they affect each other. Well, I think that things became a little more, ah, clear in some ways for me when I was in school just recently with the Ph.D. level, able to look at some of the theories that were in place. Ah, initially when I was doing all my thinking, it was more of an intuitive kind of feel that -- that a feeling that, ah, there's -- there's something else that's going on, ah, more so than what we understand and, ah, I could see that there was a pattern in place, and it specifically when you're looking in families who have been in abusive or neglectful situation, you can see generations of people involved, but just that feeling that there was a, ah, there -- there was more to the situation. And I was able to look at, ah, you know -- look more from the systems, again, perspective. P14

Another therapist describes how she saw more results from her referrals to a family therapy clinic that she ended up joining them and getting additional training:

Well, I was working for Children's Protective Services years, years, years ago and left to go to graduate school…I was always looking for therapists to refer families to and found that I was most comfortable referring to [name]… I saw it first as a referring person and then because they had such a strong emphasis on the multiple helpers being involved in the therapy…I was involved in lots of therapy over there as a worker…[with an] undergraduate degree at UT Austin in social work then a graduate degree …I think social work is systemic, that was the theory…but the

> context maybe was a bit different and the meaning that -- in the programs I was in, the meaning was a bit different than what I would say my systemic thinking is now based on the influence of this group. P20

Nearly all of the participants (90%), in recounting their stories and without any prompting, described an experience of fit and resonance as this initial theoretical orientation appeared to choose them. One of the white male therapists described it like this:

> ...the [Imago] approach...made sense to me. ... theoretically, it made sense to me...[and] experientially it made sense. P7

Although a white female participant talked about it in this way:

> I think it is a more pragmatic approach [solution-focused], which also fits with my, the way that I, my style the way that I see my moving through life. And that could be because I have a background in accounting... So that philosophy for some reason really fit. P22

Other influences that aided in experience of fit and affected their choice of initial theoretical orientation included early family experiences similar to this description given by this white female therapist:

> I was raised in a family by a father who would ...look at the multiple-realities, the multiple-perspectives...and so then when family therapy came along... I knew this is where I belonged... So I have, looking back, the advantage of, one, having a dad who really taught me about multiple realities and looking at things from different perspectives...I had heard

where I think many people sought her [my mother] out also to get support…she was a good listener. P1

Books and authors were often referred to as highly influential in how several of the therapists arrived at their initial theoretical orientations as this white male and African-American female relate:

> Really even before any of this, the first thing that really steered me toward, and it's amazing I know that it affects my interpersonal style and my therapy hugely. I don't know whether to give it a 30 percent or 50 percent or what size, but it is huge, and that is simply reading the book *How to Win Friends and Influence People*. P2

> [I use] holistic systems…through Andrew Billingsley and Robert Hill and W. E. B. DuBois and …they all talk about …[it] from the cultural perspective. They look at the history of an African-American people … of our heritage that, ah -- that contribute…. P14

Other therapists related how their positive and negative supervisory experiences affected their choice of initial theoretical orientation as this white female describes:

> So [my professor] was talking about emotional cutoff and I went "Ohhhhh," that's what my family does. [So Bowenian fit]…first of all because of [my professor], I think he practiced what [he] preached…The other professor …I was turned off by him. He didn't walk the talk … so I wasn't much interested in the other theories he taught …which in hindsight now may not have been fair to the theory. P9

Theme #2: Convergence to a Personal Practice Orientation

In response to the second interview question of "Would you tell me the story of how you arrived at that?", each participant recounted their individual story of the theories (their initial one and others) that influenced them along with other external influences. It was if the more they talked about one orientation or philosophy, the more it led them to add something else. The theme that emerged from this process was how, through analyzing the participants' stories, it appears that a personal practice orientation develops both through personal and professional experience over time and that it blends with their initial theoretical orientation that is not omitted but is in addition, while also adding depth to their meaning and understanding of how to be the most therapeutic.

After identifying an initial theoretical orientation, all the participants identified other influential orientations as well. An example is this quote from a white female therapist who initially identified herself as Bowenian:

> I think a lot of theories are essentially the same. I mean there are a lot of similarities such as respect for clients which is something though I didn't feel about strategic ....and I am thinking about Rogers. P9

Many of the therapists placed significance on relational factors as this white male explains:

> I am much more likely to focus on the therapeutic relationship than any model at this point. I don't believe the model necessarily is what brings people into some place of healing or some place of desired outcome... I think once that dance starts with a client the model may become more or

less important. … [I] would rather respond to them in a more human way at that moment… The spiritual nature of doing therapy requires that I…. I...uhh connect deeply with myself and connect deeply with those with whom I work… I don't find that sort of essence in models and if I do find that sort of essence in models….[there] seems to be something that models with their techniques or even assumptions can't quite get to because …[there] is something a bit mysterious about it….something a bit ineffable about it…something a bit ...unknown about it. P3

Another white male therapist points out how music and past church experiences now are also part of his therapeutic influences:

A strange influence of what I do is my movies and my music… I'll listen to music that comes from movies or any other kind of music and it moves me so much, and I feel like it's so deep and so spiritual, so real, and so beautiful, and I think how can I bring this [to my therapy]…[and]…Well, I grew up in the church…I wonder how -- how much, you know, the sitting around in the prayer meetings has helped [my therapy]… you might have a prayer request…[and help by] validating her or being her friend. P2

This Hispanic female therapist talked about the significant shifts that occurred after her initial theoretical orientation was reached:

So I think the first break for me came, I think it was '87 when I met Tom and just the whole notion of reflecting teams. I know that really changed the ways I looked at the world…..and just …[being]with [name] really

changed me. I think that's the biggest influence I've ever had....ah, the openness, the tentativeness.....that was a big thing for me. Again, most people tell me that my personality doesn't go with being tentative, but being tentative and not claiming to know or have the truth, I think transformed me as a person...more, more first as a person and then as a therapist...I love theory. So I started to read Maturana and Bateson and I just started to look for other frameworks that would come outside of the field...reading Ken Gergen's *The Saturated Self*, more than Ken Gergen, Walter Truet Andersons'... *Reality Isn't What It Used To Be*.... other theoretician I really like is Walter Benjamin, and Benjamin talks about translation in language and multiple meanings...all these authors come from the Talmud. They come from the Jewish heritage...of telling and retelling... [and] comes from the Talmud. I don't believe you can do this work if you don't change the way you see the world...I know that [post modern] really changed the ways I looked at the world.... just moving from being strategic...really changed my outlook on life and that's when, ah, the next big change came when, ah, Anderson and Goolishan article was published in '88, The Human Systems of Linguistic Systems...that article just really changed the way I thought. And, ah, made a big, big shift in me...Most people tell me that my personality doesn't go with being tentative, but being tentative and not claiming to know or have the

truth, I think transformed me as a person ---more first as a person and then as a therapist. P15

Interestingly enough is this quote from an African-American female therapist where during her post mental health training, her understanding becomes one where even though she blends some theories together, she is not eclectic:

> And, you know, that's one of the things that I like[d about my Ph.D. training]...the fact that while they teach us about Bowen, they teach us about different kinds of things, they, ah, don't say, Okay. And this is the only one that you must study. You get a chance to arrive at that from my points of view. At this time, we get a chance to look at that....and that was what I was hoping when I first went into the graduate school that I would be able to understand the theories and then to decide, okay, what is it that I really want to do, because, ah, when I first went in, ah, if you had asked me this question before I went to school this last time, then I would have said, Well, I'm eclectical, or something along that line, and not have a clue about where I really fit in. P14

This white female therapist talked about how, even though she defined herself strictly with one theoretical orientation, she used other theories to better aid her clients:

> [I am] ...definitely solution focused....ah, not that I would stick just strictly with that because of course like everything, it kind of depends on the client in some ways. So, ah, for example I have one individual client who's been through tons of previous counseling. She's kind of one of

those long-term ones. And she's real intellectual and so she wants to, to discuss, you know, the meaning of the universe almost. And so I decided, well, that's okay. You know, so I became much more--I'm more narrative with her. But I still have an underlying solution focused view. So when she comes up with something that seems like an exception or something that is more solution focused then I just hop on it. P22

Another white female therapist talked about how her own growth affected her theoretical orientation:

....and I think, too, that my own process of change is important...Change for me is hard...and so I think I integrate all these into my practice. It's sort of my own personal growth comes into this room. P5

Of those therapists that identified themselves as eclectic, this white female therapist described her personal practice orientation in this way:

I was eclectic to start...I've had at various times various needs for, ah, different influences and have utilized them and used them really without thinking at this point... I really can't say that I buy into anything 100 percent, but I use something from just about everything I've been exposed to...it blurs. P12

Summary

The characteristics of the participants were described and included tables of both personal and professional demographics. Appendices of the descriptions of the participants' work setting and practice were discussed. The results of the data analysis

emerged as two themes: a theme of an initial theoretical orientation was revealed first with a progressive process as more experience and practice was gained to a theme of convergence where a personal and professional orientation emerged. Relevant quotes for each theme were also given to support the findings along with other influences the participants mentioned as part of their stories.

CHAPTER V

DISCUSSION, CONCLUSIONS, IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS

This study explored how marriage and family therapists (MFTs) arrived at their theoretical orientations. Twenty licensed practicing MFTs agreed to participate in a semi-structured face-to-face audiotaped interview. A qualitative methodology using a phenomenological approach was utilized to collect and analyze the data. This chapter discusses the findings, conclusions, implications, and limitations. Recommendations are also made.

Discussion of Findings

After the data analysis, two themes emerged from the research questions.

Initial Orientation

Consistent with the participants' stories was the experience of being drawn to an initial theoretical orientation. Many of the participants recounted when that occurred and described it as feeling of fit or stated how much it just made sense to them. Several of the participants, as the interview progressed, added other outside influences that deepened that fit and resonance. These included early family experiences, significant books and/or authors, music, church experiences, and both positive and negative supervisory experiences. In fact, the extent to which the personal and professional experiences were intertwined was inseparable and completely unexpected. Nearly every time one of the

participants mentioned a theory, they did it in connection with a personal experience, be it a supervisor, an author, or a personal memory. This could explain how past research into theoretical orientation led to a variety of quantitative methods and attempts to measure what theoretical orientation was being used the most, but never really captured the complete picture. As each study became more complex, they remained difficult to compare as there was little standardization in definition, in format (open-ended or forced choice), or what exactly was surveyed, theoretical orientation(s), model(s) or, intervention(s). The results of this study suggest that clinicians have a starting point, a preferred theoretical orientation that fits with them and that this theoretical orientation evolves and may change. It is as though an initial theoretical orientation is like the foundation and framework of a house, essential but structurally skeletal where the sheet rock, windows, and roof add substantive depth and wholeness. It is then ,when occupied and furnished to the individual's taste, the foundation and frame become invisible, but crucial to the stability of the home.

This initial theoretical orientation process appears to support Skovholt's and Ronnestad's (1992) themes that "beginning practitioners rely on external expertise while senior practitioners rely on internal expertise" (p. 107), that "conceptual system and working role style become increasingly congruent with ones' personality and cognitive schema" (p. 109), and that "development is impacted by multiple sources which are experienced in both common and unique ways" (p. 112).

Several participants also recounted how in their search for fit, they encountered professional training and environments that were not resonant with them or became

limited when the participants went out into the field. This appears to support the idea that the dissonance that can occur when mismatches between theoretical orientation and the practitioner's values happen that may lead to a revision or enlargement of the paradigm or the abandonment of the career (Vasco, Garcia-Marques, & Dryden, 1993).

Convergence to a Personal Practice Orientation

Through the data analysis, it became obvious that the development of an initial theoretical orientation was complex, personal, experiential, and congruent with who the therapists were as people. By the end of the interview, many participants stated that they believed they did not even have a specific theoretical orientation anymore. They described a congruence between their personal and professional lives that just could not be separated. This appears to support Skovholt's and Ronnestad's (1992) themes that "optimal professional development is a long slow and erratic process" (p. 112), that "post training years are critical for optimal development" (p. 114), that "interpersonal encounters are more influential than impersonal data" (p. 116), and that "extensive experience with suffering produces heightened tolerance and acceptance of human suffering" (p. 123).

Several of the MFTs stated that the quality of the relationship with their clients was significantly more important than what orientation, model, or intervention they identified with. This finding appears to support the research that common factors between theoretical orientations (Sprenkle and Blow, 2004) and multi-level models of therapeutic change (Sexton, Ridley, & Kleiner, 2004) may be more indicative of therapeutic efficacy

than theoretical orientation which, according to Lambert and Bergin (1994), may be a minimal factor (15% at the most).

Several of the participants narrated in detail what their personal practice models were and revealed a fluidity of response to differing circumstances. Also, it appeared that some of the therapists developed a cognitive lack of awareness of a single theoretical orientation. This is supported not only by the themes of Skovholt and Ronnestad (1992) but also may reflect a normal process of experience and development as Norcross (1985) notes: "It is the talented clinician who is able to respond effectively to the unique needs of different clients and settings" (p. 12).

Several of the participants also recounted how their own personal growth became an important influence in their practice. One participant noted how her own attempts at change gave her patience and compassion for her clients as they attempted to change. This could relate to Skovholt's and Ronnestad's (1992) theme that "as the professional matures, continuous professional reflection becomes the central development process" (p. 105). The findings of this study also appear to support Poznanski's and McLennan's (2003) conclusion "that theoretical orientation seems to be intimately associated with the person of the practitioner" (p. 226).

Conclusions

The findings of this study suggest that experienced MFTs integrate a variety of theories, training experiences, personal experiences, and the meanings they make of these, so that when an experienced MFT talks about his/her theoretical orientation(s), an MFT talks about self to a large degree. This was an unexpected finding. Due to the open-

endedness and scope of this study, the results may speak more about how MFTs talk about their theoretical orientations. Nearly 100% of the participants, without any prompting, described those moments when something in them resonated with a particular theory. The results also suggest that this is a very individual process since what resonated for some participants about a specific theory was not what drew others to the same theory. The results also suggest that the MFT training received by the participants of this study was diverse enough for resonance and fit to occur, be it through a supervisor, professor, a certain author, a certain book, a certain theory or a certain seminar.

This study also found that time and experience, both professional and personal, may lead to a process of convergence where a personal practice orientation develops from an initial theoretical orientation. It also appears that with an average age of more than 55 years for the participants of this study, the influence of lifespan development could also be intertwined in this convergence to a personal practice orientation. Another surprising result was that no significant differences were found between the demographic groups. The demographic variables of gender and level of education were potentially thought to make a difference, but none was evident. This may be due to the small number of participants in each demographic group.

Implications

The results of this study have implications for academic settings, training settings, licensing boards, and continuing education programs in order to best assist students/professionals to become/be the therapists they want to be. Present and future therapists need to know how to examine themselves in regard to their theoretical

orientation through personal growth skills to continue to expand and grow. Students could gain from exposure to diverse theoretical orientations. This could aid them in locating their fit and resonance. Developed professors and supervisors, who are aware themselves of this evolving process, can greatly assist the student toward locating congruence and prevent the dissonance that can lead to disillusion, burnout, ethics violations, and drop out . This may be accomplished by encouraging students to find the family therapy model that most resonates with them and to become proficient during training while continuing to be exposed to other models. The importance of this theoretical fit and resonance clearly needs to be a major factor in the choice/placement of practicum sites so that practicum students have the optimal environment to polish and perfect their model of choice/fit.

Another implication of this study is that basic relational skills, along with a practice of self examination, appear to be necessary to navigate, not only the initial theoretical orientation, but those periods of dissonance that need to occur as growth occurs until congruence is reached again.

Limitations

The limitations of this study that may affect the transferability of these findings are: a.) that a limited geographic area was represented, b.) that this study was preliminary research, c.) that only those MFTs comfortable about themselves and their practice volunteered to be interviewed, d.) that Caucasian women were over-represented, and e.) that this was a small study and not representative of the MFT population.

Recommendations

As the scope of this research was exploratory and open-ended, recommendations are for much further study as the preliminary results of this study may speak more about how MFTs talk about their theoretical orientations. Further and continued research is needed. To follow up on this study's results, the assumptions should be widened and the scope narrowed by having more detailed research questions especially concerning the personal fit and resonance these participants experienced. Additional research questions could include: asking how an MFT defines theoretical orientation (for the sake of comparison), if their definitions have changed over time, what influenced that change, and how great is the influence of relational factors. In addition, the interview structure could include getting more detailed examples of where and how theoretical orientation changes occurred.

Other proposed areas of focus would be to determine when and how convergence takes place and the inextricability between theoretical orientation and the person of the therapist as there appears to be a gap in the research about the relationship between those two. Due to this inextricability, extreme caution needs to be taken when evaluating different orientations. Also further research should be done with diverse ethnic groups, more males, therapists from different training programs, and in other areas of the country to confirm the transferability of this study's results.

Different methodologies, such as a longitudinal study following trainees for 10 years, are recommended, perhaps even a larger random sample study of a clinic setting, professional association or another MFT group. A study of this type could be beneficial

to determine, if during training, how immersion into practicing a different single theoretical orientation after fit and resonance are found affects a therapist's professional development. Additionally, this type of study could locate if/when/how incongruence and dissonance occurs between a professional's theoretical orientation and their worldview and personal values that may halt professional/personal development and where professional intervention could be done so as "to do no harm."

The results of this study also call attention to the need for more research into the common factors: of theoretical orientations; the interaction between therapist, client, and their relationship; the expectancy of both therapist and client; and other factors outside of a particular model. Also it is recommended that research and development continue into theories of therapeutic change. It is also recommended that, as supervisors, academic professors, and trainers understand, guide, and aid their students in finding a fit between a theoretical orientation and who their students are as people, exposure to several diverse theoretical orientations as well as general relational skills appear to be very beneficial in aiding in this development. This then calls for a need for more MFT theories from diverse cultures, ethnicities, and gender, not only to aid in students finding the fit they need, but to add the depth that is needed for a field to continue to expand and be resonant with the community it is attempting to heal.

Summary

With two themes emerging from the data analysis, initial theoretical orientation was discussed first along with its relevance to past research into theoretical orientation and therapist development. The second theme, convergence to a personal practice

orientation, was also discussed along with its possible relation to other research findings concerning professional development, common factors between theoretical orientations, and the personal growth of the therapist.

Conclusions concerning the results were drawn and implications for initial training and continuing education programs were discussed as were the study's limitations. Several recommendations regarding future research were made.

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APPENDIX A

Flyer

ATTENTION MARRIAGE AND FAMILY THERAPISTS !!!!!!

SEEKING MFTs TO INTERVIEW ABOUT THEIR THEORETICAL ORIENTATIONS

DO YOU IDENTIFY YOURSELF AS A MARRIAGE AND FAMILY THERAPIST?

DO YOU HAVE A MASTER'S OR DOCTORAL DEGREE IN FAMILY THERAPY?

DO YOU HAVE AT LEAST 10 OR MORE SESSIONS PER WEEK ON AVERAGE?

HAVE YOU BEEN PRACTICING FOR AT LEAST 5 YEARS?

IF YES TO ALL THE ABOVE, THEN PLEASE CALL 214 793-0158 TO PARTICIPATE IN A NEW STUDY.

The interview will be audio-taped, confidential, and will not take more than 30 minutes of your valuable time. The interview will focus on what your theoretical orientation is and how you arrived at that? The purpose of this study is to explore how MFTs formulate and arrive at their theoretical orientations. Please call Elizabeth Zedaran at 214 793-0158 or email to processmatters2@yahoo.com to schedule an appointment time and she will interview you at the location of your choice. Participation is voluntary and you may withdraw at any time.

Elizabeth is a licensed therapist and PhD candidate at Texas Woman's University in family therapy and is being advised by Linda J. Brock, PhD, 940 898-2713.

APPENDIX B

Consent Form

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: How Marriage and Family Therapists Arrived at Their Theoretical Orientation: A Qualitative Study.

Investigator: Elizabeth H. Zedaran, M.S. 214 793-0158, processmatters2@yahoo.com
Advisor: Linda Brock, PhD 940 898-2713, LBrock@mail.twu.edu

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Zedaran's dissertation at Texas Woman's University. The purpose of this research is to explore with licensed and practicing marriage and family therapists how they formulated and arrived at their theoretical orientations.

Research Procedure

For this study, the investigator will conduct face-to-face interviews of marriage and family therapists. This interview will be done at a private location agreed upon by you and the investigator. You will be audio taped during the face-to-face interview. The purpose of the audio taping is to provide a transcript of the information discussed in the interview and to assure the accuracy of the reporting of that information. Your maximum total time commitment in the study is estimated to be approximately one half hour.

Potential Risks

There is a risk of emotional discomfort. You may at any time stop the interview, take a break, or end your participation. The researcher, herself, will ask if you would like to continue or take a break if she notices any continued signs of discomfort. There is also a risk that as a result of your participation in the study a release of confidential information could occur. Confidentiality will be protected to the extent that it is allowed by law. A code number, rather than your real name, will be used on the audiotape and transcription. Only the investigator and her adviser will have access to the tapes. The tapes, hard copies of the transcriptions, and the flash drive containing the transcription text will be stored in a locked filing cabinet in the investigator's office. The tapes and flash drive will be erased and the hard copies of the transcriptions will be shredded within five years. It is anticipated that the results of this study will be published in the investigator's dissertation as well as in other research publications. However, no names or other identifying information will be included in any publication.

_____
Participant Initials

The researcher will try to prevent any problem that could happen because of this research. You should let the researcher know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. The only direct benefit of this study to you is that at the completion of the study a summary of the results will be mailed to you upon request. An indirect benefit is that your participation may benefit the field through the results of this study.*

Questions Regarding the Study

If you have any questions about the research study you may ask the researchers; their phone numbers are at the top of this form. If you have any questions about your rights as a participant in this research or the way this study has being conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu. You will be given a copy of this signed and dated consent form to keep.

_____ _____

Signature of Participant Date

***If you would like to receive a summary of the results of this study, please provide an address to which the summary should be sent:**

_____

_____

_____

APPENDIX C

Demographics

DEMOGRAPHICS

DATE OF INTERVIEW_____ PARTICIPANT CODE #_____

AGE:_____

FEMALE_____ MALE_____

RACE/ETHNICITY: Asian_____ African-American____ Caucasian____ Hispanic ____Other_____

YOUR BIRTH ORDER: Only child____ oldest_____ 2nd_____ 3rd_____ #_____ youngest____

RELATIONSHIP STATUS: Married___ Single__ Divorced___ Widowed___ Other___

NUMBER OF CHILDREN: _____ AGES: ____, ____,____, ____, ____, _____

EDUCATIONAL LEVEL:

Bachelor's degree in (field) _____ on (date) _____, from _____

Master's degree in (field) _____ on (date) _____, from _____

Doctoral degree in (field) _____ on (date) _____, from _____

Other (field) _____ on (date)_____, from _____

COAMMFTE accredited yes _____ no _____

CACREP accredited yes _____ no _____

LICENSE(S) HELD: LMFT ____ LPC____ LMSW_____ Approved Supervisor_____

SOCIO-ECONOMIC LEVEL: below $20,000 _____ $20,000-34,999_____ $35,000-42,999 _____
$43,000-52,999 _____ $53,000-above_____

WORK SETTING AND %: Private Practice_____ Agency_____ Other_____

% OF PRACTICE: individual _____ couple _____ family _____ group _____ other _____

SPECIALTIES: _____

HOURS PER WEEK IN SESSION: _____

POPULATION OF PRACTICE: _____

MANAGED CARE PROVIDER? yes_____ no_____

APPENDIX D

Interview Protocol

Interview Protocol

Participant's code_____

Date of interview_____

"As we discussed earlier, this study is for the purpose of exploring how MFTs formulate and arrive at their theoretical orientation."

(Give consent form).

"Are there any questions that you have?"

(If yes, I will answer them to my best ability).

(If no, then) "***Well, if you have no further questions, then let me press play***."

"***What is your theoretical orientation?"***

(use prompts as needed)

"***Would you tell me the story of how you arrived at that***?"

(use prompts as needed)

<u>Prompts</u>:

Oh.
Could you say more about that?
Smiling.
Summarizing.
Yes.
Yeah.
I see.
Silence.
Mm-hm.
Uhhh....
Nodding.
Anything else?
What was that like?

And by that you mean.....?
Sooo.....
What else comes to mind?
Laughing.
How has that influenced you?
How was that for you?

".....and thank you."

(Turn tape recorder off.)

" Would you know of anyone else who meets the requirements that might like to participate in this study?"

(If yes)
"Please feel free to take a few of these fliers to anyone who might be interested?"

PILOT STUDY

"Is there anything else I should have added or done differently that would have been beneficial?"

NOTE TO RESEARCHER:

Give participant demographic sheet before you leave.

APPENDIX E

Description of Participants' Family Therapy Practice

DESCRIPTION OF PARTICIPANTS FAMILY THERAPY PRACTICE

P#	Indiv	Couple	Family	Group	Other
1		20	75		5
2		80	15		5
3	50	25	20		5
5	85	15			
6	15	70	15		
7	4	95	1		
9	50	30	20		
10	60	15	20	5	
11	60	38	2		
12	50	50			
13		60	40		
14			100		
15			100		
16	20	10	70		
17			100		
18	40	20	40		
19	30	40	30		
20	30	10	60		
21	15	10	75		
22	10	10	40		40

****participant #4 and #8 did not complete interview process****

APPENDIX F

Participants' Work Settings

PARTICIPANT'S WORK SETTINGS

P#	Private	Agency	Other
1	20	75	5
2	80	15	5
3*	100		
5	100		
6	100		
7*	100		
9	100		
10	100		
11	100		
12	100		
13	100		
14		100	
15	100		
16		100	
17			100
18	35	30	35
19	15	85	
20	10	90	
21		100	
22		100	

****participant #4 and #8 did not complete interview process****

APPENDIX G

Results Grid

RESEARCH QUESTION	INTERVIEW QUESTION	THEMES
How do marriage and family therapists arrive at their personal theoretical orientations?	1. What is your theoretical orientation?	Initial Orientation #1-post modern #2-systems
	2. Would you tell me the story of how you arrived at that?	Convergence to a Personal Practice Orientation