

EXPLORING THE EXPERIENCES OF COUPLE AND FAMILY THERAPISTS  
LEARNING AND USING AN EVIDENCE-BASED PRACTICE

by

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## ABSTRACT

Couple and family therapists are rarely the focus of research yet are critical for positive outcomes in therapy. The field of couple and family therapy includes diverse theoretical approaches that focus on relationships and the environment as part of the understanding of how challenges emerge for couples and families as well a source of resources to help deal with those challenges. Initially developed in the medical field, evidence-based practices now pervade mental health fields including couple and family therapy. The attempts to integrate evidence-based approaches into the practice of couple and family therapy have been controversial resulting in passionate and at times divisive dialogue. The aims of this research project were to explore what influenced couple and family therapists to use an evidence-based practice and what do couple and family therapists experience when learning an evidence-based approach to working with couples and families.

To examine these questions, a literature review was completed to explore the benefits, challenges, and social justice considerations of evidence-based practices. A total of 14 couple and family therapists were then interviewed about their experience with learning an evidence-based approach. The research was guided methodologically by interpretive phenomenological analysis. Drawing on phenomenology, hermeneutics, and ideography, this approach to research focuses on participants' personal meaning and sense making of their experiences of learning an evidence-based practice. Three themes emerged from the participants' experiences including: the supports and challenges in learning; the embodiment of a therapy practice; and the experience of shame while learning.

The analysis of the supports and challenges while learning an evidence-based approach was aided by the use of the Dreyfus model of skill acquisition. The participants found evidence-based approaches a necessary step that helped to structure and organise their learning though a continued focus on an evidence-based approach may limit a therapist's development over the long term. The role of embodiment while learning was examined with the aid of Gendlin's understanding of focusing and Merleau-Ponty's notion that we all have a view from somewhere. For some of the participants, the body was an important source of information and means for learning as they integrated a new therapeutic approach. Finally, shame was an experience discussed by half of the participants and this is further explored in light of one of the action tendencies while experiencing shame, which is to hide from others. This thesis concludes with further examination of each theme and options are discussed for therapists, supervisors, and trainers.



## **LIST OF ABBREVIATIONS USED**

AAMFT	Association of Marriage and Family Therapy
APA	American Psychology Association
ACGC	Atlantic Child Guidance Centre
ABFT	Attachment-Based Family Therapy
CFA	Common factors approach
CFT	Couple and family therapy
CFT	Couple and family therapist
EFT	Emotionally Focused Therapy
EBP	Evidence-based practice
FAD	Family Assessment Device
GCT	Gottman Couples Therapy
IRT	Imago Relationship Therapy
IPA	Interpretive phenomenological analysis
IWK	Izaak Walton Killam Hospital
PP	Possible prompts
RCT	Randomised controlled trial
SoTT	Self-of-the-therapist
SEA	Social Ecological Approach

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## **Chapter 1 Introduction**

### **1.1 Introduction**

The experiences of couple and family therapists learning about and using an evidence-based practice are the focus of the current research project. Engagement with evidence-based practice is growing across many aspects of the mental health and health care systems. As Hunsley (2007) noted, “Initially developed and promoted within medicine, the evidence-based practice model is now being applied in a broad range of health and human service systems, including mental and behavioral health care, social work, education, and criminal justice” (p. 113). The dialogue about the role of evidence-based approaches in the practice of couple and family therapy (CFT) and its research literature is also evolving (Sexton et al., 2011; Sprenkle 2012). Interestingly, while the research delves into what are the best approaches with different populations and presenting issues, little research has explored the experience of CFTs themselves, particularly while learning and adopting an evidence-based practice. Using a hermeneutic-phenomenological approach called interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009), this research project will explore the experiences of couple and family therapists learning and using an evidence-based practice. As researchers, educators, administrators, policy makers, and clinicians struggle with what works best with which populations and when, how best to allocate resources, how best to educate and support clinicians, and the complexity of doing research in real-life settings, this research project has the potential to contribute to those varied dialogues.

## 1.2 The Researcher's Location

Bronfenbrenner (1979) suggested that meaningful analysis of research findings is easier when researchers participated in similar roles and if they are members of the subculture from which the research participants come. I've come to this research as a couple and family therapist who is a Clinical Fellow of the American Association of Marriage and Family Therapy and someone who is trained and certified in evidence-based approaches to working with couples and families. I also train and supervise others who are learning an evidence-based couple or family therapy approach and teach a Family Psychology course at a local university. My practice over the last eight years has included referrals from the provincial Department of Community Services, Children's Aid Society, as part of their Policy 75 services. This directive provides for the preparation of court-ordered psychological, psychiatric, or other assessment by private practitioners for children or families pursuant to *Children and Family Services Act*. The directive also covers requests by child welfare for private assessments or counselling services. I have also worked with numerous couples and families who were in- and out-patients of the Nova Scotia Rehabilitation Centre and clients of the Family Services Association (a community, sliding-scale fee organisation). My current clinical work is primarily in private practice where I see self-referrals as well as couples and families referred by Employee Assistance Programs.

As a couple and family therapist who is both interested in evidence-based practice for my own work while at the same time fascinated by the promise of one-size-fits-all solutions for complex presenting issues, the current research project presents an opportunity to identify and examine both my location, such as is prudent in qualitative

enquiries, and to attempt to illustrate the tensions in the research. As Dahl and Boss (2005) suggest, “Our feelings, beliefs, values, and responses (about things like equality, patriarchy, matriarchy, mastery over nature, acceptance of nature, communitarianism, and individualism) influence the research questions we ask, as well as our interpretation of the data” (p. 67). While continuing to practice, train, teach, and supervise CFT, this embodied experience presents a way of knowing that has the potential to enrich the research as well as the need to be bracketed. This way of knowing “that is often expressed through the body, what it knows, what has been deeply inscribed on it through experience” has a complexity that “can rarely be voiced and named from a distance” (hooks, 1994, p. 91). The following literature review includes a brief overview of the field of couple and family therapy, a review of how evidence-based practice (EBP) is defined including the benefits and challenges of EBPs, and the practice considerations for CFTs.

### **1.3 Literature Review**

Beginning with a general overview of couple and family therapy as a field and a profession, the literature reviewed here will then look briefly at the six approaches to working with couples and families that research participants noted during the interviews as a means to further illustrate the field of CFT. The six approaches that research participants discussed were: the Social Ecological Approach (Ungar, 2011; 2012), Attachment-Based Family Therapy (Diamond, Diamond, & Levy, 2013), Gottman Couples Therapy (Gottman, 1999), Imago Relationship Therapy (Hendrix, 1988), McMaster Approach (Ryan, Epstein, Keitner, Miller, Bishop, 2005), and Emotionally Focused Therapy (Greenberg, Ford, Alden, & Johnson, 1993; Johnson, 2004; Johnson, &

Greenberg, 1987). The research literature about the benefits, challenges, and social justice considerations of evidence-based practices was located across mental health fields such as psychology and social work, and to a lesser extent, the CFT literature. Finally, the practice considerations for CFTs will also be briefly reviewed. The second chapter will provide a review of the methodology and methods proposed for this research project.

### **1.3.1 Couple and Family Therapy**

Couple and family therapy draws from diverse theories and fields, such as: anthropology and cybernetics (Bateson, 1973), attachment theory (Bowlby, 1969), psychology and psychiatry (Bowen, 1978; Haley, 1963; Minuchin, 1974), circular epistemology (Bateson, 1979), sociology (Anderson, 1971; Bernard, 1972; Blumstein & Schwartz, 1983), systems theories (Bertalanffy, 1969; Bronfenbrenner, 1979), biology (Maturana & Varela, 1992), physics (Prigogine, 1978), communications theory and mathematics (Watzlawick, Bavelas, & Jackson, 1967), and other areas as well. Historically, there have been phases of practice and research in the CFT field that favoured particular theorists at different times.

As Hoffman (1981) points out, “the family field did not develop in a straight forward fashion from the ideas of [the] early thinkers” (p. 5). The various strands of the history of CFT in North America have been identified as follows: early 20<sup>th</sup> century social workers who did home visits; couple and family advice offered by religious leaders such as ministers; the child guidance movement that emerged in the 1920s under the leadership of Alfred Adler among others; the formation of the American Association of Marriage and Family Therapy in the 1940s; and the formation of the American Family Therapy Academy in the 1970s (Nichols, 2010). Locally, the Atlantic Child Guidance

Centre (ACGC) was established in the late 1950s out of a perceived need for community-based child and adolescent mental health services. This newly incorporated organisation (ACGC) collaborated with the Izaak Walton Killam Hospital (IWK) to have ACGC provide a relatively wide range of community-based child and adolescent mental health services in the greater Halifax-Dartmouth area. In the mid 1990s the Nova Scotia government required the IWK, the Nova Scotia Hospital, and the ACGC to merge child and adolescent mental health services. The result was a “Trifacilities” service, which in turn led to the IWK taking over all child and adolescent mental health services and in the ACGC ceasing to exist (W. Hollett, personal communication, February 23, 2012).

Family research with families where one member was diagnosed with schizophrenia “was the primary focus of the majority of the pioneers in the family movement” (Guerin, 1976, p.3). Nodes of research, practice and leadership formed in California, Baltimore, Milan, Philadelphia, New York, and Atlanta, each centre with its own charismatic leader. Sometimes, these centres would build on each other’s work while often there were competing paradigms and approaches that each vied to be recognised as the most effective. For example, Don Jackson (1968) built on Bateson’s cybernetic model through the 1960s while Paul Dell (1981; 1985) developed the thinking of families as evolving, nonequilibrium systems capable of transformations. Currently, there are numerous approaches to working with couples and families. Some of the more recent innovations in the field draw on the research about resilience with authors such as Froma Walsh (2006) and Michael Ungar (2011; 2012) developing approaches to working with families that situates them in their social ecologies. Also Sue Johnson’s (2004) development of Emotionally Focused Therapy for working with couples is an

experiential approach heavily influenced by attachment theory and systems theory that is currently gaining popularity.

In general, a couple or family therapy approach views change in terms of the systems of interaction between members of a couple or family. Sprenkle, Davis, and Lebow (2009) explain that “one distinctive common element in all larger systems therapies is conceptualizing human difficulties in relational terms” (p. 35). Problems may originate with an individual, be caused by interactions among family members, or arise from forces external to a couple or family such as a catastrophic event. Each couple or family system develops unique operating rules which govern their behavior and life (Balcom, 1996). CFT emphasises couple and family relationships as an important factor in one’s psychological health. The field of couple and family therapy also understands that the structure and dynamics of family relationships are strongly shaped by forces within the broader social context, such as culture, race, gender, politics, and economics (McGoldrick, 1998).

While the main professional associations use marriage and family therapy to describe the profession and the term “Marriage and Family Therapist” is regulated in every state in the United States, Quebec, and about to be in Ontario, this researcher uses the term couple and family therapy. The term couple refers to two partners who have a relationship history together and anticipate a shared future (Miller, Miller, Nunnally, & Wackman, 1991). My practice and research interests include people who are in a couple relationship, some of whom are married; therefore the term couple is a better fit than marriage for this research project.

There are numerous professions that lay claim to couple and family therapy, the



most prominent being the American Association of Marriage and Family Therapy (AAMFT) which reports that it represents “the professional interests of more than 50,000 marriage and family therapists throughout the United States, Canada and abroad” (American Association of Marriage and Family Therapy, 2012). They describe the field of marriage and family therapy as having evolved to become an area of specialization with numerous approaches. Division 43 of the American Psychological Association is the Society of Family Psychology and provides a “home for psychologists interested in families in their many forms” that “strives to educate the professional community regarding the many advantages of a broader conceptual focus” (American Psychological Association, 2012). The Registry of Marriage and Family Therapy in Canada is a chapter of AAMFT at this time, linking to them to process applications for clinical membership and deferring to the American association’s code of ethics. The Canadian Psychological Association has a Family Psychology Section and describes their members as having interests in “a number of domains, including marital, parental, and sibling relationships, the impact of normative and non-normative stressors on family functioning, and the treatment of psychological and medical problems within a family context” (Canadian Psychological Association, 2012). There are numerous organisations around the world such as the Association of Family Therapy and Systemic Practice in the United Kingdom and the Australian Association of Family Therapy, as well as international associations including the European Family Therapy Association and the International Family Therapy Association.

The field of couple and family therapy has a rich and diverse history over the last 100 years or so. The research literature began to emerge more fully in the 1950s with a

focus on families dealing with schizophrenia and has evolved since then to cover a number of approaches rooted in different paradigms. To further illustrate the field of CFT, I will now briefly describe the six approaches that were discussed by the participants in this research project starting with the Social Ecological Approach to working with families.

### **1.3.1.1 Social Ecological Approach**

The Social Ecological Approach (SEA), developed by Ungar (2011; 2012), is a model of intentional practice that helps individuals and families with complex needs change problem behaviours and sustain those changes by increasing their capacity to navigate and negotiate for resources meaningful to them. Changing this capacity to navigate and negotiate does not mean just changing individuals. Changing the way systems interact with individuals and with other systems can make it more likely that people find meaningful substitutes for problem behaviors. Changing the environment (and the individual's interaction with it) can be just as effective in stimulating change and ensuring the sustainability of any change that is made. SEA builds on several years of research about resilience with youth across 11 countries. Based on this research with 1500 youth, Ungar (2008) defined resilience as follows:

In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways. (p.225)

This definition of resilience highlights two areas of practice: the capacity of families to navigate and to negotiate. These two areas of practice are necessary based on SEA's theory of change, which includes: the 70-20-10 rule, the rule of protective processes, the rule of cumulative resilience, the rule of differential impact, and the rule of maladaptive coping (Ungar, 2004). A theory of change is an essential ingredient in any evidence-based CFT approach and offers a clinician a set of principles to follow when working with couples or families.

The research-based understanding of resilience and what contributes to change in the SEA relates to the two roles of a CFT using this approach. First, families require help navigating to the resources they need to enact their capacities and deal with the stresses in their lives and environments. Secondly, families need help negotiating for resources that are meaningful for them. An effective CFT uses a broad set of skills to intervene effectively. These skills make it more likely they will see people's strengths and hidden resilience. These skills help position CFTs to help others without imposing their own worldview and may seek to validate a family's experience of being marginalized. The SEA is based on decades of research with youth and their families across cultures, countries, and presenting issues. As such, the outcome-based research about this approach is evolving (e.g. Allan & Ungar, 2014); meanwhile any program manager or CFT can point to a substantial body of evidence that incorporates an understanding of human development, elements that contribute to change in family therapy, and a set of strategies for working with families in challenging contexts.

### **1.3.1.2 Attachment-Based Family Therapy**

Attachment-Based Family Therapy (ABFT) is a manualised family therapy model developed to target family and individual processes associated with adolescent suicide and depression. ABFT emerged from interpersonal theories with a foundation in attachment theory and is based in the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process (Diamond, Diamond, & Levy, 2013). ABFT is an emotion-focused therapy that focuses on the repair of interpersonal ruptures and rebuilds an emotionally protective and secure parent-child relationship. There are five treatment tasks in ABFT which include: reframing the therapy to focus on interpersonal development, building alliance with the adolescent, building alliance with the parents, facilitating conversations to resolve attachment ruptures, and promoting autonomy and competency in the adolescent. Attachment-based Family Therapy evolved from Multidimensional Family Therapy (Liddle, 2009), Emotionally-Focused Therapy (Johnson and Greenberg, 1988), and attachment theory (Bowlby, 1969).

To date, five studies have demonstrated that ABFT can reduce adolescent depression or suicide better than treatment as usual or wait list control groups (Diamond, Diamond, & Levy, 2013; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Diamond et al, 2010). ABFT has been adapted and shown effective with suicidal gay, lesbian and bisexual adolescents (Diamond et al., 2012). Diamond, Siqueland, and Diamond (2003) also reported on several process studies about the mechanisms of change in ABFT.

### **1.3.1.3 Gottman Couples Therapy**

Gottman Couples Therapy emerged from the observational research of John Gottman and Roger Bakeman conducted during the 1970s where they identified consistent sequences of behaviour that differentiated happily married from unhappily married couples (Gottman, 1979). Gottman continued this research through the 1980s where he sought to replicate his findings and expand the understanding of what contributed to marital happiness and discord. It was during this phase that Gottman's research could predict whether a couple would divorce with an average of over 90% using the ratio of positive to negative comments, the presence of four negative communication patterns (criticism, defensiveness, contempt, and stonewalling), physiology, and the Oral History Interview (Gottman, 1991; 1994). Gottman continues his research at the University of Washington where he maintains the Relationship Research Institute (also known as the "Love Lab"). The Institute's focus is on building and testing his theories.

Gottman Couples Therapy (GCT) evolved from Gottman's research and the belief that to make relationships endure, couples must be better friends, learn to manage conflict, and create ways to support each other's hopes for the future. The GCT model is a "Sound Relationship House" that includes a series of steps and rooms such as: building love maps, sharing fondness and admiration, turning towards one's partner for needs, managing conflict, creating opportunities to discuss life dreams and hopes, creating shared meaning, trust, and commitment (Gottman, 1999; Gottman & Silver, 1999). The intent of the interventions in GCT is to help couples increase respect, affection, and closeness, resolve conflict when they are stuck, generate greater understanding between

partners, and keep conflict discussions calm. A therapist using GCT starts with a series of assessments and measures to determine a couple's communication patterns, where they get stuck, as well as other factors and then leads them through a series of guided exercises that develops their "Sound Relationship House".

Research about GCT is among the more extensive for couple therapy. In a randomised clinical trial of workshops teaching the components of a "Sound Relationship House" on their own and with GCT, effectiveness was demonstrated with the greatest one-year effectiveness for the combined workshop and nine sessions of GCT (Babcock, Gottman, Ryan, & Gottman, 2013). Seven longitudinal studies of couples have been completed exploring variables such as predictors of divorce in newlyweds (Carrere & Gottman, 1999) and what contributes to marital satisfaction over the long term (Gottman & Krokoff, 1989).

#### **1.3.1.4 Imago Relationship Therapy**

The first clinical trials of Imago Relationship Therapy (IRT) are currently under way. The approach was developed by Harville Hendrix out of his clinical and workshop experience. Hendrix described how he "brought together depth psychology, the behavioral sciences, the western spiritual traditions, and added some elements of Transactional Analysis, Gestalt psychology, systems theory, and cognitive therapy" (2014a) to develop his approach to working with couples. The initial therapeutic focus of IRT was on facilitating couples through a series of five exercises: re-imagining the partner, re-structuring frustrations, resolving rage, re-romanticising, and re-visioning the relationship (Hendrix, 1988). IRT has evolved from a focus on skill development to engage in the five previously mentioned procedures to dialogue as process which

incorporates the five procedures (2014b). The research about IRT to date has focused on the underlying theory and Imago constructs. What follows is a brief summary of that research.

A scale and research process has been developed for exploring the ideas related to IRT personality functions and defensive adaptations (Hannah et al., 1998; Marrone, Hannah, Bause, & Long, 1998). Researchers have explored IRT therapists use of Imago skills in therapy and therapists' dyadic adjustment in relation to their use of Imago skills with the couples they had worked with (Beeton, 2006; Hannah et al., 1996). Pitner & Bailey (1998) surveyed 110 couples who attended nine different IRT workshops (called "Getting the Love You Want") across the United States. The workshop participants showed an increase in their Marital Satisfaction Scale-Short Form scores after the workshop and again at six weeks after the completion of the workshop. Additional research exploring the impact on marital satisfaction after participating in a short-term intervention of IRT (Hannah et al., 1997; Luquet and Hannah, 1996) and participation in the IRT workshop (Hogan, Hunt, Emerson, Hayes, & Ketterer, 1996) reported an improvement in marital satisfaction and reduction in conflict. IRT claims to provide couples the skills to deal with the four relationship patterns that Gottman (1993) determined were predictors of divorce: criticism, defensiveness, stonewalling, and contempt. Finally, Imago theory offers an antidote to the negative relationship attitudes that have been found to be indicators of divorce (Markman & Hahlweg, 1993).

#### **1.3.1.5 McMaster Approach**

The origins of the McMaster Model of Family Functioning can be traced back over 50 years to the work of Nathan Epstein at McGill University (Ryan et al., 2005).

Based on research with non-clinical families (i.e. no family members have a psychiatric diagnosis) and on the process and outcome of family therapy, the model has evolved.

The McMaster model is based on a family systems approach where the family is viewed as a system as a whole with subsystems (e.g. parents, siblings) that relate to other systems (e.g. other services, church, school, sport teams). The focus of the McMaster approach is to clarify how a family is under stress and where the focus of the difficulties are which in turn guide where a therapist needs to work. The McMaster model is a time limited approach (6-12 sessions) and focuses on problems in the here-and-now as opposed to inter-generational patterns. The McMaster approach draws on communication theory and as such places an importance on the therapist's relationship with the family and the need for clear and open communication. Insight is not a necessary ingredient for change in the McMaster approach as the focus is on "the process occurring within the family that produces the behavior" (Ryan et al., 2005, p. 15). Miller, Ryan, Keitner, Bishop, and Epstein (2000) note that the McMaster Model assesses for a number of dimensions that have been shown to be problematic for families including: problem-solving, communication, roles, affective responsiveness, affective involvement, and behaviour control. Assessment in the McMaster Model is facilitated by the use of the Family Assessment Device (FAD).

Family therapy based on the McMaster model has been proven effective for adults dealing with depression in both in- and outpatient settings (Carr, 2009). The FAD may be the most researched aspect of the McMaster approach and has been found to have high levels of internal consistency (Epstein, Baldwin, & Bishop, 1983) and acceptable levels of test-retest reliability (Miller, Epstein, Bishop, & Keitner, 1985). The other assessment



and measures of fidelity measures that have been researched within the McMaster model include the McMaster Clinical Rating Scale (Miller, Kabacoff, Bishop, Epstein, & Keitner, 1994) and the McMaster Structured Interview for Family Functioning (Bishop, Epstein, Keitner, Miller, & Zlotnick, 1980).

Research about the McMaster treatment approach has been more limited. Support has been shown for this treatment approach at an outpatient children`s clinic for behavioural or academic problems (Woodward, Santa-Barbara, Levin, & Epstein, 1978), for people with major depression and bipolar disorder (Miller, Solomon, Ryan, & Keitner, 2004; Miller et al., 2000), and for stroke survivors and their caregivers (Miller, Weiner, Bishop, Johnson, & Albro, 1998).

#### **1.3.1.5 Emotionally Focused Therapy**

Emotionally Focused Therapy (EFT) is an empirically supported treatment that arose out of emotion theory and attachment theory formulated in the early 1980s by Johnson and Greenberg. It views emotions as centrally important in the experience of self, in both adaptive and maladaptive functioning, and in therapeutic change. From the EFT perspective change occurs by means of awareness, regulation, reflection, and transformation of emotion taking place within the context of an empathetically attuned relationship. The goals of EFT are to: expand and re-organize key emotional responses; create a shift in partners' interactional positions and initiate new cycles of interaction; and foster the creation of a secure bond between partners (Johnson, 2004).

EFT includes a series of steps where partners can explore key issues that are having a negative impact on their relationship. These steps include: delineating of conflict issues in their core struggles; identifying their negative interaction cycle;

accessing unacknowledged feelings; reframing the problem in terms of underlying feelings; promoting identification with disowned needs and aspects of self; promoting acceptance of the partner's experience; facilitating the expression of needs and wants; facilitating the emergence of new solutions; and consolidating new positions. "From a systemic perspective the task of the EFT therapist is to use the emotional experience of the spouses, to change interactions by evoking new responses which motivate reciprocal positive behavior in the partner" (Johnson & Greenberg, 1987, p. 556).

In terms of research, one meta-analysis (Johnson, Hunsley, Greenberg, & Schindler, 1999) review of early EFT outcome studies found 70-73% of couples moving into recovery from distress and 86-90% experiencing significant improvement. No other couple therapy research has surpassed these results. Three process variables have shown significance across EFT studies (e.g. Johnson & Talitman, 1996; Bradley & Furrow, 2004). They are the quality of the therapeutic alliance, particularly the task aspect of alliance; the depth of emotional processing, particularly in stage two of EFT; and the couples' ability to move into interactions where they can articulate fears and needs. A key change event, labeled a "softening", has been found to predict treatment success (Johnson & Greenberg, 1988).

Research has explored the use of EFT for couples facing trauma (MacIntosh & Johnson, 2008), depression (Dessaulles, Johnson, & Denton, 2003), and illness (Walker, Johnson, & Manion, 1996). Overall, there is significant research on this approach and it has been found that 70-75% of couples move from distress to recovery and that the gains are sustained for months to years following the end of EFT-based treatment. As such, EFT is an evidence-based treatment protocol (Denton, Johnson, & Burlison, 2009;

Greenberg, Ford, Alden, & Johnson, 1993; Johnson & Greenberg, 1987; Johnson, Hunsley, Greenberg, Schindler, 1999).

### **1.3.2 Evidence-Based Practice**

There are a number of considerations to explore when discussing evidence-based practice. To start with, there are the various terms used to describe the research about evidence-based approaches to CFT, such as: empirically supported treatments, evidence-based psychological practices, empirically validated treatment, and principles of empirically supported interventions, among others. For the purpose of this research, I will use the term evidence-based practice (EBP) as an umbrella term to encompass a range of CFT approaches developed with the assistance of efficacy and effectiveness research.

The American Psychology Association (APA) took steps to identify what constitutes an EBP in 1995 by defining criteria for empirically validated treatments. These criteria included at least two studies demonstrating efficacy, defined as being superior to a pill or to a psychological placebo or to another treatment, or equivalent to an already established treatment. Alternatively, a large series of smaller studies demonstrating efficacy was also acceptable. For either scenario, experiments had to be conducted with treatment manuals, the characteristics of the research participants had to be clearly specified (i.e. a single diagnosis), and the effects must have been demonstrated by at least two different investigators. The APA also defined “probably efficacious treatments” as two experiments showing that treatment is more effective than a wait-list control group or a larger study or a series of smaller studies meeting all of the previously

mentioned criteria except the requirement to have the effects demonstrated by more than one investigator (American Psychological Association, 1995).

Central to understanding these criteria is efficacy and effectiveness research, with the former viewed as more in line with empirically validated treatment research. Efficacy research contrasts one kind of CFT to a comparison group under well controlled conditions (Seligman, 1995). The ideal efficacy study will include the following criteria as outlined by Seligman (1995):

1. The patients are randomly assigned to treatment and control conditions.
2. The controls are rigorous: Not only are patients included who receive no treatment at all, but placebos containing potentially therapeutic ingredients credible to both the patient and the therapist are used in order to control for such influences as rapport, expectation of gain, and sympathetic attention (dubbed nonspecifics).
3. The treatments are manualized, with highly detailed scripting of therapy made explicit. Fidelity to the manual is assessed using videotaped sessions, and wayward implementers are corrected.
4. Patients are seen for a fixed number of sessions.
5. The target outcomes are well operationalized (e.g., clinician-diagnosed DSM-IV disorder).
6. Raters and diagnosticians are blind to which group the patient comes from.
7. The patients meet criteria for a single diagnosed disorder, and patients with multiple disorders are typically excluded.

8. The patients are followed for a fixed period after termination of treatment with a thorough assessment battery. (p. 965)

Another option for exploring whether a CFT approach has a therapeutic impact on a couple or family is to do an effectiveness study.

Effectiveness research is the study of how CFT participants fare under the actual conditions of treatment in the field (Seligman, 1995). There are five elements that characterise how CFT is actually done in the field that are missing from efficacy research. First, it is rare to have a fixed number of sessions for CFT in real life. Generally, a therapist would set goals with a couple or family, assess progress towards those goals and the quality of the therapeutic alliance, and therapy would end when some or all aspects of the goals have been accomplished. Second, therapy is self-correcting; if one approach does not work a CFT might choose to try another approach and not simply stick to a scripted manual waiting for clients to improve. A third difference between efficacy research and CFT in the field is that patients often actively shop for a therapist. A fourth and oft-noted difference is that patients usually have more than one presenting problem. Finally, another difference in a CFT's practice as compared to efficacy research is that there is concern for general improvement as well as improvement in a specific disorder and relief of specific symptoms. Effectiveness research provides an opportunity to incorporate one or many aspects of real-life practice and may be an important step for transportability research and dissemination research.

Transportability research explores the movement of efficacious treatments to usual-care settings. There are three broad questions one can consider in transportability research: what is the intervention; who, and under what circumstances, can the

intervention in question be conducted; and to what effect for clients and systems (Schoenwald & Hoagwood, 2001). Transportability research is a precursor to dissemination research, which examines whether a treatment approach produces the desired outcomes under conditions faced by the ultimate consumers of the treatment. It is both reasonable and ethical to attempt a broader distribution and to evaluate the impact of these distribution efforts, to develop strategies to raise awareness of the treatment among potential consumers and to identify consumers likely to reject, adopt, or adapt it (Schoenwald & Hoagwood, 2001).

The field of couple and family therapy research has explored the role of EBPs for practitioners as well as developed EBPs. As previously mentioned, one present day example is the Social Ecological Approach, which is currently undergoing effectiveness research. Also recent, an article in a prominent CFT research journal proposed a set of guidelines for EBPs for couple and family therapy (Sexton, Gordon, Gurman, Lebow, Holtzworth-Munroe, & Johnson, 2011). The article was co-authored by influential researchers in the field who had developed these guidelines when working together on a sub-committee of APA's Division 43 (Family Psychology). In 2007, they submitted an "official recommendations" report to Division 43 with an outline for guidelines for evidence-based treatments for CFTs. The proposed guidelines consist of three levels of evidence-based practice ranging from "evidence-informed" to "evidence-based" as pictured in figure 1 (Sexton et al., 2011, p. 383). The three levels are intended to provide "both a hierarchical index of confidence that a treatment model 'works' and a comparative index of clinical applicability" (Sexton et al., 2011, p. 382).

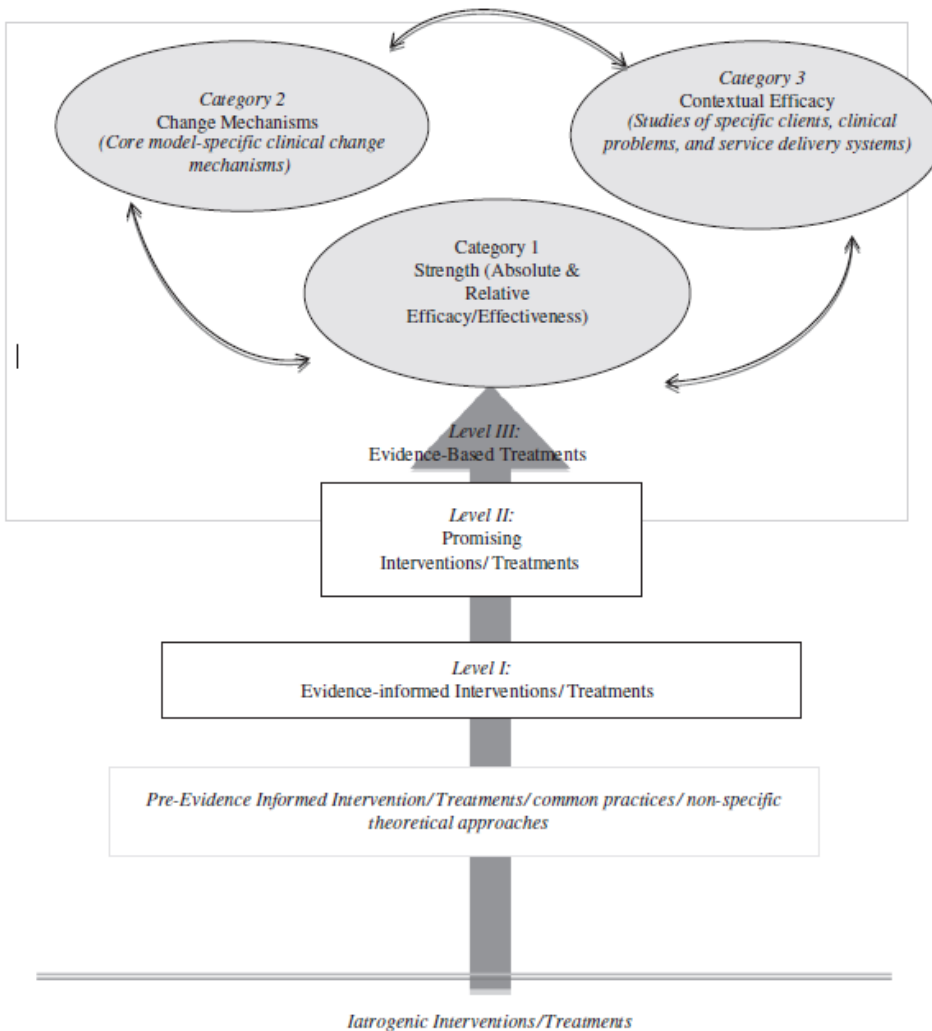


FIGURE 1. Levels of Evidence in Couple and Family Therapy Research.

The third or highest level of EBPs in this model have three additional categories of evidence that are intended to further “demonstrate effectiveness by considering model-specific change mechanisms, superior performance when compared with other viable treatment options, and generalizability to a diversity of client populations and clinical settings” (Sexton et al., 2011, p. 382). The authors go on to suggest that the categories in the third level are intended to be more “contextual” than hierarchical and provide guidelines for researchers about what questions to consider regarding the use and implementation of a model.

Interestingly, Sexton et al. (2011) suggest that evidence should include at least two outcome studies with research coming from multiple sites and go on to indicate that to be evidence-based, couple or family interventions should include:

- (a) clear specification of the content of the treatment model (e.g., treatment manual);
- (b) measures of model fidelity (therapist adherence and/or competence);
- (c) clear identification of client problems;
- (d) substantive description of the service delivery contexts in which the treatment is tested; and
- (e) the use of valid measures of clinical outcomes. (p. 385)

These criteria are very similar to the APA guidelines released in 1995, and while suggesting elsewhere that there are contextual factors that are important to attend to, they do not attend to how EBPs can design research to attend to these factors.

Another consideration rarely attended to in the research literature is the author or researcher's location and whether we are required to disclose this as part of an ethical research practice. EBPs are increasingly being sought by funding agencies, particularly state funding agencies in the United States, as the reason for funding a program. For example, the University of Colorado's Centre for the Study and Prevention of Violence has developed an extensive Blueprints for Violence program that focuses on determining if a program can be listed as evidence-based. Being listed by the Blueprints program can be a key criterion for a state to fund a CFT program. Some of the researchers involved with APA's Division 43 sub-committee that created the recommendations for evidence-based CFT treatments are strongly aligned with CFT practices that offer extensive



training programs run much like a business. To draw a crude analogy intended to highlight the potentially more difficult aspects of this work, can this be compared to pharmaceutical companies having the only say in research guidelines for drug trials on humans? We know the reality is that pharmaceuticals have enormous influence, but there do seem to be some measures in place to mitigate that influence. While worth mentioning, the scope of this question is beyond this research project and has been briefly noted elsewhere in the literature as “allegiance issues” (Sprenkle, 2012). More relevant for this research are the practice considerations for CFTs that EBPs bring to the fore. The next section will focus on the benefits, challenges, and social justice considerations for CFT practitioners and researchers.

### **1.3.3 Practice Considerations for Couple and Family Therapists**

As previously noted, the role of EBPs in all aspects of mental and health care are growing. As Alexander, Sexton, and Robbins (2000) note:

The philosophy and guidelines embedded in the empirically validated and supported treatment movement have come to define the practical application of current (CFT) intervention...the evolution of this movement is at the hub of several social, professional, and historic forces that are converging. (p. 23)

There is a sense of hope about the possibilities for EBPs in the development of the CFT field, both for the people receiving a service as well as for practitioners and researchers who can increasingly feel confident that their work is supported by research. While there are short-comings of the randomised controlled trial (RCT) methodology that is required for a practice to become evidence based, RCTs are still seen as the “gold standard” for intervention methodology research (Sprenkle, 2012). Further, “if CFTs want to have

their discipline taken seriously by the external world (including other disciplines, governments, insurance companies, and other third-party payers), they will have to continue producing high-quality RCTs” (p. 4). It is therefore critical that CFTs pay attention to the benefits of EBPs in their practice.

What follows is a list of a number of the benefits of the evidence-based movement for CFTs. Efficacy studies are seen as the best “scientific instrument” for telling us whether an intervention is likely to work with a given disorder (Seligman, 1995). Clinicians have a clinical, ethical, and legal responsibility to attend to the results of RCTs (Persons & Silberschatz, 1998). Knowing about and understanding EBPs in general are important for CFTs who work across disciplines because “whether in medicine, education, or mental health, the culture of evidence based practice pervades almost every aspect of our public lives” (Midgely, 2009, p.323). Developing evidence-based CFT practices is seen as a natural progression and evolution of our field, a maturing of sorts from anecdotal clinical reports to “conceptual and methodological sophistication” of CFT research and clinical practices (Sexton & Alexander, 2002).

Continuing with the benefits of EBPs, for CFTs the knowledge of, or certification in, an EBP provides a professional reputation and legitimacy as well as a knowledge base for practitioners. CFTs also have an ethical responsibility to ensure our work is as beneficial as possible and there are opportunities to promote a research culture within an evidence-based approach and promote stronger researcher-practitioner alliances. For program managers, funders, and government departments, there is an increased pressure to allocate resources on an explicit rational basis and in consideration of consumer rights, which again means attending to the results of research (Morago, 2006; Plath, 2006).

There is also the hope that EBPs will improve the quality of the service, potentially influence policy makers to increase access to CFT, and allow for faster and better training. The culture of EBP is intended to have a heuristic value as well “to encourage further development of guidelines and lists of effective treatments; they do not have to be perfect to be useful for the field” (Elliott, 1998, p. 118). In keeping with disciplines interested in empirical research, there is a notion that unless it has been studied using an RCT, “we have no compelling evidence that it is effective and we cannot be certain it is not harmful” (Persons & Silberschatz, 1998, p. 126). While there are a number of benefits of evidence-based research for CFTs to consider, there are other perspectives on the role of EBPs in the field of couple and family therapy that enrich the dialogue and bring forth a range of compelling reasons to explore the issue further.

These other perspectives challenge the focus on EBP and how the research is done as well as raise social justice considerations for CFTs. What follows is an outline of the challenges associated with EBPs and the related research. The challenges associated with integrating science into the practice of CFT through EBPs “have always been controversial, resulting in frequent, passionate, and at times divisive debates in the field” (Sexton et al., 2011, p. 378). While characterising the debate as passionate and divisive might suggest that some may want to raise unnecessary challenges, these challenges are integral to the development and evolution of the field. For example, connected to a singular framework (Wendt, Jr., 2006), the narrow epistemological band of empiricism that asserts that “we can only know, or know best, those aspects of our experience that are sensory” (Slife, Wiggins, & Graham, 2005, p. 84) limits what and who engages in that dialogue. Empiricism is “merely one epistemology or philosophy among many, each

with inherent strengths, limitations, and biases” (Wendt, Jr., 2006, p. 91). CFT practitioners apply a broad range of “experiential knowledge and strategies that are hardly mentioned in the text books” (Malterud, 2001, p. 398). EBPs emphasise evidence for interventions over evidence for assessment and planning and do not sufficiently conceptualise how practice expertise and service users’ values can be included (Gilgun, 2005). As Seligman (1996) noted, “experiments resemble real therapy only slightly” (p. 1072) and lack an ability to reflexively engage in noting what’s seen as well as what is not seen (Burke, 1954).

Another challenge for CFTs to consider is that EBPs have been criticised for promoting a view of decision making that is deterministic, which is inconsistent with the reflective process noted as integral to ethical CFT practice (Coulter, 2011). Further, as Staller (2006) noted, the “monolithic notion of best evidence—at the exclusion of other competing informative evidence—is reductionistic and dangerous” (Staller, 2006, p. 512). Henry (1998) raises six concerns about the “benign but naive scientific efforts” of EBPs that, when “coupled with political and paradigmatic agendas” (p. 127), need to be considered by researchers and CFTs. The first is that an EBP approach fundamentally sacrifices a traditional approach in favour of a medical model of questionable utility for the phenomena under study. Secondly, it has the potential to decrease the quality of CFT training in favour of technical approaches that limit the understanding of training to a set of steps much like a recipe book. Third, it “may give even greater power to third-party payers as de facto untrained supervisors” (p. 127). Fourth, it may actually discourage research in some areas such as couples or families presenting with multiple problems or personality disorders. Fifth, the research findings distributed are of little value to

consumers' best interest. Finally, it "entrenches an outdated research paradigm that militates against the discovery of new knowledge" (p. 127). Another aspect of the EBP dialogue for CFTs to consider is social justice considerations.

The social justice aspects of the evidence-based dialogue in CFT explore the role of our professional associations, who has been included and excluded from research, whose needs are served by research and programs, how EBPs are constructed, who is included in the dialogue as well as a number of other areas. What follows is a brief outline of some of the social justice issues for CFTs to consider, starting with professional associations that regulate the various practitioners who practice CFT and "have political, social, and economic functions and interests" (Gambrill, 2010, p. 307-8). One of the roles afforded to the helping professions in our mental and health care systems is social control (Gambrill, 2010). Practitioners who naively ignore this role, attributing it to something their employer does but they have nothing to do with, run the risk of absent-mindedly replicating some of the very mechanisms that led a couple or family to seek services in the first place. One of the more troubling aspects of the empirically supported treatment enterprise is the "systematic discrimination against certain classes of research, treatment, and patients" (Elliott, 1998, p. 118), in particular, non-English research, qualitative research, research with ethnic minorities and children.

A leading proponent of APA's empirically-validated treatment project through the 1990s was Diane Chambless who wrote that, "We know of no psychotherapy treatment research that meets basic criteria important for demonstrating treatment efficacy for ethnic minority populations" (Chambless et al., 1996, p. 2). Furthermore, the "dearth of culturally cross-validated measures makes even beginning such research problematic"

(Chambless et al., 1996, p. 2). CFT practice cannot be guided by research findings alone; it relies on multiple values, tacit judgement, local knowledge, and a range of skills (Hammersley, 2004). This contrasts the notion of the clinician as “an institutional subject who is presumed both to know the truth of disease and to have the moral and intellectual authority to prescribe treatment” (Holmes, Murray, Perron, & Rail, 2006, p. 183). How we know what works and for whom will always be debated by CFTs, researchers, and the people who seek services. Some researchers advocate for an “intentional practice” where CFTs’ work should reflect what they know is most likely to be helpful (Ungar, 2011), recognizing that there will always be tension between practice and theory, positivist and other research paradigms, and social, political, and pragmatic considerations.

The hope expressed in the literature is that RCTs have the potential to be externally valid, can include qualitative components to add richness and relevance, and can be used to study common factors. Many of the problems noted with RCTs are not rooted in the paradigm itself but rather how they are used and misinterpreted to make claims that are too far reaching (Laska, Gurman, & Wampold, 2013; Sprenkle, Davis, & Lebow, 2009). There is a need to improve research by doing more in real-life settings that approximate actual practice and not over-interpreting results of RCTs by attributing the reasons for which interventions work for specific problems or populations (Sprenkle, 2012). The over-reliance on evidence as solely determined by APA’s guidelines makes it difficult for “scholars to express new and different ideas in an intellectual circle where normalisation and standardisation are privileged in the development of knowledge” (Holmes, Murray, Perron, & Rail, 2006, p. 182). EBPs present a range of benefits, challenges and social justice considerations for CFTs and researchers alike.

Some of the benefits of EBPs that CFTs cannot ignore are that they are a given of present-day practice and research. EBPs present an opportunity to improve service, training, and save programs money. The key challenges with EBPs are the lack of epistemic agility that informs them and the lack of recognition of the role of the therapist and consumer. While social justice considerations raise questions about whom EBPs serve and highlights the stark absence of research ability or actual research with non-English speaking populations and ethnic minorities. Another possibility for EBPs noted by Gambrill (2008) is to help narrow the gap between what a CFT knows and what they can do. According to Gambrill, the authority of a CFT can be replaced by a well-informed couple or family who can make decisions about whether the intervention is useful. Then, the CFT's role becomes "to present the evidence to clients and invite them to engage with the service that is being provided if they believe they are likely to derive benefits from doing so" (Ungar, 2011, p. 310). The role of the CFT becomes that of openly explaining what they are doing, being aware of EBPs, and working with couples and families to work towards outcomes that they themselves find meaningful.

Chapter one introduced the reader to this research project where couple and family therapists were asked about their experiences of learning an evidence-based practice. After the researcher located himself in relation to the research, the chapter then provided an overview of the field of couple and family therapy. The overview included a brief description of the six couple and family therapy approaches that were discussed by the research participants. A review of the benefits, challenges, and social justice considerations of evidence-based practice was then provided followed by the practice considerations of EBPs for couple and family therapists. The next chapter introduces the

methodology and methods used for this research project. The methodology used for this research project is interpretive phenomenological analysis (IPA) and the review includes a discussion of the theoretical underpinnings of IPA.



## **Chapter 2**

### **Methodology**

This chapter details the research methodology and methods employed to explore the experience of couple and family therapists (CFT) learning and using an evidence-based practice. The methodology relies on a phenomenological framework, specifically interpretive phenomenological analysis (Smith et al., 2009), and is therefore interested in the experiences of the therapists themselves and the meanings they attribute to these experiences. At the same time, interpretive phenomenological analysis calls for the researcher to engage a hermeneutic of suspicion (Ricoeur, 1970) by using theoretical perspectives from outside to shed light on the phenomena. From an interpretive phenomenological perspective, experience is always constructed and enacted through a variety of mechanisms. It is therefore critical that discussion of the research design acknowledges the relations between the experiences of CFTs and their interpretations; theory and experiences; methodologies and methods with the hope of engaging the reflections of significant events of the research participants (Smith et al., 2009). Beginning with the research questions, this chapter will outline the methodology, study design, sampling strategy, participants, ethical issues, and data analysis.

#### **2.1 Research Questions**

1. What influences a couple and family therapist to explore and use an evidence-based CFT practice?
2. What do couple and family therapists experience when learning about an evidence-based CFT practice?

3. What do couple and family therapists experience when adapting and using an evidence-based practice in their day-to-day clinical work?

## **2.2 Overview of CFT Phenomenological Research**

Phenomenological research originated well over fifty years ago and has roots in the works of phenomenological philosophers such as Husserl (1927), Heidegger (1962), Merleau-Ponty (2002), and Sartre (1948; 1956) as well as the symbolic interactionism of Mead (Mead & Morris, 1934). While there is a more established tradition of phenomenological research in psychology in general (Giorgi, 1985; Spinelli, 2005), the field of couple and family therapy research came to it more recently.

During the 1990s, CFT researchers “became increasingly interested in how family members experience their everyday worlds and how their perceptions of what they experience lead to different meanings” (Dahl & Boss, 2005, p.65). While seen as a means to further explore the lived experience of the couples and families that CFTs work with, phenomenological research ruts against the outcome-oriented research described as “state of the art” by leading researchers in the field (Sprenkle, 2002). The tendency within health service fields such as CFT “to favour a positivistic research paradigm and, by extension, quantitative methods...ignores the social and political context in which research takes place” (Ungar, 2001, p. 18). Phenomenological research goes to the heart of this dilemma particularly when the research approach includes a hermeneutic of suspicion (Ricoeur, 1970) as IPA does (Smith et al., 2009).

At the heart of this dilemma is the understanding of what reality is and how we research it. “To a phenomenologist, then, the importance of reality...is not likely to be found in the laboratory or clinic...” (Dahl & Boss, 2005, p. 65). Phenomenological CFT

researchers see knowledge as socially constructed and, as such, reality can be seen in a variety of ways by different members of a family or a couple. Gubrium and Holstein (1993) note that “it is not appearance per se, but rather what appears to be that is critical...Indeterminacy derives from varied interpretations, which in turn is constituted by and through language” (p. 654). CFT phenomenological researchers focus not only on the perceptions and experiences of each member of a couple or family but also on the “whole”. CFT phenomenological researchers “attempt to hear the ‘[couple/] family conversational voice’ as a whole to observe the ‘[couple/] family world’ as a whole” (Dahl & Boss, 2005, p. 66). The focus on understanding the “whole” is not only when couples or families are faced with a challenge but also in their day-to-day lives.

Understanding a couple or a family’s everyday experiences is as important as understanding the challenges that they face such as at the onset of an illness or a catastrophic event. Most CFTs meet with couples and families when they are in crisis and would benefit from meeting with them when there is no need for professional help. Gubrium & Holstein (1993) explain that “The study of [couple/] family discourse highlights how language serves to assign meaning to objects and social conditions in everyday life” (p. 653). Language remains an important symbol of human interaction and the therapy room is not a natural setting. It is important to get away from the therapy room not only to observe couples and families but also couple and family therapists themselves.

### **2.3 Interpretive Phenomenological Analysis: The Framework for this Research**

Interpretive phenomenological analysis (IPA) “represents an epistemological position, offers a set of guidelines for conducting research, and describes a corpus of

empirical research” (Smith, 2004, p. 40). IPA was first identified as a distinctive method in the mid-1990s in an article that appeared in *Psychology and Health* (Smith, 1996). In the article, Smith argued for an approach to psychology that could capture the experiential and qualitative elements of research while maintaining a dialogue with more mainstream understanding of research in psychology. Smith (1996) drew on the work of a psychology phenomenologist (Giorgi, 1985), on hermeneutics (Palmer, 1969), and on an engagement with subjective experience and personal accounts (Smith, Harre, & Van Langenhove, 1995). Subsequently, symbolic interactionism has also been identified as an influence in IPA (Eatough & Smith, 2008).

The key elements of IPA are that: it is an inductive approach; participants are experts on their own experience and are recruited because of their expertise in the phenomenon being explored; researchers analyse data to identify what is distinct (idiographic study of persons) while balancing that with what is shared in the sample; and the analysis is interpretive, grounded in examples from the data, and plausible to the participants, supervisors, and general public. Much of the early research using IPA was in the health psychology field (Smith, 2011a) and the introduction of IPA has made phenomenological research more accessible for those who do not have a philosophical background (Willig, 2008). Yet, that does not negate the relevance of the philosophical traditions of phenomenological research and the onus on the researcher to be authentic to aspects of these traditions.

IPA is particularly suitable for this research project and the exploration of CFT’s experience with learning and using an evidence-based practice. As Shaw (2001) outlines, “The focus is very much upon the uniqueness of a person’s experiences, how experiences

are made meaningful and how these meanings manifest themselves within the context of the person both as an individual and in their many cultural roles...it is rich and diverse data that IPA can delve into and explore in depth” (p, 48). Smith et al. (2009) identify three key areas of the philosophy of knowledge that IPA draws on: “phenomenology, hermeneutics, and idiography” (p. 11). What follows is an exploration of each in turn, beginning with phenomenology.

### **2.3.1 Phenomenology**

In terms of its theoretical position, IPA is phenomenological in that it aims to explore participants’ lived experience and how they make sense, or make meaning, of these experiences. “Phenomenology, as methodology, explores the experiential, the lived, and the humanity of everyday life” (Goldberg, Ryan, & Sawchyn, p.542).

Phenomenology draws on the writings of Edmund Husserl (1859-1938) and those who expanded on his views, such as Heidegger, Sartre, and Merleau-Ponty (Spiegelberg, 1982). Husserl encouraged researchers to go to the things themselves, describe phenomena as accurately as possible, and repeat analyses to sharpen the interpretation. A key concept in Husserl’s approach to phenomenology is the intentionality or consciousness about something. Husserl suggested that intentionality is made up of two inseparable poles that he labelled noema and noesis (Langdrige, 2007). Noema refers to “the initial focus of experience, standing out within my sensory field” (p. 16) while noesis refers to “the reflexive nature of the experience itself” (p. 17).

Husserl (1927) wrote that it was necessary to step back from the “natural attitude” (p. 239) to examine everyday experience. To do this, he proposed adopting a “phenomenological attitude” to reflectively engage in “the correct performance of a pure

phenomenological reflection” (p. 246). The steps involved in this reduction include bracketing or suspending the natural sciences and the natural attitude, eidetic reduction, and the transcendental reduction (Finlay, 2008). Each reduction leads to something being put in “brackets” and in a “reduction” of the field that commands one’s attention (p.5).

The bracketing of the natural sciences includes the suspension of scientific theories and scientific preconceptions. The bracketing of the “natural attitude” involves suspending the taken-for-granted or ordinary intention. The eidetic reduction involves a procedure for reducing a phenomenon to its essence (eidos). In the transcendental reduction, Husserl proposed a “radical (bracketing) which involves standing aside from one’s subjective experiences and ego, in order to be able to focus on transcendental consciousness” (Finlay, 2008, p. 6).

Many have criticised Husserl’s transcendental turn, notably Heidegger and many other of Husserl’s students (Moran, 2000). Finlay (2008) contends that the transcendental reduction is a more purely philosophical direction rendering it less useful to a psychological or a CFT researcher. Heidegger expanded on Husserl’s work and diverged by emphasising that people are part of a world of objects and relationships and that our being in the world is always in relation to something or someone, so that the interpretation of people’s meaning-making activities is central to phenomenological inquiry (Krell, 1993). Heidegger (1985) did not abandon the role of bracketing in phenomenological research and described it as follows:

This bracketing of the entity takes nothing away from the entity itself, nor does it purport to assume that the entity is not. This reversal of perspective has rather the sense of making the being of the entity present. This phenomenological

suspension of the transcendent thesis has but the sole function of making the entity present in regard to its being. (p. 99)

Smith et al., (2009) propose that Husserl was primarily concerned with “individual psychological processes” (p. 16) while Heidegger “is more concerned with the ontological question of existence itself, and with the practical activities and relationships which we are caught up in” (p. 16-17). The Heideggerian concept of being-in-the-world suggests human existence as situated in a particular historical, social, and cultural context. This being-in-the-world can be conceptualised within language, as “language is the house of being” (Heidegger, 1978, p.193).

Merleau-Ponty, like Heidegger, wrote about the situated and interpretive quality of our knowledge about the world. For example, Merleau-Ponty (2002) further considered the reflective move afforded by the reduction:

Reflection does not withdraw from the world towards the unity of consciousness as the world's basis: it steps back to watch the forms of transcendence fly up like sparks from a fire; it slackens the intentional threads which attach us to the world, and thus brings them to our notice. It, alone, is consciousness of the world, because it reveals the world as strange and paradoxical. (p. xv)

Both Heidegger and Merleau-Ponty saw a role for bracketing, not solely as a means to remove oneself from the world but as a means of further understanding how we are in the world.

For Heidegger, human existence is seen as inextricably linked with others. This notion of intersubjectivity was further developed by Merleau-Ponty (2002):

The phenomenological world is not pure being, but the sense which is revealed where the paths of my various experiences intersect, and also where my own and other people's intersect and engage each other like gears. It is thus inseparable from subjectivity and intersubjectivity. (p. xxii)

It is how people engage each other that is central to most couple and family therapies with cognitive and behavioural approaches being the exceptions. Often, CFTs see couples and families when they are in conflict with each other.

Merleau-Ponty builds on the notion of intersubjectivity as not only isolated to interactions with others or to our experience of those interactions but also situated in and between our bodies. Further to Merleau-Ponty's view of intersubjectivity is the importance of the body as critical to our knowing about the world: "the body is the vehicle of being in the world" (Merleau-Ponty, 2002, p.94). This research project shares an interest in both an embodied and relational understanding of experiences with other phenomenological research (e.g. Goldberg, 2008). For Merleau-Ponty, physical and perceptual ways of knowing about our world are more important than abstract or logical ones (Anderson, 2003). The lived experience is difficult to capture but important to consider and explore. Merleau-Ponty (1968) used concepts of reciprocity and reversibility to explore the interrelatedness between subjectivity and intersubjectivity:

Between my body looked and my body looking, my body touched and my body touching, there is an overlapping or encroachment, so that we must say that things pass into us as well as we into the things. (p. 123)



Sartre extends the understanding of the situated nature of our experience. That is, experiences are always understood by the presence and absence of our relationships to other people.

Sartre described intersubjectivity in terms of antagonism and conflict. Zahavi (2001) points out that Sartre's account of intersubjectivity "rejects any attempt to bridge or downplay the difference between self and other" (p. 157). Sartre shares with Heidegger that we are caught in projects in the world, seek after meaning, and have a self-consciousness that engages with our world. Sartre (1948) extends the project of existential phenomenology by noting that "existence comes before essence" (p. 26). The concern with what will be connects with another important concept for Sartre, nothingness. For Sartre, what is absent is as important as what is present for defining who we are. Human nature, for Sartre, is more about becoming than being. In this becoming, we have freedom to choose and are responsible for our actions. This freedom is linked to the concept that we can never escape from our awareness of ourselves.

Sartre (1956) used two terms, "le pour-soi" (for itself) for the human consciousness, and "en-soi" (in itself) for physical objects in the world. As in, we would like to be what we are (pour-soi) with the full awareness of that we are it (en-soi). Sartre would suggest that we play at being ourselves, e.g. a CFT, and that we are conscious of what we are and can never entirely be what we are. We try to fit in by performing a role, e.g. CFT, that makes us part of a larger group. This attempt at fitting in or playing a role will be central to this research project.

While not reviewed in the IPA literature, it is worth noting both queer and feminist approaches to phenomenology. Like other approaches to phenomenology, there

is no singular understanding of a queer or a feminist phenomenology. Queer can refer to “non-normative gendered and sexual identities, actions, stances, practices, subject positions, linguistic operations, and theoretical stances” (Fryer, 2010, p. 4). Queering or a queer phenomenology includes foregrounding orientation and reflecting on what it means for sexuality to be lived as orientated (Ahmed, 2006). Queer thinking is noted as both anti-normative thought and post-normative thought (Fryer, 2010). “Post-normative thinking does not assume that all professionals are white, that all presidents will be men, or that all people are straight” (p. 5). Feminist phenomenology (de Beauvoir, 1949/89; Young, 1990) builds on Merleau-Ponty’s “notion of the lived body, unlike Cartesian dualism, which objectifies the body and disassociates it from the mind” (Goldberg, Ryan, & Sawchyn, 2009, p. 541), feminist phenomenology embraces an embodied view of the self. One of the aims of feminist phenomenology is to include women’s lived experiences in a world seen through a male lens.

The various approaches to phenomenology reviewed here are foundational for researchers using IPA. Husserl provides a “rich source of ideas about how to examine and comprehend lived experiences” (Smith et al., 2009, p. 11). IPA also looks to the phenomenological philosophers that view a person as embodied, embedded and in the world. Smith et al., (2009) summarise their contributions as follows:

Husserl’s work establishes for us, first of all, the importance and relevance of a focus on experience and its perception. In developing Husserl’s work further, Heidegger, Merleau-Ponty and Sartre each contribute to a view of the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns. (p.21)

While phenomenology was seminal in the development of IPA, another area of influence was hermeneutics, to which I'll now turn my attention.

### **2.3.2 Hermeneutics**

Hermeneutics, a method and theory for interpreting text and meaning, is another major theoretical underpinning of IPA. The brief review included here will include discussion of three major hermeneutic theorists: Schleiermacher (1998), Heidegger (1962), and Gadamer (1990). The practice of hermeneutics began with the interpretation of biblical texts and later, Enlightenment thinkers set about systematising a practice into a method of understanding (Moran, 2000). Schleiermacher (1998) described hermeneutic practice as including two inseparable parts, a grammatical interpretation and a psychological interpretation:

As every utterance has a dual relationship, to the totality of language and to the whole thought of its originator, then all understanding also consists of the two moments, of understanding the utterance as derived from language, and as a fact in the thinker . . . Every person is on the one hand a location in which a given language forms itself in an individual manner, on the other their discourse can only be understood via the totality of language. But then the person is also a spirit which continually develops, and their discourse is only one act of this spirit of connection with the other acts. (As quoted in Smith, 2007, p.4)

So one understanding of hermeneutics is as an individually located and evolving notion driven by language as a central location.

Scholars have critiqued Schleiermacher's concept of psychological interpretation as an ahistorical reconstruction emphasising the author's intentions. For example,

Gadamer argued that an interpretation focused on the author and the author's original intent is superfluous to hermeneutics. Yet in his defense, Ricoeur (1991) suggests that Schleiermacher's

psychological interpretation - this term replaces "technical interpretation" - is never restricted to establishing an affinity with the author. It implies critical motifs in the activity of comparison: an individuality can be grasped only by comparison and contrast. So the second hermeneutics [the psychological interpretation] also includes technical and discursive elements. We never directly grasp an individuality, but grasp only its difference from others and from ourselves. (p. 57)

Smith et al.(2009) agree that it is not possible to recreate the original meaning; however, Schleiermacher's psychological interpretation makes sense in relation to contemporary research interviews. For example, "In the context of IPA research, some of the 'added value' is likely to be a product of systematic and detailed analysis of the text itself, some of it will come from connections which emerge through having oversight of a larger data set, and some of it may come from dialogue with...theory" (p. 23). In this respect, the IPA perspective on interpretation differs from the postmodern literacy theory perspective, where the author is not significant, and differs from a social constructionist approach where the focus is on the use of language rather than the meaning the language has for the person.

Heidegger (1962) described hermeneutics as a prerequisite to phenomenology which requires the uncovering of meanings sometimes concealed by the phenomenon's mode of appearing. That is, the appearance has a dual quality; there are certain visible

meanings (which may or may not be visible) and certain hidden meanings. For Heidegger, the interpretation is always influenced by a researcher's prior experiences, assumptions, and preconceptions: "The interpretation has already decided for a definite way of conceiving it, either with finality or with reservations; it is grounded in something we grasp in advance – in fore-conception" (Heidegger, 1962, p. 190). This sets him apart from Husserl, in that "an interpretation is never a pre-suppositionless apprehending of something presented to us" (p. 191-192). The focus in interpretation is not to rid oneself of these preconceptions but to give priority to the new object.

Further, from a Heideggerian perspective, it is important to pay attention to the sequence that preconceptions and the new object emerge. A researcher may not know which part of their fore-structure is relevant when reading a text and this may only emerge after exploring the phenomenon. From an IPA perspective, Heidegger's formulation of phenomenology as an interpretive activity is important. Another important aspect of Heidegger's conceptualisation of phenomenological research is his take on bracketing. He promotes a more complex and engaged dynamic with fore-understanding that helps researchers see bracketing as a cyclical process that can only be partially achieved. For researchers interested in using IPA, "this connects bracketing with reflective practices in qualitative psychology more generally" (Smith et al., 2009, p. 25).

Gadamer (1990) picks up on Heidegger's hermeneutics and the relation between fore-structure and a new object. Gadamer refers to fore-structures as "prejudices (that) are not necessarily unjustified and erroneous...In fact, the historicity of our existence entails that prejudices...constitute the initial directness of our whole ability to experience.

Prejudices are biases of our openness to the world” (Gadamer, *The universality of the hermeneutic problem*, as quoted in Moran, 2000, p. 278). Gadamer contends that rather than putting one’s preconceptions upfront before doing interpretation, the clarity of one’s fore-structures emerges while doing the interpretations. This approach makes for a dynamic interpretive process where a “new projection constitutes the movement of understanding and interpretation” (Gadamer, 1990, p. 267). As such, the phenomenon influences the interpretation, which in turn influences the fore-structure and promotes a dialogue between something that is old (the fore-structure) and something that is new (the text itself).

Gadamer took exception to Schleiermacher’s notion that the interpreter can know the author better than he/she knows themselves. Gadamer makes the distinction between the meaning of the text and the meaning of the person, placing an emphasis on the former. This research project and IPA in general, seeks a middle ground between these two notions. For example, Merleau-Ponty (1993) promotes a holistic approach for analysing accounts of participants and Smith (2007) contends this is particularly important in IPA research projects. In an essay on Cezanne, Merleau-Ponty (1993) notes that “although it is certain that a person’s life does not *explain* his work, it is equally certain that the two are connected. The truth is, *that work to be done called for that life*” (p. 70) [italics in source]. Merleau-Ponty offers a phenomenological account of existence that focuses on the relation of the body as it is lived and experienced in the world. Embodied perception “must be understood as a process of integration in which the text of the external world is not so much copied as composed” (Merleau-Ponty, 2002, p.10). This composition can take many forms and shapes and shift as the analysis evolves, thus

lending itself to the possibilities of returning repeatedly to specific aspects of a research participant's text, the text across different research participants, and the text as a whole.

The hermeneutic circle resonates with different hermeneutic writers and is concerned with the dynamic relationship between the parts and the whole. There is a dance between understanding any given part by looking at the whole and understanding the whole by looking at the parts (Finlay, 2008):

Caught up in the dance, researchers must wage a continuous, iterative struggle to become aware of, and then manage, pre-understandings and habitualities that inevitably linger. Persistence will reward the researcher with special, if fleeting, moments of disclosure in which the phenomenon reveals something of itself in a fresh way (p.1).

It is these moments of disclosure from the research data that engages the researcher in a dance, some might say struggle, with the hermeneutic circle.

Hermeneutics offers crucial insights for IPA. As an interpretive approach, IPA is concerned with how a phenomenon appears and Heidegger's explicit understanding of phenomenology as a hermeneutic exercise is central. Heidegger and Gadamer offer rich and dynamic understandings of the dialogue between fore-structures and the new phenomenon emerging. Schleiermacher's attention to historical texts and both a textual and psychological interpretation are important for IPA and will be applied in this research project. Finally, the hermeneutic circle "provides a useful way of thinking about 'method' for IPA researchers" (Smith et al., 2009, p. 28). Another way of knowing central to the method of IPA is idiography.

### **2.3.3 Idiography**

A third major influence in IPA is idiography, which is concerned with the particular. IPA is idiographic, “starting with the detailed examination of one case until some degree of closure or gestalt has been achieved...and so on through the corpus of cases” (Smith, 2004, p. 41). At least six parties can be identified who are involved in the evaluation of mental health services: patients, clients, clinicians, managers, sponsors, and researchers (Krause & Howard, 1976; Strupp & Hadley, 1977). Of the six parties identified, the area of focus for this research is on the therapists’ experience of adapting an evidence-based CFT approach. Researchers have identified “the importance of therapist, relational, and contextual factors in psychotherapy outcome and calling into question many of the assumptions of RCTs” (Angus et al., 2010, p. 360).

Anderson and Niles (2000) “suggest that practitioners consider the systematic collection of client self-reports about counselling helpfulness and the use of that data as one basis for assessing counselling effectiveness” (p.259). Asking patients to reflect on what they found most helpful during a therapy process may well contribute to their own knowledge of how to manage challenges in their lives and the strategies that work best for them. The question of what patients find most helpful in therapy can only be “answered idiographically, in terms of a particular patient’s response to the treatment being provided by a particular clinician” (Howard, Morass, Brill, Martinovich, & Lutz, p. 1059). Interestingly, the same has tended not to be asked of the therapists themselves. While there is a longstanding tradition of having CFTs video themselves for training and supervision (Bodin, 1969; 1972), researchers have tended not to explore the CFTs’



experience of learning about evidence-based therapies nor their engagement with, or delivery of, therapy.

While idiography suggests an emphasis on the particular, this is not the same as an emphasis on an individual. As we have seen, the phenomenological view of experience is complex. On the one hand, experience is embodied and situated. On the other hand, it is relational and offers a concept of the individual that is worldly and not so discrete and contained. Either way, individuals can offer a unique perspective on their engagement with the phenomenon and become the unit of study themselves. As such, “a commitment to an idiographic psychology is obviously closely linked to the rationale for case-studies” (Smith et al., 1995, p. 63).

The case can be seen as the unique “bearer or instantiation of type” (p. 67) and collected together with other cases, can lead to more general claims. Smith et al. (2009) suggest two approaches for moving from a single case to more general claims: analytical induction and the quasi-judicial approach. The former involves attempting to develop theoretical explanations from a set of cases by proposing an initial hypothesis that is then tested against each case in turn. Bromley (1986) advocates a quasi-judicial approach which parallels case law development. In this approach, single cases are written up and considered in relation to other cases. The intent is to produce detailed accounts of persons in situations within relatively narrow areas of scientific and professional interest.

An idiographic approach highlights the particular, detail, context, and texture of lived experience (Smith et al., 2009). While a single case study can highlight the shared commonality of lived experience, the study of several participants can also bring a focus to shared themes and experiences. The focus on an individual case affords a ground up

approach to theory development by building to more general claims by drawing together additional cases.

## **2.4 Method**

### **2.4.1 Data Collection**

From a phenomenological perspective, I included multiple methods of data collection to hear the voices of CFTs for the purpose of understanding the meaning within their lived experience and to make visible their use of evidence-based practices. These methods included: interviews, an iterative review of related theoretical and philosophical literature, and reflexive journaling. This combination of qualitative research methods enhances the study rigour and improves credibility and transferability of data (Cresswell, 2007; Yardley, 2000).

#### **2.4.1.1 Interviews**

Data were collected through interviews with CFTs who have at least a Masters degree in a mental health field such as counselling, psychology, social work, or marriage and family therapy. These professions were targeted for interviews because it is these professionals that are recognised as offering couple and family therapy. The interviews were focused on their experience of learning and using an evidence-based couple or family therapy practice. Participants were able to discuss what influenced their decision to learn an evidence-based CFT practice, how they went about learning this new practice, what they found most helpful and not, and what impact this has had on their day-to-day clinical practice. The interviews were guided by the interview guide outlined in Appendix A. As suggested by the methodology, questions were “prepared so that they

[were] open and expansive; the participant...[was] encouraged to talk at length” (Smith et al., 2009, 9. 59).

Individual interviews with 14 CFTs occurred either face-to-face or via Blackboard Collaborate, had a semi-structured format, and took place at a mutually agreed upon time and place. Prior to starting each interview, I asked participants to sign a consent form (Appendix B) to demonstrate they understood the purpose of the study and what was expected of them. BlackBoard Collaborate is an on-line learning software system that Dalhousie University uses. Among other functions, one can conduct, record, and save an interview in this system. BlackBoard is hosted in Calgary and was not directly exposed to the effects of the USA PATRIOT Act. Also, using BlackBoard satisfied Dalhousie's policy Protection of Personal Information form Access Outside Canada.

The interviews lasted 60-100 minutes using the interview guide outlined in Appendix A. The interview guide was designed to promote the research participants' comfort starting with a descriptive question (Smith et al., 2009). Interviews were audio-recorded and transcribed verbatim by a paid transcriptionist and further reviewed and cleaned by the researcher to capture the specific text of the interview as well as the intonation, utterance and other components of speech which may lend itself to further interpretation.

#### **2.4.1.2 Journaling**

Finlay (2005) calls for researchers to incorporate into their methods a process that involves reflexively engaging “with the embodied intersubjective relationship researchers have with participants” (p. 271). Of note for this research project is a similar process for an epistemological reflexive engagement. One method that helps with the process of

reflexivity is journaling. As Finlay (2003) outlines, this “process of continually reflecting upon our interpretations of both our experience and the phenomena being studied” helps us to “move beyond the partiality of our previous understandings and our investment in particular research outcomes” (p. 108). Willig (2008) suggests that when journaling, a student should write as if writing to their supervisor and there are two types of reflexivity to engage in journaling: personal reflexivity and epistemological reflexivity. The first involves "reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (Willig, 2008, p.10). It also involves thinking about what impact the research may have and how it may change us, as people and as researchers. Epistemological reflexivity, Willig (2008) suggests:

requires us to engage with questions such as: How has the research question defined and limited what can be 'found'? How has the design of the study and the method of analysis 'constructed' the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation? (p. 10).

Thus, epistemological reflexivity encourages us to reflect upon the assumptions about the research, about the related literature, and about the world that we have made in the course of the research. This approach to reflexivity helps a researcher think about the implications of these assumptions for the research and its findings.

While not formalised into a journal, the constant reflection about and engagement with the research topic by the researcher took place in a number of ways. I carry a note

book with me where I make notes about what I am reading, when I am in discussion with a member of my PhD committee, while at conferences or workshops, and thoughts that come up in relation to the research. I also started to carry a small notebook in my jacket pocket where I could take notes about the research as ideas came to me while I was going about my daily business. As my analysis evolved, I started to keep notes in an MS Word document in a file on my computer that had articles and related material to the theme that I was exploring. Throughout this research project, I have assisted others in the training of an evidence-based approach to working with couples and families, supervised therapists learning an EBP, and saw couples and families in my private practice. At times, each of these provided moments of intensity in my reflexivity as I recognised something that a research participant mentioned or was mentioned in the research literature, as trainees and supervisees struggled and celebrated in their learning, and as I experienced my own sense of competence and struggle in my work with couples and families. A few of these reflections are included in the analysis here but, primarily, they functioned as a background in my analysis and a reminder of the importance to focus on the experiences of the research participants. This is an area of interest that I will consider in a future research project, that is, whether to create a systematic way to gather these reflections and experiences as part of the data collected.

### **2.4.3 Recruitment**

The sampling strategy had to be theoretically consistent with the qualitative research paradigm in general and IPA in particular. Purposeful sampling, consistent with qualitative research (Creswell, 2007), was used to select participants on the basis that they can speak to the experience of learning and using a CFT evidence-based practice.

Homogeneity is recommended for IPA studies and there is a need to speak to what situations these CFTs practice in, such as: how they vary, how they are similar, and how the contexts shape their practice. The focus, however, was on the CFT's experience with adapting an evidence-based practice, the practice of CFT as a cultural frame, and the potential for theoretical transferability.

With the sample being drawn from different professions and a focus on a particular aspect of psychotherapy practice, there is potential to make “a rich, transparent and contextualised analysis of the accounts of the participants” (Smith et al., 2009, p. 51). This will enable the reader to make links to their own experiences, the theory literature, and the IPA accounts, and explore transferability to their own contexts. In terms of sample size, “IPA challenges the traditional linear relationships between ‘number of participants’ and value of research” (Reid, Flowers, and Larkin, 2005, p. 22). For example, Smith et al., (2009) describe n=3 as the default size for a Masters level IPA study, while they write of the varied demands of different doctoral programs.

In some cases, Smith et al. (2009) recommend three self-contained but related studies for doctoral students. The first being a single case study, the second a detailed examination of three cases, and the third a larger sample of eight participants from different locations. “Much depends on the research question and the quality of the data obtained” (Smith et al., 2009, p. 52). This research project recruited 14 participants which is high for a PhD dissertation. The committee encouraged the researcher to recruit more based on other approaches to qualitative research that they are familiar with (e.g. grounded theory), other approaches to phenomenological research that have sample sizes that exceed 14, a concern for the ability to publish the research at the conclusion and

acquiesced as the research evolved and an academic familiar with IPA joined the committee.

A variety of strategies were deployed to recruit research participants:

1. The researcher approached CFTs that they know directly in person, by phone, or via email and provided them a research recruitment letter (Appendix C) about the research project and an invitation to participate.
2. Snowball sampling was also used, which is when “participants who have enrolled in the study are encouraged to recruit others or to provide names” (St. Lawrence & McFarlane, 1999, p. 586) of people they know “so that the researchers may approach them about participating in the study” (p.586).
- 3- The researcher posted the research recruitment letter on the Nova Scotia College of Counselling Therapists web site and the American Association of Marriage and Family Therapy’s research recruitment web site.
- 4- The researcher sent the research recruitment letter to:
  - all provincial directors of the Canadian Counselling and Psychotherapy Association with a request to forward to their provincial membership;
  - the Nova Scotia Association of Social Workers and the Association of Psychologists of Nova Scotia for distribution to their membership;
  - the Emotionally Focused Therapy, the American Family Therapy Academy, and the International Family Therapy Association’s listservs;
  - contacts at McGill University’s M. Sc. in Couple and Family Therapy program and the Quebec Association for Marriage and Family Therapy.

5- The research recruitment letter was placed in International Family Therapy Association research newsletter.

6- The research recruitment letter was distributed to email networks of the Clinical Manager, Lutherwood Family Counselling Services, Cambridge, Ontario.

This purposeful sampling strategy lead to a rich collection of cases for exploration.

Patton (2002) suggests that the:

logic and power of purposeful sampling derive from the emphasis on in-depth understanding. This leads to selecting *information-rich* cases for study in depth. Information rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term *purposeful sampling*” (p. 46).

In the following section, the participants and recruitment criteria will be described further.

#### **2.4.4 Participants**

The target population for this research project was CFTs who have at least a Masters degree in a mental health field, such as counselling, psychology, social work, or marriage and family therapy, and who have, or were in the midst of, learning and utilising an evidence-based couple or family therapy practice. In some areas, the U.S. in particular, there is a profession called Marriage and Family Therapy that is clearly defined and regulated. In Nova Scotia, most of the rest of Canada, and Great Britain and Ireland, couple and family therapy is performed by a range of practitioners from professions such as counselling, social work, psychology, and occasionally by people who have trained specifically as a marriage and family therapist.



Participants had to be, or had been, actively engaged in learning about and using an evidence-based couple or family therapy practice that included the following elements:

- the evidence-based practice has a treatment manual;
- the clinicians received training specific to that practice;
- the clinicians received supervision specific to that approach; and
- the evidence-based practice has a theory of change that clinicians were required to relate their practice to.

A total of 14 participants were interviewed and descriptions of each participant with a brief reflection from the researcher about the interview are included in Appendix D. This is a large number of participants for a PhD study using IPA. “Because IPA is an idiographic approach, concerned with understanding particular phenomena in particular contexts, IPA studies are conducted on small sample sizes” (Smith et al., 2009, p. 49). The focus in IPA is a detailed account of the phenomena being explored. “The issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases” (p. 51). Details of the research participants are summarised in Table 1 below.

Participant name	Age range	Gender	Location	Profession	Length of time in practice
Jessica	40-49	F	Canada	Counselling	8 years
Ken	60-69	M	Canada	Social Work	40 years
Cassandra	40-49	F	United States	Marriage and Family Therapy	4 years
George	60-69	M	Canada	Mental health professional	33 years
Kathy	60-69	F	Canada	Social Work	20 years
Louise	40-49	F	Canada	Counselling	12 years

Beth	30-39	F	Canada	Psychology	10 years
Helen	40-49	F	Canada	Social Work	28 years
Sally	40-49	F	Canada	Psychology	20 years
Raylene	60-69	F	United States	Marriage and Family Therapy	25 years
Mary	30-39	F	United States	Marriage and Family Therapy	3 years
Tina	40-49	F	Canada	Marriage and Family Therapy	5 years
Peter	50-59	M	United States	Marriage and Family Therapy	25 years
Eric	30-39	M	Canada	Counselling	1 year

Smith et al. (2009) recommend homogeneity among the research sample to further the focus on a particular experience. The criteria used for this research project focused on some the criteria that relate to what constitutes an evidence-based practice. I could have focused on one evidence-based approach to working with couples and families but this research project is not about the practice elements of learning one therapy approach. This research project focused more on the shared elements of learning and relating one's practice to a specific model with shared features such as a treatment manual and supervision to the specific approach. The shared theoretical elements of the experience explored in this research project are that of evidence-based practice and the elements that constitute that as defined professional bodies such as the American Psychological Association (1995; 2012). These shared theoretical factors are important influences on the experience of learning an evidence-based approach to working with couples and families.

Practical criteria are also important to address in IPA (Smith et al., 2009). The choice to include a minimum of a Masters degree reflects the standards that professional associations across Canada and the United States set for entry into therapy practice with

couples and families (e.g. Nova Scotia College of Counselling Therapy, Nova Scotia Board of Examiners in Psychology, Nova Scotia Association of Social Workers). The need to recruit participants from across North America reflects the limited experience I have noted with a substantive engagement with evidence-based approaches to couple and family therapy in Nova Scotia. For example, there is only one certified Emotionally Focused Therapist (EFT) listed in Nova Scotia on the International Centre for Excellence in EFT's web site, none are listed on the Gottman Couples Therapy referral network web site, and one is listed on the Imago Couples Therapy referral web site. Being certified by a recognised professional association in an approach to working with couples and families is one means of clarifying that a therapist has demonstrated the ability to relate their practice to that specific therapy approach. Finally, the opportunity to use BlackBoard Collaborate as well as in person interviews made gathering a sample for this research project doable and affordable. I do not have the resources, nor does my graduate funding cover the costs, of travelling throughout North America conducting interviews. Moving towards exploring data analysis, the next section outlines how data analysis is conducted in IPA and provides specific examples of how it was done for this research project.

#### **2.4.5 Data Analysis**

The inductive procedures of IPA are “intended to help the researcher to develop an initial insider’s perspective on the topic” (Reid et al., 2005, p. 22). This flexible technique allows the researcher to identify unanticipated topics or themes during analyses. The role of an IPA researcher is not to verify or deny a hypothesis but to develop broader research questions which lead to the collection of expansive data. “The

orientation of researchers towards these objects of interest (experiences, understandings) is generally open and often explicitly process-oriented” (Smith et al., 2009, p.46).

Understanding is attained by describing lived experiences and the meanings that emerge from them.

The balance of emic and etic positions in IPA is achieved first with the idiographic nature of the inquiry and then by the researcher’s attempts to make sense of the participants’ experiences and articulate them in a way that addresses a particular research question. This interpretation is “underpinned by a process of coding, organising, integrating and interpreting of data” (Reid et al., 2005, p.22). IPA is grounded in the text but moves beyond it to a more interpretive and psychological level. IPA also recognises that different levels of interpretation are possible.

There are four levels that can be explored within an IPA framework. The first level is the main substantive theme, the second level is the use of metaphors or other content (e.g. gesture, action) that has meaning one derives through analysis. The next level looks at a temporal construction of the experience and how meanings have evolved over time. A fourth level of interpretation is the use of theory to examine participant’s text. In IPA a successful interpretation is one that is principally based on themes and sub-themes identified from within the participant’s own text. “Broadly, one can say that most of the interpretive levels employed in IPA are more in keeping with...a hermeneutics centred on empathy and meaning recollection. However, IPA also allows a hermeneutics of questioning, of critical engagement” (Smith, 2004, p. 46). This allows for the researcher to engage theory and suggest other analytical lenses to understand the text while still giving priority to an empathic hermeneutic.

Smith (2007) describes data analysis as an iterative and inductive cycle, which draws on a number of different strategies including: line-by-line analysis of experiential claims, concerns, and understandings (Larkin, Watts, & Clifton, 2006); identification of segment patterns or themes emphasising both convergence and divergence first for a single case then across cases (Eatough & Smith, 2008); the development of a dialogue between the researcher, the coded data, and their CFT knowledge, about what it might mean for participants to have these particular concerns at this time in this context, which leads to a more interpretive account (Smith, 2004); the development of a frame, which illustrates the relationships between the themes; the use of supervision, collaboration, or audit to test and develop coherence in the interpretation; the development of a full narrative, which includes detailed commentary of data extracts and takes the reader through theme by theme; and, finally, reflection on the researcher's own perceptions, and processes (Smith, 2007).

While there are suggestions for how to proceed, IPA is not intended to be a prescribed set of steps meant to be followed like a paint-by-number kit. The guidelines are meant to be a model for how to come to a rich and thick description of the phenomenon being researched. "These meanings or understandings or insights constitute the findings of the study" (Smith et al., 2009, p.178). In general, IPA moves from the particular to the shared, from the descriptive to the interpretive, it maintains a commitment to understanding the participant's point of view, and has a psychological focus on personal meaning making in particular contexts. Smith et al., (2009) outline a six-step process for the analytical process which this researcher will use:

- 1- Reading and re-reading the transcripts and other data. Note anything of interest within a transcript.
- 2- Initial noting at three levels paying attention to the participant's content, linguistic interpretations, and conceptual comments.
- 3- Develop emergent themes beginning to decrease the volume of data while maintaining complexity in items by mapping inter-relationships, connections, and patterns between exploratory notes.
- 4- Search for connections across emergent themes, identify and explore oppositional items, identify contextual or normative elements, and identify the purpose a theme may play in a CFT's life.
- 5- Move to the next case and repeat same analytical process.
- 6- Begin to look for patterns across cases and identify most important things to say about participants.

Table 2 below provides a sample of how this researcher completed the analysis.

Using MS Word, I created a box with five columns. The first column numbered the passages in the transcript, the second column had the transcript of the interview, the third column had initial noting at three levels about the participant's content, linguistic interpretations, and conceptual comments, the fourth column had the emergent themes, and the fifth column the super-ordinate themes. The initial noting in the third column included descriptive comments in normal text which are comments that focused on describing the content of what participant has said or the subject of the talk within the transcript; linguistic comments were italicised and focused on exploring the specific use of language by the participant; finally, conceptual comments are underlined with a focus

on engaging at a more interrogative and conceptual level. These comments were made directly in line with the place they appear in the transcript so that one could read across and when that was not possible, I colour coded the comments to link them with the place in the transcript that is being commented on. The passage from the transcript that is commented on is also italicised or underlined as is relevant.

Table 2  
*Sample data analysis*

Transcript	Exploratory comments	Emergent themes	Super-ordinate themes
<p>P: I <u>just really wanted to be more effective with my couples</u>. I had taken training in Imago, I had trained with, I've done so many different things, I've done Shamanic training which I love, I've done interactive guided imagery and hypnotic imagery and hypnosis, and I'm thoroughly trained in EMDR since the mid-90s, and we've done a lot with individuals, but I consistently found that, the thing that was most helpful actually with my clients was learning Heidi Scheffler's work and she worked with something called the bridge, she sort of advanced the Imago work. And I found that was really effective in the sessions but that people wouldn't do it, they wouldn't do it at home, they didn't, they'd have these changes in the session but they had to keep coming back to see me. <u>So my real motivation, actually it's interesting, one of my biggest motivations for learning EFT at the time was that I wanted to be able to really help clients in twelve sessions</u>. Since then I've <u>learned that very few therapists get through EFT in twelve sessions</u>, but that was my motivation is <i>I really wanted to learn a technique, well it's not a technique</i> which is part of this issue, but I was thinking I was going to learn a technique, an approach that was going to <u>serve my couples better and that was my entire motivation</u>.</p>	<p>- <u>learning EFT- want to be more effective with couples</u>  - did Imago training, Shamanic training, interactive guided imagery, hypnotic imagery and hypnosis, trained in EMDR</p> <p>- training in other approaches individual or couple not leading to the kinds of enduring changes she was looking for in her practice</p> <p>- <u>motivation was to have an approach that would work in a set number of sessions as promised by the research literature</u>  - <u>after become involved with learning, find out that few therapists accomplish what is outlined in the EBP literature</u>  <i>- a cognitive dissonance, want to learn a technique- it's not a technique</i>  <i>- serving couples – a calling for her?? called to serve how?? Why??</i>  - <u>learning an EBP- want to be more effective with couples</u></p>	<p>- driver to learn EFT was to be more effective with couples</p> <p>- how the research literature influences a therapist's decision to learn</p> <p>- driver to learn EFT was to better serve couple</p>	<p>The varied and divergent roles of research and being identified as an EBP</p> <p>The varied and divergent roles of research and being identified as an EBP</p>



#### **2.4.6 Evaluation of the Research**

Qualitative research approaches to couple and family therapy are best evaluated by criteria that “flow directly from the theory and purposes of the research” (Sprenkle & Piercey, 2005, p. 5). A number of guidelines for assessing the quality and validity of qualitative research have been developed. Yardley (2000) presents four broad principles for assessing the quality of qualitative research. The first principle that Yardley outlines is sensitivity to context. A researcher can show sensitivity to context in a number of ways, including the socio-cultural milieu in which the research is situated, the existing literature on the topic, or the material obtained from a research participant. Yardley’s second broad principle is the commitment and rigour of the researcher. Commitment can be demonstrated by attentiveness to the participant during data collection and the care in which the analysis of each case is carried out. “Rigour refers to the thoroughness of the study, for example in terms of the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis undertaken” (Smith et al., 2009, p. 181). The third principle Yardley outlines is transparency and coherence. The former refers to the clarity of how the stages of the research are written up, including how participants were selected, how the interview schedule was constructed and how the interview was conducted, and what steps were used in the analysis. Coherence refers to whether themes identified hang together logically, the write-up presents a coherent argument, and ambiguities or contradictions are clearly dealt with. The fourth and final broad principle is impact and importance. Yardley suggests that the real test of validity is whether the reader finds something interesting, useful, or important about the write-up.

In this research project, I attended to sensitivity to context in a number of ways. First was the attention to the material obtained from the research participants. A second means that I am sensitive to the context is the review and knowledge I have of the literature, both the research and clinical literature. A third way that I was able to demonstrate sensitivity to context draws from my own experience of learning evidence-based approaches to working with couples and families, assisting in the training of therapists learning an EBP, and supervising individuals integrating a CFT approach. Each of these kept the context alive and vibrant throughout the research process and assisted me in being sensitive with elements of the contexts that research participants were learning in. Yardley's second broad principle that is reflected in this research project is the commitment and rigour of the researcher.

In terms of rigour of analysis, a sample of the analysis is included in Table 2 below and a table of group super-ordinate themes in Appendix F. Smith et al. (2009) define super-ordinate themes as "a construct which usually applies to each participant within a corpus but which can be manifest in different ways within the cases" (p. 166). Previously noted in the "participants" section is the careful consideration of the sample and the criteria used for recruitment. A commitment to the research participants and their experiences was required throughout his research project and how that was reflected by the researcher was mentioned by a few of the interviewees. For some of the participants, talking about their experience of learning an EBP included very personal aspects of their lives, places of struggle in their learning, and a need to feel safe with the interviewer - me. Raylene reflected my efforts when she mentioned that "...I'm sitting here talking to you, I mean I feel completely comfortable being totally transparent with you". Another

participant, Helen, wanting to raise a difficult aspect of her training, checked in with me by mentioning that “I don’t want to make this personal, but I respect your work, so I think, you, you are looking for my honesty, with this”. I reassured her at the time and she went on to talk about a situation that I was familiar with; Helen provided me her frank assessment of that event. I will next address Yardley’s third principle, transparency and coherence.

The coherence of the narrative developed from the research participants will be for others to judge. Some of the feedback I have received while presenting a theme at conferences has been positive and reflects the aims of IPA. For example, one participant emailed me after my keynote address at the 2014 Canadian Counselling and Psychotherapy Research Conference in Moncton, New Brunswick. She noted that:

Your phenomenological approach has allowed a study that reads like literature; something that can be read on a superficial level for plot related to the counsellor’s response to EBT and something that can be read on a deeper level for the thematic components that allow an informed criticism of the efficacy of EBT in relation to the therapeutic process. (L. Martin, personal communication, February 28, 2014).

The careful analysis completed by the researcher and review provided by others is an important aspect of the transparency of the process in this research project. Two full transcripts that were analysed were reviewed by the committee members. Based on their feedback, the transcripts were re-analysed and the committee re-reviewed them, providing approval of the work as it developed. Finally, a sample of my analysis was presented to the London IPA group at the Tavistock Clinic, the session was video

recorded, and the video was sent to the committee for their review. The fourth and final of Yardley's principles to attend to in qualitative research is that of the impact and importance of the research project which is discussed in the final chapter.

#### **2.4.7 Ethical Issues**

Qualitative researchers face a number of ethical issues, particularly during data collection and in the analysis and dissemination of research findings (Cresswell, 2007). This research was guided by the following ethical guidelines: informed consent, right to privacy and anonymity, protection from harm, and sensitivity and duty of care. In keeping with the Tri-Council Policy, ethical approval was sought and received from the Human Ethics Review Board at Dalhousie University. All possible measures were taken to ensure confidentiality. All data has been stripped of identifying characteristics and any information or quotations that may disclose identity are omitted. Interviews were digitally recorded to preserve the accuracy of the text. The recordings are stored on a password protected computer drive. Interviews were conducted at a time and place mutually agreed upon between the researcher and the participant. Participants were advised that their participation was voluntary and all possible measures will be taken to ensure confidentiality. In addition, participants have the option of withdrawing at any time and any data collected will be destroyed if the participants choose to do so. Paper copies of transcripts, consent forms and other identifying material are stored in a locked filing cabinet in the researcher's office. Electronic, sensitive data is password protected and stored on a dedicated drive.

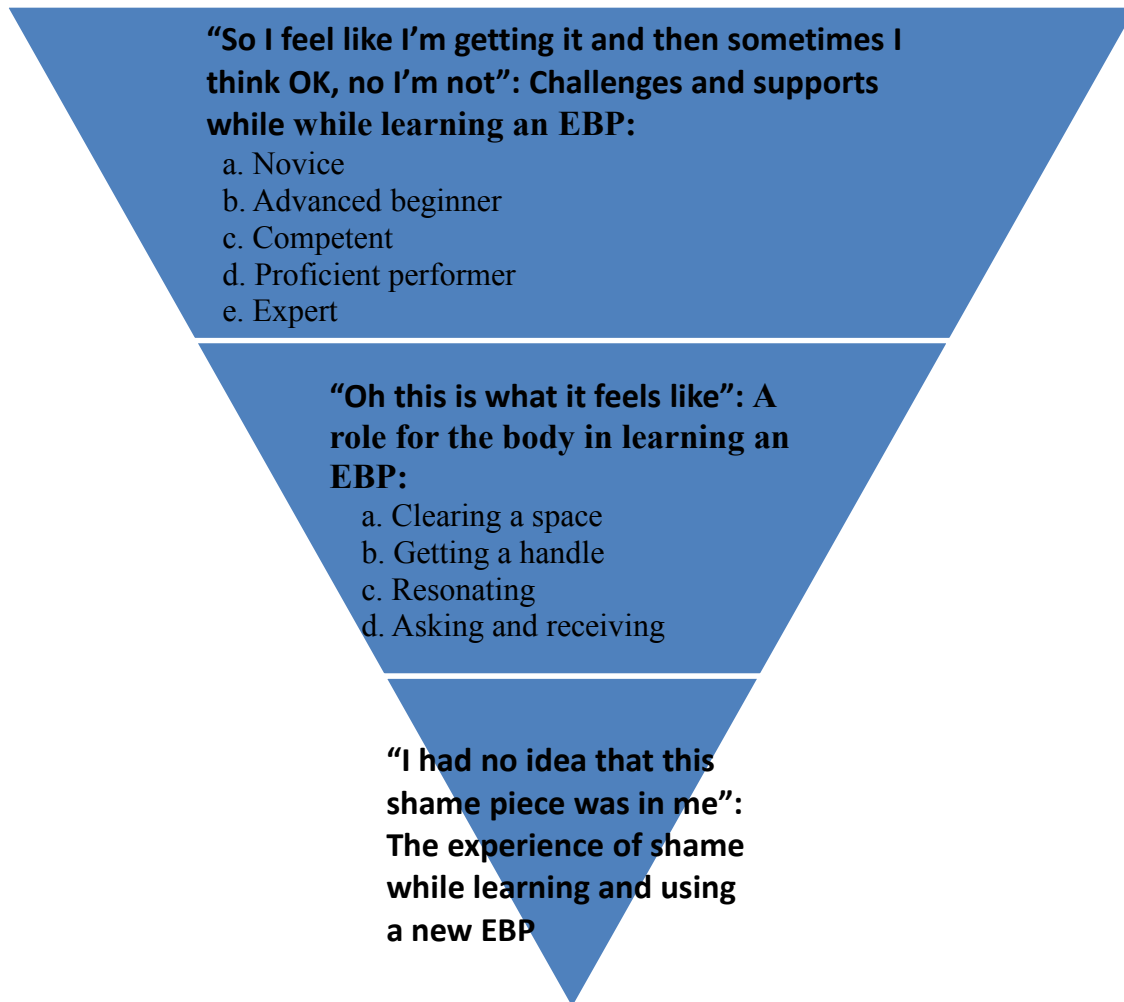
Since this topic has the potential to cause emotional distress, counselling resources were made available through the researcher upon request. The researcher was

particularly well-suited to carry out this research considering his professional background. As a psychotherapist, the researcher is equipped to deal with crisis management and emotional stress during recall of difficult experiences and is very familiar with resources available for support and follow-up. Given these qualifications, the research was conducted in a safe and ethical manner.

## **Chapter 3**

### **Overview of Results**

This chapter provides an overview of the principles that guide the analysis in the following chapters and a description of the three super-ordinate themes that are further explored in chapters four to six. These three themes are: the experience of shame while learning an evidence-based practice (EBP); the role of embodiment while learning an EBP; and what supports and challenges the learning of an EBP. The three themes are represented visually in Figure 2 below and are further explored in chapters 4-6. The visual representation in Figure 2 both reflects the number of participants who provided substantive discussion about the theme and the depth of impact that it had on their lives as they discussed the theme. The most representative theme, the challenges and supports while learning an EBP, incorporates extracts from the majority of participants and addresses each of the research questions. A second theme, the role of the body in learning an EBP, reflects the deep meaning that some of the participants made of their experiences and how they spoke of that meaning making process. The experience of shame while learning an EBP was the third theme identified and represents what Smith (2011b) refers to as a gem in the research findings. The titles of the themes combine quotes from the research participants and a note about the experience in an effort to reflect the interpretive and ideographic nature of IPA.



**Figure 2 Representation of Super-ordinate Themes**

The analysis followed the guidelines as outlined in Smith et al. (2009) that were described in chapter two of this dissertation. The results reported here follow Smith’s (2011a) guidance about interpretive phenomenological analysis (IPA) studies being concerned with convergence and divergence, “not only presenting both shared themes but also pointing to the particular way in which these themes play out for individuals” (p. 10). Accordingly, the participants’ experiences are foregrounded in each of the three themes that emerged, then each theme is further explored using a hermeneutic of

suspicion (Ricoeur, 1970). This approach follows the guidelines that have been identified for reporting results from an IPA study.

For example, in a research paper evaluating the contribution of IPA that included a review of 293 published papers between 1996 and 2008, Smith (2011a) outlines four criteria for an acceptable IPA paper. The first is that the research “clearly subscribes to the theoretical principles of IPA: it is phenomenological, hermeneutic and idiographic” (p. 17). Secondly, that the write up is sufficiently transparent that the reader can see what was done. The third criterion that Smith outlines is that the analysis be coherent, plausible, and interesting. The final criteria addresses the sampling required from all research participants to demonstrate the density of evidence for each theme. Smith recommends the following guidelines for sampling:

N1-3: extracts from every participant for each theme;

N4-8: extracts from at least three participants for each theme; and

N>8: extracts from at least three participants for each theme + measure of prevalence of themes, *or* extracts from half the sample for each theme. (p. 17)

What follows is an outline of how the final criterion is addressed in the current study.

With a total of 14 participants in this research project, the suggested requirement is that extracts from at least three participants be included as well as a measure of prevalence of the themes. Extracts from more than half the participants are included for two of themes (embodiment and learning) and extracts from exactly half the number of participants are included in the same chapter. A table of frequency of occurrence of super-ordinate themes across participants (Appendix E) and a full set of quotes in a table of super-ordinate themes (Appendix F) are included in the appendices. The supports and



challenges while learning an EBP was the most prevalent theme across participants followed by embodiment then the experience of shame while learning an EBP. These themes emerged from the research participants' experiences with a focus on the research questions outlined for this project which are: what influences a couple and family therapist to explore and use an EBP; what do couple and family therapists experience when learning about an EBP; and what do couple and family therapists experience when adapting and using an EBP in their day-to-day clinical work. What follows is a brief outline of each theme, the theoretical literature used to further explore participants' experiences, and an overview of the analytical choices made to develop these themes. The title of each theme is linked with the participants' own words in an attempt to provide an experiential feel for the theme.

### **3.1 Challenges and Supports while Learning an Evidence-Based Practice**

This is the most prevalent theme and best represents Smith's (2011a) notion of "capturing of similarity and difference, convergence and divergence" (p. 24) that are good hallmarks of IPA research. As the most prevalent theme, there is more emphasis in this chapter on the theories considered to further the analysis and discarded as this theme emerged. There are a number of factors that contributed to this being the most prevalent theme including: the focus of the research questions, the interview questions, the wording and distribution of the recruitment letter, the sampling strategy, the researcher's position and focus, and the research participants' understanding of what it meant to talk about their experiences of learning an EBP.

This theme presents the experiences of couples and family therapists (CFT) while learning about and adapting an EBP into their practice including what supported that

process and what they found hindered or made the process more challenging. These supports and challenges include specifics such as their experience of a trainer, the role of supervision, and what resources the participants drew on when they felt challenged. This theme speaks to each of the research questions as all of the participants mentioned that they pursued training to improve their work with couples or families. The participants could also talk about their experience while learning a new EBP while some of the research participants could address their experience of integrating a new EBP into their practice. Starting with the research about master therapists, what follows is a brief outline of two theoretical frameworks considered and rejected to further analyse participants' experiences and a brief introduction to phenomenological model of learning used to further explore participants' experiences, the Dreyfus (1986, 2004) model of skill acquisition.

### **3.1.1 Master therapists**

One body of research that has explored the development of therapists over time is the work of Jennings and Skovholt (1999) who researched the cognitive, emotional, and relational characteristics of master therapists. Continuing the research longitudinally, Skovholt and Starkey (2010) describe the cognitive characteristics as including a “voracious appetite for learning” (p. 126), emotional characteristics of master therapists include a “fine tuned self-awareness” (p. 126), while relational characteristics allowed for “a proficient ability to intensively engage clients” (p. 126). Participants in this research project spoke to the role of each of these elements in their development as well.

Cassandra for example, discussed how she engages cognitively while learning a new approach primarily through reading and mentioned that “I find that really helpful,

the intellectual piece of it and kind of that guidance”. She also went on to discuss the challenges she experienced in learning EFT and the limitation of approaching it using her cognitive strengths:

Well do you have five hours? It’s a hard, you know it’s really funny that at the time, back in 2009, I was about a year and a half into the clinical psychology program and I’d really gotten good at the program that I’m in. There’s a lot of independent learning, so I thought I can learn anything, I can learn this, it’s not going to be that hard, so I go the books, I got the videos. I even thought well I probably won’t even need training, I can just train myself and I pulled down articles and I was reading everything and I was watching the videos. And then you get into a room with a couple and even if I felt like I had a decent idea of what I wanted to do you know I thought I did. At this point I realized that like what it looks like on paper and what it looks like in the room and what you’re really trying to do, that translation in and of itself takes a lot of the time.

While skilled at integrating the reading she did into her clinical work, Cassandra is also painfully aware of the limitation of this kind of approach in her own development.

Despite her voracious appetite for reading and all the articles, books, and videos she could access, Cassandra describes more a sense of hunger pangs that emerge as she notes “the translation” takes a lot of time. For Cassandra, while the literature is important, she also describes a need for something else to satiate her appetite.

Louise also talked about the cognitive aspects of her learning. She reported that she is always reading and how that contributes to her thinking, case conceptualisation,

and treatment planning. She talked about focussing in on particular aspects of her current caseload while reviewing research and therapy:

It's a very, very rich way to learn because it is like doing lab work right. I mean ah, you know you read an article, anything I read, like I said I'm constantly reading, and anything I read, I have three or four cases in my mind as I'm reading it going oh right, so that's what's happening here you know.

Louise went on to describe the value of learning about her therapy in this way; describing how "...it's very rich. So you're, you know I'm very engaged because I have live people who I'm going to see [laughter] within 24 hours often, you know so talk about something coming alive". The strong desire to learn reported by Cassandra and Louise fits well with the category of cognitive characteristics noted by Skovholt and Starkey (2010). Research participants similarly discussed the role of attending to emotional awareness in their development.

A number of research participants mentioned the role of supervisors, peers, or just moments in their learning where they developed a new emotional awareness and began to see the learning as incorporating a means to explore the emotional aspects of their learning. Kathy mentioned that:

...one of the things I value very highly is supervision in my own therapy to do the work that I do, so ah this was just another piece of it, really helping me to understand relationships better and the struggles that we have.

For Kathy, the opportunity to explore her own relationship, as well as those of her clients, was an important aspect of supervision and one that she saw as contributing to her emotional awareness of herself and the couples she worked with. Cassandra took the

initiative to form a peer support group specifically for the means of exploring the emotional material that arose for her and colleagues while learning:

So I actually ended up organizing for a period of time, a support group kind of for therapists themselves and to really deal with our personal feelings related to what it's like to learn this model and to do this model. So I ended up finding a bunch of kind of compadres.

This focus on self-awareness noted by Kathy and Cassandra was an integral part of their learning process. Finally, the relational domain was also addressed by the research participants.

The aspects of the relational domain that participants most spoke of were the demands on the therapist. While working with more than one person in the room, thinking relationally and systemically, and considering the impact on self of the therapist left participants seeking specific supports to aid them in their learning. For example, Cassandra mentioned that what she sought out was:

Either people who are further down the path or at the same place with me. That you know that I could talk to other colleagues who weren't learning EFT about some of those struggles, but they couldn't quite relate because I think the model itself demands so much of the therapist. More so than say Gottman did or, you know one of the other gals in my office was a Hendricks Imago therapist. I think it's very structured and doesn't demand quite as much of the therapist and so I couldn't really find support outside of the EFT community.

Cassandra is aware of the demand on the self-of-the-therapist in her learning and sought out people who would have been on the leading edge of her experience with the EBP she

was integrating into her practice. While Jennings and Skovholt's (1999) research about the cognitive, emotional, and relational domains of master therapists gives us clues about what contributes to therapist development, there are shortcomings noted in the research literature regarding their approach to therapist development.

The challenge with conflating data about so called master therapists is that it “produces a fictional ideal that may never be found in any practitioner” (Orlinsky, 1999, p. 12). This critique may have lead Ronnestad and Skovholt (2003) to add to their model of therapist development by identifying 14 themes that emerged from the longitudinal qualitative study of the development of 100 therapists. Another shortcoming of situating therapist learning within a development framework is the need to isolate the learning about therapy from other aspects of the therapist's life. Is it truly developmental if other aspects of a person's life are not explored? As Holloway (1987) questions, “how are the developmental shifts that are postulated in these models evidenced (a) outside of the supervisee role, (b) in the counselor role, (c) in the student role, and (d) in other roles of the person's life?” (p. 215). Another possibility for exploring the participants' experiences with learning could have been to use a cognitive or rational approach.

A cognitive approach to learning that focuses on a step-by-step process for integrating something new and the rules that need to be learned offers a clear map that appears easy to follow. Cognitivists attempt to simulate the problem-solving in computers and artificial intelligence (Flyvberg, 2001). These models work well when tasks are well-defined with clear solutions. The challenge for CFTs, however, is that couples and families or solutions for their problems are rarely well-defined, linear, and have simple solutions. This approach to learning sees people as “problem-solving beings

who follow a sequential model of reasoning consisting of elements-rules-goals-plans” (p. 14). One such approach to learning that incorporates neurology is outlined by Daniel Coyle (2009).

### **3.1.2 The talent code**

For his book, *The Talent Code: Greatness Isn't Born. It's Grown. Here's How.*, Coyle (2009) researched high performance centres that are producing some of the world's leading sport and music talents. Coyle drew on recent developments in neurology to help explain the efficacy of the training centres that he researched. Coyle writes that “the talent code is built on revolutionary scientific discoveries involving a neural insulator called myelin, which some neurologists now consider to be the holy grail of acquiring skill” (p. 5). Siegal (2012) describes that the growth of myelin along the length of neurons “increases the speed of nerve conduction by one hundred times and reduces the refractory period during which a just-fired neuron must reset before firing again by thirty times” (p. 23). Myelin functionally improves “the linkage among synaptically connected nerve cells by three thousand times” (p. 23). With a focus on the process of myelination, Coyle suggests that “skill is insulation that wraps neural circuits and grows according to certain signals” (p. 58). In other words, the suggestion is that the process of myelination makes movements and thoughts faster and more accurate. The key to developing these myelin wraps is effective practice.

What Coyle saw at leading sport and music training centres was a three part training process where trainees were introduced to an effective practice process that Coyle (2009) described as: chunk it up, repeat it, and learn to feel it. The first part, chunk it up, involves looking at the task as a whole, dividing the task into its smallest chunks,

and playing with time by slowing the task down or speeding it up. Ken described a chunking up process that was part of two supervision groups that he participated in online:

I joined two group supervisions, so the one group supervision context was basically part of it was a question and answer about people's practice in EFT and then the half of that supervision was looking at a tape of a couple...you know minute by minute or second by second analyzing what was going on...And the other one, was where each member of the group presented a videotape of a couple that they were working with and then got supervision mostly from the supervisor.

One group allowed the therapists to present a small chunk of their work, a 5 minute segment of a therapy session, while the other group focused on the second by second analysis of an EFT session that was meant to offer a strong demonstration of the model. As Coyle notes, slowing down "allows you to attend more closely to errors, creating a higher degree of precision with each firing—and when it comes to growing myelin, precision is everything" (p. 85). This slowing down also aids the learner to develop "a working perception of the skill's internal blueprints" (p. 85) thus providing shape and rhythm to interlocking skill circuits. Ken experienced both the slowing down of his own work and second by second feedback as well as the slowing down of a strong demonstration of the model he was leaning.

I have experienced the process of chunking it up on a number of occasions and one example is when I reviewed and transcribed sessions for another therapist that was preparing a video set that was being sold on psychotherapy.net. The opportunity to focus intently, review and rewind, and completely understand what the therapist was saying,



when they intervened, what they did, describe the intervention, and make sense of the session as a whole was a surprise learning for me. The surprise was that I thought I was doing a somewhat tedious job and I did get quite a bit out of it having to slow down, identify specific interventions, and clearly understand each moment in the session.

Another part of the effective practice that Coyle described was the need to repeat it. Coyle (2009) writes that the repetition is not mindless but attentive and “in the sweet spot at the edge of your capabilities, attentively building and honing circuits” (p. 88). Coyle suggests that learning is built on the paradox of struggling in targeted ways and writes that “operating at the edges of your ability, where you make mistakes—makes you smarter” (p. 18). Louise talked about the role of reading for her development. She is in private practice on her own and rarely has the opportunity to consult with colleagues. The importance of the treatment manual, workbook, and research articles takes a prominent place in her learning because as Louise said “I don’t, I’m not talking with other people except myself right. I am constantly reflecting on it”. She went on to note how she benefitted from returning to the same foundational material about the approach she was leaning, saying that “you could re-read that stuff and something that you missed the first time jumps out the third time”. Louise reflected a similar experience reviewing video of her work saying that “it’s like anything else I guess you go over it and you know get some and then you could watch your tape fifteen times and get something new from it”.

The third part of effective or deep practice that Coyle notes is to feel it. Here a trainee will experience the uncomfortableness of learning at one’s edge of capabilities. As Coyle (2009) describes it, “that productive, uncomfortable terrain located just beyond

our current abilities, where our reach exceeds our grasp” (p. 92). Coyle notes that rather than learning in the sweet spot it may better be named the “bittersweet spot” (p. 93). Here the suggestion is to use a cognitive process where one identifies a target, reaches for it, evaluates the gap between the target and the reach, and starts again. While this cognitive process may be of use at certain stages of learning, the Dreyfus model suggests a different understanding of skill acquisition at this stage. “The point...is not to analyze one’s mistakes and insights but just let them sink in” (Dreyfus, 2004, p. 179). This distinction was reflected by Raylene as she discussed an important contribution to leaning EFT:

There’s another EFT therapist and we went through Core Skills training at the same time and we began to get together to study. Well what our study group turned into which was much more useful, was us talking about our own attachment and our own attachment history. And our own personal challenge in trying to get this EFT down and what was happening inside of us internally and what was happening in our own relationships, that was more helpful than any of the training. And not that the training hasn’t been helpful, but now that I’ve got the internal map, through my own personal experience, now all of that cognitive stuff makes sense [laughter].

For Raylene, the focus was not on returning to practicing a skill, chunking it up and repeating it, but to feel it by literally letting it sink into her own life, relationships, and understanding of herself and with colleagues learning the same therapy approach. Departing from a rationalist approach, Raylene found a way to focus on developing an “internal map”. This departure from rationalist approaches is an important distinguishing

feature in the Dreyfus model of skill acquisition and an important reason why it was a useful means to explore the experiences of the participants in this research project.

The challenge was to find a phenomenological means to explore how the participants made meaning of their experience. The Dreyfus model of skill acquisition became a useful epistemological tool to explore participants' experiences. Dreyfus and Dreyfus (1986, 2004) offer a phenomenological model of skill acquisition that provides a rich means to explore the broader experiences of therapists learning and using an evidence-based approach to working with couples or families. The Dreyfus model is a phenomenological approach to learning and provided a means to situate therapists' learning developmentally while recognising the complexity of CFT tasks. While the Dreyfus model is not specific to learning couple and family therapy, there is limited research about the experience of therapists learning a new therapy approach. The Dreyfus model of skill acquisition will be explored more in depth and be used to further reflect about the participants' experiences in chapter four. Moving to another theme, the role of the body while learning an EBP, what follows is a brief introduction to the theme and the options considered as the theme emerged.

### **3.2 A Role for the Body in Learning an EBP**

Participants' experiences with embodying an EBP and the struggles they had with embodiment was the second most frequently occurring super-ordinate theme. In the introduction of the chapter exploring this theme I use the metaphor of participants slamming up against parts of themselves as their learning evolved. For some of the participants, this was an apt metaphor as they discussed the experience of being "pushed", "drawn to", or compelled to explore something "deep inside" them. Possibly

two of the bigger influences on participants' willingness to discuss how they embodied a practice would be the particular therapy approach they discussed and their professional background and training. Research participants came from a variety of professions including psychology, social work, counselling, marriage and family therapy and other mental health professions. Each of these professions has a different understanding of whether exploration and understanding of one's self or exploring felt senses is part of the training and within each profession there are different schools of thought about how students should be prepared for the profession.

My own graduate training is one example where there was little to no exploration of self-of-the-therapist (SoTT) issues which could be a means of understanding the process of embodiment or relating to a felt sense as a therapist. While I went on to do post-graduate studies in marriage and family therapy and received substantial supervision where SoTT was a central feature, it was shockingly absent during my master's degree. This is in stark contrast to the central positioning of SoTT related work in the Master's in Marriage and Family therapy offered at the University of Winnipeg. When I interviewed the director of the program for an article (McLuckie, Allan, & Ungar, 2013), he reported that they have mandatory year-long weekly SoTT groups for the students with a focus on family of origin issues and students were encouraged to seek out individual therapy as well. My comfort level at discussing a range of SoTT issues, including that of embodying a practice, changed substantially with training and supervision that provided me the opportunity to develop that awareness and understanding. There are also different epistemological paradigms that inform the education approach for and within each profession. For example, a few of the social workers that I interviewed came out of

graduate social work training that is informed by an anti-oppressive (AOP) framework as opposed to a clinical approach. The AOP framework develops practitioners to oppose the roots and effects of social oppression and it provides a comprehensive understanding of a range of economic, social, and other forms of oppression. These research participants had a very different approach to talking about their own experiences of learning an EBP than those who came out of training and supervision that was clinically focused and where SoTT issues were a feature of the training. Those participants who came out of an AOP-based program struggled to make sense of their experience of learning an EBP. The therapy approach discussed was another factor that influenced research participants' experiences with embodying a therapeutic approach.

The research participants who discussed EBPs that were influenced by attachment theory were more likely to discuss the experience of embodying a practice. This was not an issue that was explored in this research project so it is difficult to suggest why some of these participants were more likely to explore the experience of embodying a therapy practice. It is possible that, as Louise suggested, attachment is a "primal theme" and the primacy of this experience evokes more from someone learning a therapy approach informed by attachment theory. Another possible consideration is whether they were encouraged to embody a practice as they were learning it. For example, whether they were encouraged to explore how different aspects of the new model felt for them or how they experienced the model in their own lives as they were learning a new therapeutic approach to working with couples or families. Couple and family therapy training in general does evoke more from a trainee and it may be that attachment-based approaches promote more reflection and consideration of those experiences in one's life. As

previously stated, this was not the focus of this research project nor explored further and these are merely tentative suggestions about the experience with attachment theory informed therapy approaches. The next section will explore the theoretical considerations that were explored to further analyse participants' experiences.

While Dahl and Boss (2005) suggested that “phenomenology is enjoying a resurgence and has an intuitive appeal among family therapy researchers” (p. 80) there is a limited range of phenomenology to draw from in the field of couple and family therapy research. I would contend that it is an area in need of development and further problematizing so that we move from discussing a “phenomenology” to the range and complexity that phenomenologies offer couple and family therapy researchers. Similarly, there is limited research within couple and family therapy exploring the experience of embodiment. Unlike learning or shame where there is a range of psychological research and approaches to draw from and given the limited research about couple and family therapists' learning previously noted, there were fewer theoretical perspectives to consider when deciding how to further explore the data. A focus on the body and felt sense lead to the work of Merleau-Ponty and Gendlin which was suggested by committee members.

For this theme, the body is understood as a form of consciousness (Merleau-Ponty, 2002); our bodies are the mechanism for perception, both objective and subjective. Merleau-Ponty offers an epistemological means to explore participants' experiences as a form of embodiment. He writes of the body as “the vehicle of being in the world, and having a body is, for a living creature, to be intervolved in a definite environment, to identify oneself with certain projects and be continually committed to them” (Merleau-

Ponty, 2002, p. 94). While Merleau-Ponty offers an epistemological framework for understanding the body as a way to make meaning of participants' experiences, Gendlin (1978) offers a means to explore what that process involved step by step.

The experience of participants embodying an EBP or the struggles with doing so, are outlined using Gendlin's (1978) process for helping individuals "make contact with a special kind of internal bodily awareness" that he calls a "felt sense" (p. 10). This felt sense is a "bodily awareness of a situation or person or event" (p. 32). Gendlin describes a process where one might have a nagging feeling or a vague uncertainty that when focussed on and processed, or embodied, there is a "bodily shift" (p. 39). A number of participants in this research project spoke about that bodily shift when describing "reaching Everest" on an issue or developing a felt sense that they were on the "right path" in their clinical work. The refrain repeated by participants when they discussed their struggles while learning an EBP was about how they were feeling or why they were feeling a certain way. They did not talk about brain states or how their neurons were firing or how their thoughts were scrambled. In other words, they did not situate the process in their head or brain or cognitively but one that emerged in their bodies and as a felt sense. As Matthews (2006) writes "human beings are embodied subjects; however, their subjectivity is not something merely attached to their bodies, but something that is inconceivable without a body of a particular form" (p. 52). From Merleau-Ponty's perspective, and Gendlin's, it is inconceivable to discuss an experience like learning an evidence-based practice without discussing the role of embodiment. Moving to the final theme that will be further explored in chapter six, the therapists' experience of shame

while learning, what follows is an outline of the role of a “gem” in IPA research and possible theoretical approaches to shame.

### **3.3 A Gem of a Theme**

This theme best reflects IPA’s commitment to an ideographic perspective where an in-depth analysis of each case can, at times, lead to a focus on a particular passage from a research participant. Smith (2011b) reflected on his own experience of conducting IPA-based research and noted that he is “aware of the pivotal role played by single utterances and small passages of the analysis of a research corpus” (p. 6). It is this recognition of the significance of a passage that is disproportionate and that he refers to as a “gem” in the research. A question arises as to how to assess the value of these kinds of findings in an IPA research study. There are two types of evaluative rigour that can be applied to qualitative research. One example is the four broad principles reviewed in the methodology chapter as outlined by Yardley (2000). The second measure of quality is a greater focus on the particulars. As Smith outlines (2011b), it has “to do with the utterance that stands out and has added value to the analysis as a whole” (p. 7). One such example that I encountered was when Raylene noted the following:

And I’m just like oh my god, that’s it, that’s it, and then I begin to tell them the story about how I had put this together through my supervision, the shame piece, my sister’s suicide and me feeling responsible and this is what I was hitting inside myself and having that line-up with the emotion was incredibly powerful and it was very disregulating. I was actually pretty disassociated there.

The experience from my work as a trainer and supervisor and from the research literature indicates that it is very rare to have someone encounter a moment in their learning that



they link so clearly to an event that happened 40 years earlier in their life. This, for me, was a gem, a pearl in the midst of the sea of data and an important opportunity to explore further as a means to illuminate this issue for the group of participants as a whole.

As I reviewed transcripts the experience of shame, on different levels, while learning an EBP was noted by other participants. George described an aspect of family therapy training that he experiences as someone who has been training for a few decades now:

We had a lot of problems with residents in training, not just residents but whoever, who come up against their own personal difficulties quite quickly, I think there's nothing like family practice to push people into a bit of a corner.

The ways we are personally confronted in couple and family therapy training seem to be more evocative than in other psychotherapy approaches. This was also noted by a committee member (Lane) when we met via Skype March 4, 2014; that couple and family therapy training confronts an individual more personally than learning about an individual psychotherapy approach. Both the evocative nature of the participants' comments and the impact of shame on a person contributed to the development of this theme. Shame is negatively related to perspective taking and the focus of cognitive and emotional energy when in a shame experience is directed inwards. "Shame often produces overwhelming and painful feelings of confusion, fear, anger, judgment, and/or the need to hide" (Brown, 2006, p. 46). This gem stood out in the reading of some of the transcripts and was an experience that half of the participants spoke to in some way. For the other half of the participants, there were a number of factors that seemed to contribute to their not being included in this theme.

While the experience of shame was not exclusively that of half of the participants in this research project, it was spoken of more clearly by half of the participants. There were a few factors that contributed to participants either talking about or not talking about the experience of shame while learning an EBP. It is important to note that participants were not directly asked about an experience of shame while learning an EBP. For some of the research participants, there was hesitancy about talking about the more personal aspects of their experiences of learning an EBP. For these participants, when I gently probed during the interview, there was a palpable stiffening that I noted during questions that were intended to explore a personal aspect of their experience. Their faces would switch to a tight grin as their jaws clenched and their eyes fixed on me as if saying “stop there”. These participants also diverted their discussion into talking about a therapy approach or about evidence-based practice in general. Of course, talking about shame is itself a shameful experience (Kaufman, 1985; Ladany, Klinger, & Kulp, 2011) and this may also have contributed to some participants not discussing this experience. For those participants whose experiences I did include in this theme, they contributed to an important gem of a theme.

Smith (2011b) describes the value of a gem is that it offers “analytic leverage, they shine light on the phenomenon, on the transcript and on the corpus as a whole” (p. 7). Smith goes on to note that he sees it as an extension of Husserl’s urging to the thing itself, where “the gem can offer one entrée into that experience” (p. 7). This entrée requires hermeneutics to question and explore the experience and for the researcher to make meaning of the participant’s meaning making process (double hermeneutic). Smith describes a process that “involves a combination of appearing and peering” (p. 10) and

there is a spectrum from shining to suggestive to secret gems. Raylene's extract noted above for example, would be a "shining" gem, "these gems are more already present" (p. 11). For others, there may be more of a suggestive or secret quality to the gem. For the suggestive gem, Smith writes that a "participant has some awareness of some of the meaning" (p. 13) while for a secret gem, "the participant may not be consciously aware of the meaning, or even of what they've said at all" (p. 14). There are examples of each of these types of "gems" throughout the chapter that further develops this theme.

Another important factor to consider for this theme was the theoretical approach and conceptualisation of shame. What follows are some of the different approaches to shame noted in the research literature starting with the functionalist perspective and the choice that was made for this research project.

The functionalist perspective on shame is "based on Darwin's theory of evolution and the notion that emotions have an adaptive function and serve to increase the chances of survival" (Mills, 2005, p. 28). This approach to shame sees emotions as regulatory processes that serve a person's goals. The adaptive purpose of shame is to maintain the acceptance of others and preserve the self while maintaining social standards and submitting to others when it is functional to do so (Barrett, 1995, 1998). As Helen noted about sitting with colleagues while learning a new evidence-based approach to working with families:

I guess I would say when it's taught, so it's challenging when there are professionals from other agencies. As much as I want to be collaborative, and I guess in essence, it's reflecting the approach, the approach wouldn't limit it, you know. It would have a wider lens. But to me that can be challenging, particularly

if you're just learning, be a little hesitant, I'm thinking in my head there's this person, this is a psychologist and has x number of years experience, or people, you know, in a program that work with families all the time.

Helen had a sense of her place as somehow inferior to that of her colleagues. This felt sense does not have to be known to this participant to affect her experience. As Mills (2005) outlines "having a conscious awareness or understanding of relevant events is not required, only the capacity to register their significance and engage in goal-directed behavior" (p. 28). From this perspective, shame has three functions: to reduce exposure to evaluation by withdrawing or disengaging, to focus attention on social standards and self in that context, and to communicate deference to others.

The research participants in the current study discussed each of these functions of shame. For example, Raylene talked about one way that she hid during her training:

A whole group of people that were getting together and studying and you had to videotape your sessions and I was very resistant to that at the time, thinking that I wanted to protect my client confidentiality, but really later, as the years went on, I realized I didn't want to have my own work exposed and be scrutinized.

Raylene also spoke to the social standards and expectations for marriage and family therapists in her context:

I ended with [founder of the EBP] in the car that time, we were going to lunch or something, a bunch of us were going to lunch. And I mentioned to her because I'm sure I felt ashamed about it, it was always shameful for a marriage/family therapist to get a divorce, so I felt ashamed and she must have picked up on it

cause I was mentioning it and she said to me, this is the most significant thing I remember from her, she turned to me and she said...oh yah I was married before and divorced.

Finally, Beth also spoke of the deference she experienced with her supervisor responsible for helping her to develop skills related to the EBP she was learning. A sort of deference by silence experience where she described being “very intimidated. Ah, I think because I really admired my supervisor so much I really thought oh my gosh, I was very nervous to say anything”. Moving along to another category of developmental theories of shame, the following will describe the cognitive attributional approach to shame.

Possibly the more common of the categories of shame research, cognitive attributional approaches address cognitive evaluation processes that elicit shame. “Overt shame involves a *feeling* of being ashamed, i.e., an awareness of autonomic reactions (e.g. rapid heart rate, blushing, sweating) with a subjective feeling (e.g., feeling small, helpless, unable to control the situation)” (Mills, 2005, p. 29-30). For example, Raylene discussed an incident with her supervisor:

In that moment, I had this like experience in my body, where I, it’s like this pain going into my gut, and all I can think of is [name of supervisor] that wasn’t my experience and then I tell him, I look like a deer in the headlights o.k. and finally he looks at me, and says what’s happening to you?

Raylene clearly conveys her sense of feeling helpless in that moment of supervision combined with an awareness of pain in her body and being physically frozen (“deer in the headlights”). From the cognitive attributional perspective, shame is believed to be activated by negative attributions that are internal and global. A person believes they are

bad, not that they have done something bad. The entire self is viewed as undesirable, unworthy, or flawed (Tangney & Dearing, 2002).

Cassandra discussed how, in the process of learning an evidence-based approach to working with couples, she had to stop seeing couples because she was aware that her work did not match the intent of the model she was learning:

And at some point I just kind of stopped seeing couples because it was so difficult to manage the dynamic. I didn't really feel like I was helping in the way that I wanted to help. I really wanted to, you know I felt like I could create superficial change, but to really create that systemic change, wasn't happening.

Cassandra went on to describe repeated moments of pain in her work, like a paper cut in the one spot on our finger that we use for several tasks throughout the day. She was constantly reminded as she was learning and using this new approach, of experiencing herself as incompetent. "There's tremendous amounts of conscience incompetent moments in the work and that for me as somebody who's...really kind of arrived at a point where I felt very confident with individuals, it was just painful." While both the cognitive attributional and functionalist perspectives on shame offer a means to further explore the experience of shame, there is something missing from these perspectives for this researcher.

The notion that we "think" our way into shame reflects the Cartesian approach to the mind-body question (Descartes, 1952). That we have thoughts about a situation while separately having a physical reaction according to the cognitive attributional approach to shame negates the role of the environment a person finds themselves in at the time, their history with significant people in their lives, and an understanding of the significance and

role of who is observing us at any given time. The functionalist perspective on the other hand, with a focus on survival and preservation, limits the experience of shame while learning an EBP to a kind of “saving face” perspective. This would suggest that people would not be willing to take risks in their learning nor delve into difficult issues in their lives or clinical work when integrating an EBP. While this was the experience for a couple of participants with limited integration of the EBP we discussed, for the other participants, this limited perspective on shame did not take into account the tremendous risk and exploration they did while learning an EBP. A more useful conceptualisation of shame for this research project is one that posits shame as a means to understand a threat to a social bond or alert a person to potential rejection.

This category of theories considers social relationships as a basic biological need and include object relational and attachment-based approaches to shame (Bowlby, 1973; Kaufman, 1985, 1989; Nathanson, 1987, 1992) and sociological and social work approaches to shame (Brown, 2006; Scheff, 2000). These theoretical approaches to shame offer the opportunity to further explore participants’ experiences of discussing shame as evolving out of an interpersonal context and always linked to relationships and connections. Another important perspective brought forward to further interrogate participants’ experiences of shame while learning an EBP was Sartre’s conceptualisation of shame. Sartre (1956) writes the following about the experience of shame, “I recognise that I *am* as the other sees me” (p. 222). The process of learning an evidence-based practice for the research participants required one to constantly submit to the gaze of an “other”. Sartre’s approach to shame along with a social conceptualisation of shame that

incorporates an attachment perspective will be used in Chapter six to further discuss this theme.

### **3.4 Conclusion**

This chapter provided an overview of the three themes to be discussed further in the following chapters as well as further criteria and clarity for the analytical process and reporting of findings in IPA. Some of the theories that were considered to further the analysis of the participants were reviewed as well as the limitations of these approaches that lead them to be discarded. The criteria that Smith (2011a, 2011b) developed provide a framework and understanding for the reporting of findings in IPA including: how many participants to include in each theme, the role of a gem for a theme, convergent and divergent data, and the role of hermeneutics. The following chapters will begin an in depth analysis of each theme beginning with the supports and challenges of learning an EBP.



## Chapter 4

**“So I feel like I’m getting it and then sometimes I think OK, no I’m not”:**

### **Challenges and Supports while Learning an Evidence-Based Practice**

*I can’t begin to explain*

*How we disassemble*

*The parts and frame*

*Maybe it’s the same late morning?*

*The same no-show?*

*It’s the same fucking habits*

*I guess we don’t know (Powers, Short, & Xayalith, 2010)*

This chapter reports the experiences of participants who are learning or have learned an evidence-based approach to working with couples or families. The findings are reported across the different therapeutic approaches reported in the introduction because of the homogeneity of the sample and to provide an opportunity to focus more clearly on convergent and divergent experiences of participants regardless of therapeutic approach. In a summary of what strong IPA research should include, Smith (2011a) writes that the analysis should explore both convergence and divergence providing a “demonstration of both patterns of similarity among participants as well as the uniqueness of the individual experience” (p. 24). There was no great divergence across participants’ experiences of learning different therapeutic approaches in this research project. Instead, the divergence came with participants’ experiences with what assisted or challenged their learning at different stages of learning as well as interesting points of convergence across therapeutic approaches. Starting with a brief review of Dreyfus &

Dreyfus' (1986, 2004) phenomenological model of skill acquisition this chapter will then provide a review of the participants' experiences with learning an evidence-based practice, then a further interrogation of those experiences using the Dreyfus model of skill acquisition.

#### **4.1 Dreyfus' Model of the Human Learning Process**

*Our task is to broaden our reasoning to make it capable of grasping what, in ourselves and others, precedes and exceeds reason* (Merleau-Ponty, 1960, p. 122).

The Dreyfus model of skill acquisition is a descriptive phenomenological account of the development of skill over time. It is not about measuring competencies or ascribing abilities to the skills or talents of a practitioner. The model suggests that a learner be open to an experiential approach to learning, be responsive over time, and recognise whole situations in terms of past concrete experiences. The Dreyfus model has been chosen because, as Flyvberg (2001) outlines, "it is especially useful for understanding the linkage between knowledge and context" (p. 9). Further, it recognises the different phases or stages that learners experience and provides a useful means for organising the research participants' successes, challenges, and comments about what contributed to their learning an EBP. Flyvberg (2001) writes that "detailed phenomenological studies of human learning indicate that people pass through several phases or levels in the learning of skills, where 'skills' are understood to range from the technical to the intellectual" (p. 10). The participants in this research project similarly experienced different stages of skill acquisition and, combined with the need to provide an interpretive account (Smith, 2011a), the researcher chose Dreyfus' model as a key means to explore the data. The research participants' experiences will be presented in the

context of Dreyfus' (2004) five levels of the human learning process beginning with the novice stage through to the expert stage.

#### **4.2 “This is really interesting theory, I wonder how it works in practice?”:**

##### **Novice**

Novice is the first stage of skill acquisition and is instructor driven with a focus on rules for action. During this stage, “the novice learns to recognize various objective facts and features relevant to the skill and acquires rules for determining actions based upon those facts and features” (Dreyfus & Dreyfus, 1986, p. 21). A therapist would experience a problem or presenting issue for the first time as well as the possibilities for how to respond to that presenting problem. Louise talked about that kind of experience when she was doing her master’s degree. While interesting, she can now reflect back and compare to her learning as an experienced therapist now. Louise noted that “you know compared to, as a graduate student where you’re reading it, it’s all just theory to you, just like oh this is really interesting theory, I wonder how it works in practice right?”. In this phase of learning the focus is on facts and characteristics of therapeutic techniques that are context independent (Flyvberg, 2001).

Research participants recognised this phase of their learning in a number of different ways. For example, Ken reflected about when he realised he was a novice in his learning EFT in a follow-up email request to provide a metaphor for his learning process. An experienced couple and family therapist, Ken realised that his learning EFT was not only about learning techniques for working with couples but a new way of thinking and understanding relationships. It was this recognition that allowed him to name himself as

a novice in this learning; that he was not just picking up a skill or two to add to what he was already doing. He described this realisation as follows:

Introducing me to attachment was like having seen lots of nature shows on the ocean and thinking that I would be able to handle it till I actually got to the ocean and realized the ‘real’ thing is different than what I saw on TV – I had been exposed to the concept of attachment in previous trainings but then really experiencing in-depth learning about attachment was totally different.

Since all but one of the research participants were experienced therapists, many reported a similar experience of realising they were new again or a novice.

The following are examples from experienced therapists about realising they were novices again in their work. Cassandra, who had a Masters of Marriage and Family Therapy, described how she initially tried to integrate a new approach to working with couples by reading about it and reviewing training videos. Realising she could not integrate the new approach in this manner she sought further supports for her learning and after two years of training and supervision she could “really help couples” and went on to describe how she still felt “like there’s plenty to learn”. George discussed the ways he would get stuck or caught with families in his early adaptation of a new approach to working with families despite years of previous training. He described how “when I started out I remember I’d just get sucked in in the early stage and just get lost” with the families he was working with. George noted the importance for his practice to integrate a model for working with families. He described how “when I started out and both in individual and family pieces...you know clearly not following models, very vague, and I think the minute that you become more defined about what you’re doing,

that in itself is really helpful”. Kathy described a sense of feeling “shaky” when she started to learn a new approach to working with couples. She had worked with couples and families for a number of years in a community organisation then left to start her own private practice at which point she started to learn a new approach to working with couples. Kathy described how “when you’re first learning it it’s sort of you know, you’re not sure but you’re sort of on shaky wheels, you’re not sure where things fit in”. Like other research participants, Cassandra, George, and Kathy discussed the experience of feeling like they were a novice again despite years of previous training.

During this phase of learning, novices are judged and judge themselves by how their skills follow the rules (Flyvberg, 2001). This phase of learning begins with the “instructor decomposing the task environment into context-free features that the beginner can recognize without the desired skill” (Dreyfus, 2004, p. 577). One important element for learning an evidence-based practice is the treatment manual. In essence, at the novice stage of learning, it becomes the rule book. This becomes the description of what the practice is, how it is done right, what the skills are, and so on. Jessica talked about referring back to the treatment manual as her source of what was the right thing to do as follows:

So I feel like I’m getting it and then sometimes I think OK, no I’m not, I need to refer back to it to find out where I’m at. Because it is a very directive type approach and so, you want to make sure that you are following the intent of the theory so I refer back a lot.

Constantly seeking for whether she was following the rules as laid out in the treatment manual, Jessica was reassured by having the resource as a guide. Helen on the other hand

saw the treatment manual for an ecological approach to working with families as providing her an opportunity to better understand what rules she had been following in comparison to the ones suggested in the treatment manual. She described that process as:

So, I haven't read the complete manual, but I do review it. So currently looking at the family work that I do do, I do refer to it. I'm, in particular it's caused me to take a look at my model of practice, and I'm looking at my, my case conceptualization, and really, it's causing me to, in a good way, maybe not question is the word, to be curious about what do I stand for, what are my beliefs.

While Jessica and Helen benefitted from reading the treatment manual and referring back to it, not all participants described reading as a helpful process in their learning as a novice. Raylene, for example, described how in learning EFT she benefitted more from an experiential process that focused on exploring her own experience with the concepts being introduced and making sense of it for her own life first. Raylene described her attempts to read the treatment manual as follows:

I tried reading. Reading is not my best way of learning, especially if it's not a story, if it's dry reading. Like most of the, you know theoretical books are kind of dry. It's tedious for me to get through and so I have to make myself do it.

While Raylene did not appear to benefit from reading the treatment manual, other participants discussed another way that the treatment manual functioned for them.

As previously noted, a number of participants spoke of the challenge for novices of working with couples and families as greater than that of working with individuals. George for example talked about the competing forces in the room when working with families:

Well I think it is what, it's interesting to have done individual psychotherapy and then do family. I would say that actually family therapy is one of the most difficult therapies to do well. And it's difficult because of the intensity of the push-pull factors in the room.

At this stage George found the treatment manual very helpful to focus on understanding what was happening with the family, and more importantly, helped to focus family therapy trainees in their work. He described using the McMaster Family Assessment Device (Epstein, Baldwin, & Bishop, 1983) with trainees and having them locate themselves within this set of rules:

...you know the stages of executive functioning of the therapist...it breaks that down into little steps, that was really useful. So we would try to get people to use that as a basis for understanding what kind of intervention was needed, or helping training therapists to identify what they were doing and where it sat in the level of complexity of therapeutic interventions.

As a trainee and a trainer, George found the rules as outlined in the treatment manual helpful in structuring learning at this stage. Other participants discussed other supports and challenges they experienced at this stage of their learning.

Eric talked about how much he liked role plays, a technique that often brings groans from participants when used:

Ah well the bits that really stand out to me were in, I remember distinctly the role plays in that fundamentals course. Ah, enjoying, even though they were brief. They left a mark on me, in terms of I just loved when I got to role play as counsellor.

Eric's enjoyment of the role plays, particularly in the role of a counsellor, may have had to do with his early career status having recently completed a master's degree. The opportunity to practice a role he was working towards, testing out the professional he was working towards becoming, and having that all broken down into a specific role play may have been factors that contributed to his enjoyment of role plays. As a grad student learning an approach to working with couples, Eric also appreciated having a peer during this learning. He described it as:

Well you know having another supervisee at the agency was helpful, very helpful. You know, she was a PhD candidate at the time and she, you know she and I could kind of commiserate about our anxieties and certainly I was doing my own therapeutic work at the same time.

The peer support and opportunity to share their anxieties experienced while learning a new therapeutic approach was important for Eric. Another participant discussed her experience of being somewhat alienated by a presenter's style of presentation, making her more isolated in the process. Helen's report of this experience suggested that the presenter's style overshadowed any content that was being offered at that time:

So the other person, so it's interesting to me, like so the other person that's presenting...It seemed to be a lot about like, where they had travelled, a lot of names of people they had worked with, and, not that, the teaching part wasn't happening, but where I see this approach is, it's definitely telling you, it's not, it's taking you out of being an individual, and what I saw was, it was very much about an individual. From my perception.



In this case, Helen was seeking the rules and the barrier to understanding the rules was how the person was sharing those rules with her. Dreyfus (2004) describes that at the novice stage, rules are given for determine actions like a computer program. For Helen, it may have been that the software [the presenter] had some features that distracted her from the rules. This focus on rules however ultimately impedes learning.

As novices develop and learn some rules for a given skill, “performing the skill becomes so complex and demands so much concentration that it impedes continued improvement of performance” (Flyvberg, 2001, p. 11). Cassandra realised she reached that point when she mentioned that “that that’s part of like yah oh my God I need training, oh my God I need supervision”. The realisation that there’s more to integrating a new therapy approach into one’s practice than learning a few rules is an important step though not always an easy one. While discussing a shift from previous skills trainees had used in therapy, George reflected about the challenges he noticed and that “you know had difficulties for people to give up what they were doing and move on”. George pointed to the need for a learner to risk giving up what they had previously been doing at this stage. While developing an awareness of the need to explore beyond a few rules lead some participants to also consider the self of the therapist. Raylene stated it as “you can learn technique but if you don’t really understand it inside your own being, you’re not going to get it”. The realisations noted by Cassandra, George, and Raylene and the development of skill acquisition in general, leads to the next phase of the Dreyfus mode—advanced beginner.

#### **4.3 “I think I am really improving my clinical skills”: Advanced Beginner**

During the advanced beginner stage of skill acquisition, performance moves “to a marginally acceptable level only after the novice has considerable experience in coping with real situations” (Dreyfus & Dreyfus, 1986, p. 22). The advancement happens because of real life experience and the learner begins to recognise relevant elements in relevant situations. At the advanced beginner stage, “rules for behavior may now refer to both the new situational and the context-free components” (p. 23). Some participants in this research project discussed the scramble to learn more rules as Ken mentioned:

What I did is they have, well you know they have the initial manual, then the workbook, so I went through all of that. I went through the Hold Me Tight and then after each of the supervision sessions, whether it was the two group ones or the individual, I would go over the tapes and then I would make my notes from the tapes. So I got all of the sessions kind of, they’re not transcribed word for word but mostly the ideas, the really critical learnings so I did that as well.

Alternatively, there is an understanding that not all situations can be encompassed by these rules, that there is also a need to look at situation specific variables and the person of the therapist. Raylene put it this way:

So the way that I really, I’m still in the process of learning it, but I’ll tell you after a year of immersing myself in it and having my own internal personal revelation open up until that happened, I didn’t really get it, I didn’t get it.

Raylene’s realisation that her skill acquisition cannot be all rule bound required specific supports. She described what assisted her through that process:

It was personal supervision helped. It was all about personal because the cognitive stuff I mean, you know, that part I'm already good at, that's not what was getting in my way. What was getting in my way was my own personal stuff. So the personal supervision where I felt comfortable exploring that and the supervisor felt comfortable exploring that.

The importance of the role of supervision was noted by all participants at different stages of skill acquisition and for different purposes.

For Mary, who was a therapist in a clinical trial of an approach to working with families, the constant review and supervision required for clinical trials afforded her important developmental opportunities. She described the benefits of supervision for her practice as follows:

But it is about having live supervision, continuous live supervision, and having had so much attention that I think I am really improving my clinical skills. I'm getting a lot of feedback about how I'm doing in the therapy room. I get the opportunity to discuss with my supervisor, very thoroughly the cases and the strategies, and to plan for each case.

Another important element that Mary noted being part of a research project was the set number of sessions that is a norm for clinical trials.

It's sixteen weeks, we cannot extend that encounter with a client. And that has forced me to really pay attention to what are the things that I consider that are more effective in therapy and to invest my time and my energy in doing that. And so that really has sharpened me, and for that I'm very grateful.

The scrutiny and support of supervision as well as the need to complete therapy within a set period of time provided a focus that Mary described as both helping her to constantly learn the rules that govern the skills as well as begin to explore situational aspects of her work with families.

Having resources to explore beyond the rules was noted by other participants as well. Jessica for example, would refer to a variety of literature as a means to discover clinical insights. She described it as follows:

I go back and read over the literature, other kind of case studies and just seeing, try and see what other therapists are doing when they come up with some of these client issues that I'm seeing. It reaffirms that the model that I'm being trained in is, is what I want.

Jessica's review of the literature had the added benefit of reminding her that this is where she wanted to be. As she confronted situations that extended beyond the rules she had learned, Jessica was reminded again that this was the model she wanted to learn. At the advanced beginner phase of skill acquisition, "personal experience via trial-and-error is more important than context-independent, explicit, verbally formulated facts and rules" (Flyvberg, 2001, p. 12). This trial and error experience requires both the willingness to risk on the therapists' part and appropriate supports.

Peter, who is also part of a clinical trial for a new approach to working with families, described his experience with the trial and error process as follows:

Ah, well you come with, with what is not supposed to be a road map, but rather like landmarks that you ah, you reach and you process before you move on to the next, towards the next road map, landmark. But the challenge has been that

myself, knowing where I want to go, I am sometimes ah [pause] kind of rushing to get to the third landmark or to the goal, and not as much taking the time to focus on where I am. And I think the other, other therapists have had a similar experience.

Peter's description of developing a sense of where he was according to the rules involved a trial and error process where he situated himself using "landmarks" that tell him where he was in the therapy model. At this stage of learning, many participants talked about ongoing supervision or workshops geared towards advanced aspects of a therapeutic approach. Dreyfus (2004) described that at this stage, "instructional maxims can then refer to these new situational aspects, recognized on the basis of experience, as to the objectively defined nonsituational features recognizable by the novice" (p. 577).

Learning "can be carried on in a detached, analytic frame of mind" (p. 577) with the notion of needing to continue to attend to and expand knowledge of the rules and a growing awareness that "experience seems immeasurably more important than any form of verbal description" (Dreyfus & Dreyfus, 1986, p. 23). Now participants also begin to develop a sense of the therapeutic approach they are learning as a framework that can serve a number of purposes.

Sally's experience of learning an ecological approach to working with families helped her to re-conceptualise her clinical work as well as consider the families she was working with in new ways. She described it as follows:

So, the social-ecological approach gave me the framework for seeing that's where I'm stuck. We need to go back, we have not really come up with a solid contract. I think before in my practice, I would have kept going through, 'ok, you have to

keep doing anxiety reduction, you have to do meetings with the school, you have to do behavioural...'- you know. Whereas with this, I'm like 'we're not all on the same page'. So it's just reframed me.

Sally's choice to describe part of the change as it "reframed me" suggests that she's not only acquired rules for new skills but is a changed person and is now able to adjust her work with the situation. Sally's statement about being reframed is likely more reflective of a later stage of skill development though it is worth mentioning the shift she experienced between applying the rules of the skills to beginning to think about the context. Alternatively, Tina talked about how, with the help of a supervisor, she could apply the rules in a new situation.

While learning a very structured approach to working with couples that required the use of a variety of measures before, during and after therapy, Tina sought assistance from a supervisor to re-establish her application of the rules. Tina described that process as:

O.K. what I found challenging was short-lived initially as I was trying out the different activities for different situations. I suppose initially I didn't have the right tools for scoring and interpreting the couples assessment so I struggled there a little bit initially until I you know plugged myself back in to a supervisor at that end and got a little bit more guidance, and so I fared well after that point.

While Tina's experience of trial and error in this case provided her new information about how to handle another situation she remained focused on the rules. There comes a time in a couple and family therapist's practice and in skill acquisition, however, where "the number of recognizable elements, which an individual sees in a concrete situation,

becomes overwhelming” (Flyvberg, 2001, p. 12). This can lead to the next stage of skill acquisition which Dreyfus and Dreyfus (1986) termed competence.

#### **4.4 “I have a sense of o.k. this is what you know”: Competence**

At the competent stage of skill acquisition, a therapist “sees a situation as a set of facts” (Dreyfus & Dreyfus, 1986, p. 24) and the focus is on sorting a decision making process. At this stage, therapists learn from their own experience, other therapists, reading, training, and supervision how to apply decision-making processes. Flyvberg (2001) writes that “selecting a plan is not simple, and not without problems for competent performers. It takes time and requires deliberation” (p. 13). Unlike the novice stage, couple and family therapists are now personally involved in the action at the competence phase of skill acquisition. Jessica captures this struggle to sort a decision making process when she mentioned that “I struggle, I think about it a lot”.

At the competence stage of skill acquisition, learners will continue to seek rules for different situations and begin to realise that there are more situations and circumstances that one can keep track of. The discomfort here is adjusting to and becoming comfortable with the therapeutic approach as a means to understand and conceptualise. As Jessica said, “the challenges is that it’s, it feels like there’s only one way to do it, so you’re really kind of compelled to follow through and once you look at a couple from that attachment-based lens, it’s hard not to”. Jessica describes being rule bound when she mentioned there is “only one way to do it” and at the same time found herself understanding that she was developing a new lens for viewing her work with couples. It was with a sense of enjoyment and excitement that she recognised her development in her skill acquisition. Jessica went on to say that “I mean because I’m really getting much better at recognizing

couples and the patterns, and habits I see it in my own relationships, I really do feel that it really explains a lot". Here Jessica describes a sense of beginning to recognise situation and context.

This observation was noted by other research participants as well. Louise for example talked about the experience of developing a framework and both the sense of excitement and safety she experienced with that realisation:

Like I said I have a framework, I have a sense of o.k. this is what you know... and like I said that's what I like so much is I have a sense of o.k. this is what, this is, you know it's endless, the perspective, the, the perspective or the framework, the modality that you can bring in right but it's really helpful for me to go o.k. this is, cause it creates safety for me I guess, you know cause I have a sense of well I know what I'm attempting right and that makes it far less stressful.

Other research participants shared a similar experience of feeling more secure, safer, and stronger in their work with a sense of competence in their skill acquisition. Sally for example described getting a "framework for how to do it" and this allowed her to experience herself as "more effective for sure, and I'm not floundering [laughs]. Just kind of doing it ad hoc". Sally went on to describe her experience of developing that framework as:

It gives, it makes you feel like you're on more solid ground with what you're doing. When I'm going into do the clinical piece, you feel stronger I guess, in what you're doing, knowing that this is backed up by theory, and, and evidence-based. So, you feel, you feel, just, you know, more effective and stronger walking into it. And, I guess in some ways I'm a little pushier [laughs].



Sally's experience of herself as being more effective allowed her to be "pushier" in therapy which for her meant attending more to the therapeutic tasks she was learning. Sally learned in training that these therapeutic tasks were effective and evidence-based which supported her capacity to approach the work in that manner. As Louise noted about developing a sense of herself as competent and understanding the skills she was learning, "it just helps me to, maybe it grounds me, you know there's a sense of, o.k. I think I have a sense of what we're dealing with here". Experiencing herself as competent, Louise felt like "I know, I'm on a road and I feel like I'm going somewhere. As opposed to, [laughter] you know when you're starting out it's just like o.k., let's go and see where we end up".

Research participants discussed a number of different strategies that assisted them in developing a sense of competence in their skill acquisition. Cassandra talked about when she felt stuck, "when I'm like what do you do when you're at an impasse, I use the workbook cause I feel that that's got a lot of the interventions". Interestingly, Cassandra made a point of mentioning that she does not go back to the treatment manual and uses the workbook instead. Louise on the other hand refers to a variety of source materials including the treatment manual and research articles. Louise mentioned that "I think that all the reading helps me to do that because it gives me a framework and it helps me to understand what's happening for them, more than it would if I didn't have that". Louise creates a dialogue between herself, the reading, and her clients, constantly reflecting. Louise describes that process as:

It gives me a framework when I come back to the session you know. So I'm listening maybe for different things or I'm just able to [pause] like it's a lens, I

guess it's a framework, it's a lens, it just helps me to go o.k. right. I know, I have a better sense of what's happening and I love that piece.

Like Louise, other research participants made reference to a framework or a map or signposts as they were developing and began to experience themselves as competent.

Peter noticed this sense of competency by recognising his self-talk. Partly influenced by mindful approaches to therapy, Peter was very cognisant of his internal dialogue and how he felt during a therapy session. He described this awareness as follows:

Ah, well, I think just with, with practice, with ah kind of self-talk in session, kind of an emotional sensitivity on the first area about ah, ah are we finished with this topic. Sort of self-talk in my mind, do we, did I ask everything here? Did I look at it from enough points of view? Have I heard them say what I need to have them say? And did they say it with the right affect? You know which shows that it really sunk in. So there's a little, there's some self-talk going on as I'm in the sessions.

For Peter, it was tracking his self-talk and felt sense in therapy sessions that provided the feedback to experience himself as competent. Another participant talked about teaching the material to his wife as a means to better understand the therapy approach he was learning. Ken would watch videos with his wife and described how “just by her challenging and also wanting to know, it of course helped me because when I had to teach her I of course had to teach myself so the clarifications would come”.

A number of research participants also talked about the desire to be effective with couples and families as an important motivator in their learning. The desire to contribute

to change and be as effective as possible seemed to propel a number of participants to get more serious about their learning. For many there was an evolution where they realised that to be competent at the therapy approach they were learning and improve their efficacy with couples and families, they needed to be more proactive and thoughtful about their learning. Cassandra described her evolution as follows:

And so, so I got serious and I thought well if I really want to start creating change for couples, I'm just going to do this, come hell or high water, and so I did the externship and then pretty quickly thereafter got signed up in a core skills and went through a full round of core skills, and found a supervisor as well and started working with her, started taping all of my sessions.

For Cassandra, that two year process left her feeling competent about EFT and clear that she had more to learn. This is an important part of beginning to transition to the next phase of the Dreyfus model of skill acquisition.

Dreyfus and Dreyfus (1986) write that “up to this point the learner of a new skill...has made conscious choices of both goals and decisions after reflecting upon various alternatives” (p. 27-28). This model of decision-making is “detached, deliberative...[and] the only one recognized in much of the academic literature on the psychology of choice” (p. 28). The problem eventually becomes that there are too many choices and too many contexts and more importantly slows learning. Flyvberg (2001) writes that the use of “analytical rationality tends to impede further improvement in human performance because of analytical rationality’s slow reasoning and its emphasis on rules, principles, and universal solutions” (p. 15). There comes a point where “bodily involvement, speed” (p. 15) are required for developing a sense of proficiency in skill

acquisition. For couple and family therapists this may also involve a sense of recognising there are more possible combinations of presenting issues, relationships, and variables in therapy than can ever be learned.

A number of participants recognised the numerous possibilities by describing themselves as lifelong learners or were excited by the notion that the learning is endless.

Tina described it this way:

In life that there's always a growing edge for me. I find that it's always, you know it's different for every person in terms of how they emotionally process things, depending on what they've brought forward from and learned in their families of origin and what's becoming more and more of a focus for me which is attachment theory, and observing how that contributes to their ability to tolerate distress and to tolerate other forms of that affect. It's giving me a greater understanding of what I'm seeing with couples as I work with couples. I find that very useful.

For Tina her learning edges were not only with the couples she saw in the therapy room but also about herself, her family, and her relationships. As learners experience themselves as competent and continue to develop, they begin to become more involved in their actions which lead to the next level of the Dreyfus model of skill acquisition, proficiency.

#### **4.5 “Right now, it is becoming second nature”: Proficient Performer**

The proficient performer “will be deeply involved in his task and will be experiencing it from specific perspective because of recent events” (Dreyfus & Dreyfus, 1986, p. 28). While the research participants in this project had less experience with both

this stage of learning and the next stage referred to as expertise, there was some reflection about the experience of feeling proficient. The deep involvement by learners at this stage of skill acquisition involves both analytical decision making and intuition. Dreyfus and Dreyfus (1986) refer to intuition as the “understanding that effortlessly occurs upon seeing similarities with previous experiences” (p. 28). They use intuition and know-how interchangeably and describe intuition as “the product of deep situational involvement and recognition of similarity” (p. 29). One research participant captured the notion of intuition well. Raylene described her process of feeling more proficient with EFT as:

I’ve got it, it’s like I got it. It’s like oh this is what secure attachment is. Oh this is what it feels like...I have that map now, it’s not just a cognitive concept. I have a direct experience of it in my body, and so now I know the terrain. So I’ve learned EFT from the inside out.

Raylene’s knowing from the “inside out” reflects an intuitive knowing that “is neither wild guessing not supernatural inspiration, but the sort of ability we all use all the time as we go about our everyday tasks” (Dreyfus & Dreyfus, 1986, p. 29). Raylene recognised that it is not a set of rules, facts, or a rational decision making process that she was using in her work with couples though they all contributed to her learning. A proficient performer begins to experience key features of a situation that will stand out while others fade away.

Flyvberg (2001) described how choices are made “via spontaneous interpretation and intuitive judgment the memory of these situations generates plans corresponding to plans which have worked before” (p. 16). George described this process as being able to

manage his own affect and thoughts while better serving families he is working with. He described it as:

So ah, you know getting to the point where you manage your own affect and manage your own cognitive understanding of what's going on, come to a kind of new level of understanding and use that to move the family forward without compounding the problem or becoming involved in it. To me it was really quite a powerful experience.

It is as a proficient performer that therapists are more likely to experience the power of their work as “proficient performers tend to be deeply involved in their actions” (p. 16). George describes the place proficient performers tend to find themselves at where they are both intuitively organizing and understanding the task and still thinking analytically about what to do (Dreyfus & Dreyfus, 1986). In the proficient stage of skill development, a learner will gradually replace theory of skill as represented by rules and principles with situational discriminations. Proficiency can “develop if, and only if, experience is assimilated in this embodied, atheoretical way” (Dreyfus, 2004, p. 179).

Mary described this evolution of her practice while discussing her use and reference to the treatment manual. As part of a clinical trial, Mary had to attend to the specifics of the model she was learning more so than most learners. Now feeling more proficient, Mary described how that changed in relation to her use of the treatment manual as follows:

... this specific model has five very clear stages, so I know now that, what are the goals of each stage, what are the markers of each stage so I don't have to go back to the manual that much now. But at the beginning I did more, more o.k. I knew

this is stage three with this client, so let me go and review what is stage three, what am I supposed to, to get myself into that mode. Right now, it is becoming second nature in that sense so I don't have to refer...to the manual that much.

With her understanding becoming “second nature”, Mary recognises herself as proficient in the therapy approach. Other research participants had colleagues notice their proficiency.

Tina mentioned that her colleagues were the ones to validate her proficiency noting that she sounded “exactly like Julie [one of the founders of the therapy approach]”. Tina went on to say that “well we do tend to emulate our mentors that's true, and that can be a good thing, but you know I think I also have an individual style as well”. Tina's experience is in stark contrast to that relayed to me by one of my mentors. Now a very senior EFT trainer in her field, when she was first learning EFT she described a phase where she tried to emulate the British accent of the founder of the approach. She described with great humour that given that she lives and works in California, her family were quite perplexed by how she spoke during this phase of her learning. For Tina, the experience of sounding like her mentor was one that came with her own voice and was an acknowledgment by her colleagues of her proficiency. The next stage of skill acquisition, expertise, is characterised by effortless performance.

#### **4.6 “Because now I know the terrain”: Expert**

Clarifying the difference between a proficient and expert performer, Dreyfus (2004) describes it as “the ability to make more subtle and refined discriminations is what distinguishes the expert from the proficient performer” (p. 180). Not only recognising situations intuitively, a proficient performer reaches a level where situations are

recognised “synchronically and holistically” (Flyvberg, 2001, p. 17). The expert stage of skill acquisition does not mean that a therapist will not deliberate about the best course of actions. As Dreyfus and Dreyfus (1986) write however, “this deliberation does not require calculative problem solving, but rather involves critically reflecting on one’s situations” (p. 32). Experts still make mistakes and still face unexpected circumstances at this stage of skill acquisition; however, problems are not seen in a detached, analytical manner. Using intuition to “draw directly on one’s own experience - bodily, emotional, intellectual - and to recognize similarities between these experiences and new situations. Intuition is internalized; it is part of the individual” (Flyvberg, 2001, p. 21).

A few participants in this research project who have been working as therapists for over 30 years recognised this expertise and how they have experienced it with the model they were discussing for this research project or in the past. Ken for example, could draw on his past experience of learning another therapeutic approach. He described a process where he had learned this other approach and

then utilizing that for the next five, six years, so the whole process takes maybe you know eight years altogether, you know type of thing. By the time you really learn it, really master it and can teach it, get certified and all that stuff and then integrate it into the rest of you know what I’ve known already.

Ken was very familiar with his eight year cycle of learning having been through it a few times in his 40 year career. Ken described a level of skill acquisition that becomes “so much a part of him that he need be no more aware of it than he is of his own body” (Dreyfus & Dreyfus, 1986, p. 30). At the expert stage of skill acquisition, intuition is alongside rationality and complementary to it, and sometimes above it.



With a progression in skill acquisition, learners seek to integrate more of themselves in their learning and the same process of skill acquisition took place for the research participants in this project. Kathy described how

it's been, I don't know, 10, 12 years since I did this studying. So that's why I'm saying, begin to utilize that or incorporate the different things that I know...and, but I think it's being able to make the space for you to do what you need to do and I think, I think any theory if you become skilled enough, you can do that.

Over time and being "skilled enough", Kathy recognised she could embody the practise and do what she needed to do. Other research participants, particularly those who are engaged learners, found the potential for experiencing themselves as experts in a therapeutic approach was exciting.

Louise reported the possibilities demonstrated and mentioned by her supervisor opened up the notion of continuing to develop, seeing her development as an ongoing process. She described it as follows:

It's been really fun again through my supervisor, seeing what's you know what's out there. Thinking oh o.k. so it's not just a matter of you get certified and you go off to your lonely corner, and you know but that there's lots more. So yah so that's been fun to think that it doesn't end, and why would it but you know it is fun to think that. And I will because, because ah because I'm a lifelong learner.

While characterising herself as a "lifelong learner", it was seeing and hearing the possibilities from a supervisor that provided the opportunity to see herself as such.

Raylene similarly experienced herself in a new way, with new possibilities. In discussing her inside out understanding of the therapy approach she was learning, she described a

sense of knowing the “terrain. And it’s just going to keep unfolding for me and it’s incredibly exciting. I feel like my heart has opened up and shown up in a way that it never fully had before”. Both Kathy and Raylene embody what the Dreyfus model makes central, which is incorporating new knowledge and making it instinctive. As Dreyfus and Dreyfus (1986) describe, “at this point not only is a situation, when seen as similar to a prior one, understood, but the associated decision, action, or tactic simultaneously comes to mind” (p. 32). Having a sense of the progression of learning and what the potential is for a couple and family therapist provides important insight into the developmental process while learning an evidence-based practice. For this research project, the Dreyfus model of skill acquisition provides a means to understand the different stages of learning research participants described while learning an evidence-based approach to working with couples or families.

#### **4.7 “My guess is that it just deepens and deepens and that’s kind of exciting”:**

##### **Dreyfus Model of Skill Acquisition**

Brothers Stuart E. Dreyfus and Hubert L. Dreyfus developed a model of skill acquisition (referred to as the Dreyfus model for the remainder of this chapter) based on the study of air force pilots, chess players, and army tank drivers and commandos (Dreyfus & Dreyfus, 1979; 1986; Dreyfus, 1982; 2004). The Dreyfus model offers a developmental approach while focusing on situated performance and experiential learning required for complex and more advanced tasks. This model of learning distinguishes itself from cognitive-based approaches that focus on decision making steps and rational processes. The “rationalist perspective focuses on those properties of human activity by which humans most resemble machines” that require “rule-based deliberation

based on formal logic” (Flyberg, 2001, p. 22). In contrast, the Dreyfus model incorporates the complexity and varied aspects of a couple and family therapy practice and how that is developed. A skilled therapist not only applies technique but uses sound clinical judgment, behaves ethically, and considers a range of research and practice-based evidence for decision making.

The breadth of couple and family therapy practice requires the translation of multiple disciplines into particular practice situations. The development of evidence-based practices in couple and family therapy and moves toward reifying EBPs acknowledges one aspect of the practice of couple and family therapy. Couples and families do not always respond the way treatment manuals wish them to and practitioners must use good clinical judgement when these variations are not accounted for by science. Some aspects of a therapist practice can be reduced to standard set of techniques. These standard techniques are what Aristotle described as *techné* (Angier, 2010). Gathering family or relationship history, assessing for depression or anxiety, and details about a family genogram are examples of CFT practice that can be reduced to *techné*. As noted in the discussion chapter, the therapeutic alliance will still be required with the application of *techné* as well as other competencies. It is in situations where the couple or family’s particular responses need to be considered that the therapeutic alliance and clinical judgement come more into play as well as a more nuanced use of therapeutic skills. It is these situations that both *techné* and *phronesis* is required.

*Phronesis* is “situated actions based on skill, judgement, character, and wisdom” (Benner, 2004, p. 189). In his 1925 Spohist lectures, Heidegger said that :

[The phronimos] ... is determined by his situation in the largest sense. ... The circumstances, the givens, the times and the people vary. The meaning of the action ... varies as well.... It is precisely the achievement of phronesis to disclose the [individual] as acting now in the full situation within which he acts. (p. 101)

In other words, there is a practical wisdom that is bound by context and situation. The sensitivity to context interpretation that Heidegger offers about Aristotle's notion of practical wisdom reflects both the need for very rich understandings as well as highly specific situations. Louise spoke to this context specific element and the need to be open to an ever growing understanding of this complexity when she said "I mean yes you'll get some expertise but my guess is that it just deepens and deepens and that's kind of exciting really, you know". The Dreyfus model incorporates experiential learning over time and is situational with a focus "on actual performance and outcomes in particular situations" (Benner, 2004, p. 189). This makes it ideal for therapists learning an evidence-based practice where they have to relate their application to a treatment manual, be supervised in relation to a specific model, and account for specific outcomes in particular situations. The Dreyfus model attends to both *techné* and *phronesis*, that is, the specific techniques as outlined in a treatment manual for an EBP while offering a means to explore participants' experiences as their practice evolves to include elements such as intuition. At the same time, the Dreyfus model is "developmental in that changes in the performance in particular situations can be compared across time" (Benner, 2004, p. 189).

Couple and family therapy requires both *techné* and *phronesis*. Treatment manuals, specific techniques and research literature are some of the aspects of *techné*.

Phronesis on the other hand is more as Louise described above or as Kathy so eloquently put it, “in terms of anything that you do, sort of the first, when you’re first learning it, you’re sort of like a technician and then you become a craftsperson and then you become an artisan”. The evolution that Kathy describes is an illustration of the stages of development as outlined by Dreyfus and Dreyfus (1986). As Benner (2004) writes “Phronesis...is the kind of practical reasoning engaged in by an excellent practitioner lodged in a community of practitioners, a practitioner who, through experiential learning and for the sake of good practice, continually lives out and improves practice” (p. 189). While techné can be recorded with a fidelity measure to an evidence-based approach phronesis is in the sinew and bones of therapy, within and between therapists and clients, and encompasses a full person of the therapist. Phronesis is located in a practice “and so cannot rely solely on a means-ends rationality because one’s acts are governed by concern for doing good in particular circumstances, where being in relationship and discerning particular human concerns are at stake must guide action” (p. 189). Couple and family therapists are in constant ebb and flow with clients, adjusting and accommodating, constantly seeking to expand horizons so that new possibilities can emerge. George for example, described how “families do not always tell you all that’s going on, often for a very long time”. He went on to elaborate that:

you know even though, when you’re struggling...at your worst, and if you’ve got a good team, work with a good team, you ought to be able to get through that and find out what’s happening and ah, move in different directions.

The dance that George described between therapists and clients cannot be learned from technique alone. The Dreyfus model suggests that experiential learning is central to

that process and requires an engaged learner rather than a technician skillfully applying expertise in techné. George captures this when he said “well, I guess ah, I just see myself as a lifelong learner, I don’t really think of myself as having been a trainee and I’m now something else, you know”. The learner who remains open and responsive within the Dreyfus model can develop “an attuned, response-based practice” (Benner, 2004, p. 190) and “recognise whole situations in terms of past concrete experiences” (p. 190). The Dreyfus model was chosen because of the understanding of the linkage between knowledge and context, the developmental nature of the model without being rationalist, and the opportunity to offer an interpretation of research participants’ experiences.

#### **4.8 Conclusion**

As reflected by the research participants in this research project, there is a paradox in training couple and family therapists in an evidence-based practice. The paradox for an EBP approach to the practice of couple and family therapy may be that fidelity to the application of techniques as outlined in a treatment manual may impede therapist development over the long term unless context and situation are considered and therapist intuition is nurtured. As Flyvberg (2001) writes about the Dreyfus model, the “model specifies that what is needed in order to transcend the insufficient rational perspective is explicit integration of those properties characteristic of the higher levels in the learning process which can supplement and take over from analysis and rationality” (p. 23). Some of the properties noted by research participants included an inside out learning, trial and error, context, need for supervision and support to deal with personal issues that arise, years of experience, the opportunity to practice, and Flyvberg would add “judgment...common sense, [and] intuition” (p. 23). The research participants here

developed both a sense of their own capacity with a particular approach to working with couples or families as well as an internalised sense of themselves as capable. Both the thought of “I know how to do something” and the internalised sense that “I am a capable therapist” were discussed by those participants who became proficient or an expert in the model they were learning.

This capacity allowed research participants to reflect back and acknowledge where they struggled in their learning and as they advanced in their skill acquisition, they could use a sense of lack of understanding to guide their exploration and problem solving. As the Dreyfus model predicts, research participants experienced themselves as having integrated the model they were learning as they developed and were better able to case conceptualise as well as situate themselves in their work. This grasp of the situation allows couple and family therapists to move from rule-based thinking to an intuitive understanding of their work (Dreyfus & Dreyfus, 1986). This intuitive grasp is based on training, supervision, and experience and “not based on extrasensory powers or wild hunches” (Benner, 2004, p. 190). At this stage, therapists foreground and background different aspects of the situation based on their experience and training. The research participants here developed a sense of the possibilities within the practice they were learning with a variety of ongoing supports as well as supervision.

## Chapter 5

### “Oh this is what it feels like”: A Role for the Body in Learning an Evidence-Based Practice

*Didn't have the money 'round to buy a Morry Thou  
Been around and seen a lot to shake me anyhow  
Begged and borrowed, sometimes I admit I even stole  
The worse crime that I ever did was play some rock 'n' roll  
But the money's no good  
Just get a grip on yourself  
But the money's no good  
Just get a grip on yourself* (Hugh Cornwell, 1977).

The lyrics from the Stranglers’ song that open this chapter is an apt place for me to start when talking about the role of the body or embodiment in learning and using an evidence-based approach to working with couples and families. I saw the Stranglers this past summer for the second time in my life while attending a family therapy conference in Chicago. The first time I saw them was over 30 years ago. The evening of this past summer’s show, I left the confines of a downtown Chicago hotel where days were spent discussing the importance of infusing our work with social justice considerations under the chandeliers and grandeur of the conference location. Against the advice of the hotel concierge, I took public transportation and quickly found myself sitting in a subway with the people for whom my interventions were apparently so desperately needed. My body relaxed, that is not what I told myself at the time, I was caught up in the excitement of seeing the band and felt like I was sneaking away from the politesse of middle-class



discourse. My body further relaxed as I entered the grotty rock club in the ‘wrong’ part of town surrounded by people, old and young, with a certain conviction that focused on the music and a working class ease with our environment. Along with the other older attendees, we held up the walls in this small venue that current lead singer Baz Warne caustically referred to as a “living room”; as the younger attendees gathered in the middle forming a mosh pit. My body further relaxed into this environment with a certain comfort and understanding about where I was, though I had never been there before, and surrounded by people engaged in what was a similar ‘project’ that night.

The project that night in Chicago was a shared interest in music and a band that formed in Guilford during the 1970s when Margaret Thatcher was the leader of the Conservative Party in the United Kingdom. One of the Stranglers’ early hits, “No More Heroes”, referenced the loss of Leon Trotsky, Lenny Bruce, and Sancho Panza and was taken up as a working class anthem in response to Thatcherism. The song that opens this chapter speaks to a love of rock and roll and a call for an engaged participant to “just strap on your guitar and we’ll play some rock n’ roll” as the song proceeds. The call to participate is not about making money but about following a feeling or a bodily sense that drove the band to commit the “crime” of playing rock and roll regardless of the monetary rewards at the time. The song, and my experience that night in Chicago, points to a pre-reflective process where the body has its own wisdom.

The participants in this research project similarly discussed a process where they felt like they were moving towards something in their training that was deep inside them. As if they were invited in by a calling that had nothing to do with money and everything to do with something inside of them. As Finlay (2011) noted, we mostly “live our body-

world interconnections **pre-reflectively**, without thought with the body having its own wisdom and memory” (p. 31) [bolded word in original text]. Much as I experienced that night in Chicago on the way to the Stranglers show, research participants discussed a felt sense of getting a grip on themselves while grappling with learning a new approach to working with couples and families. While none of them shared the experience I had over 30 years ago of then Stranglers’ lead singer Hugh Cornwell spewing beer over me and others slam dancing near the stage, they did discuss ways they felt like they slammed up against parts of themselves they did not know were there. For most participants they were on a quest to become more effective in their work with couples and families and were surprised how much personal work was involved and how much it had to do with something “in” them. Some participants identified it as a “part” or a “piece” inside them while others discussed a “feeling” or described a felt sense they had when they struggled or experienced success at integrating an aspect of a new therapy approach they were learning with their clients.

This chapter will first describe the participants’ experiences in relation to integrating a new therapy approach. This integration will then be further explored using the writings of Merleau-Ponty (2002), specifically his notion of embodiment, and Gendlin’s (1978) understanding of how that process can happen with something he calls focusing. Here the body will be considered as “a form of consciousness” (Romdenh-Romluc, 2011, p. 62) and a means to experience the world and start to make sense of it. In fact, that it is not possible to make sense of an experience without one’s body. As Merleau-Ponty (2002) writes:

The body is our general medium for having a world. Sometimes it is restricted to the actions necessary for the conservation of life, and accordingly it posits around us a biological world; at other times, elaborating upon these primary actions and moving from their literal to a figurative meaning, it manifests through them a core of new significance. (p. 169)

Gendlin (1978) on the other hand offers a means to understand what that process looks like in more detail and described focusing as “a process in which you make contact with a special kind of internal bodily awareness” (p. 10). He refers to this awareness as a felt sense where the focus is a move “inside of a person” (p. 21). While Merleau-Ponty offers an epistemological means for situating the body as pre-reflective, Gendlin writes of a praxis to explore the process of embodiment. I have chosen to organise the participants’ experiences with the assistance of Gendlin’s six movements for facilitating focusing which he described as: clearing a space, felt sense, getting a handle, resonating, asking, and receiving. The interpretive choice to describe them loosely using Gendlin’s six movements emerged with the data as I was organising the participants’ experiences. This interpretive selection also facilitates further discussion of the participants’ experiences at the end of the chapter. What follows is a brief discussion of what influenced the researcher’s interpretive choices for the body.

The research participants were not asked about bodily feelings; for me, this emerged from the data and reflects another interpretive decision that I made. Drawing on Merleau-Ponty’s (1964, 2002) writing that we all have a “view from somewhere”, the body came to the fore as I was analysing participant data. As I sit here typing this, shoulders hunched, head shearing forward from my spine, staring at the keyboard, typing

with my index and middle fingers, the tension I experience is felt in my body. My stomach churns as I struggle to piece together a narrative that will best reflect the participants' experiences, the research methodology, and trigger the magical feedback from the committee that will indicate it is "good enough". The various seeing others that I experience as I type this leads to tension that I feel in my upper back between my shoulders. Another researcher may posit a cognitive process whereby there is a tension between different ideas or how they used a mindful procedure to address questions of methodology and committee requirements.

Much as my head bobbed to the music that night at the Stranglers concert without "thinking" about making my head bob or telling my body to bob its head, my decision is to reflect Merleau-Ponty's notion that I am my body not that I have a body (Moran, 2000). Further, none of the participants offered an experience such as "my thoughts were confused" or "I struggled with the different ideas" coming from their experience of learning an EBP. Nor did they preface experiences of "tension" as emanating from conflicting ideas or competing cognitive processes. Also, exploring embodiment is not just about the physical body but also about felt sense. As Finlay (2005) wrote, "Phenomenological researchers aim to tap into the insight that our bodies are in continuous relation with the world by focusing explicitly on the kinaesthetic, sensory, visceral and **'felt sense'** dimension of bodily lived experience" (p. 30) [bolded word in original text]. Finally, I was also influenced by passages from participants as they discussed key events that impacted their learning of an EBP.

When I heard Ken talk about his experience of feeling like he had reached Everest at a point in his learning, I imagined the physical exertion it took to get there. Another

example came from Louise as she discussed a major life event that influenced her choice about which EBP to learn, that of adopting her four year old niece:

because I saw so viscerally what that does in terms of the four year old, my four year old daughter right, I saw how different her world looked when she was securely attached, and what a different experience of the world she's going to be and what a different gift to the world she's going to be because she's known secure attachment.

Louise saw “viscerally”, of or pertaining to the viscera which are the internal organs in the main cavities of the body, especially the abdomen (Oxford Dictionaries, 2014a).

Further in the interview with Louise when she described the role that reading played in her learning an EBP, I imagined how the reading impacted her “viscerally” because that is the foundation that she laid for her understanding of the EBP she was learning.

Another example from the participants that influenced my interpretive turn towards embodiment came from Raylene. As she discussed a key point in a supervision session that led to an important revelation that assisted her learning of an EBP, she reflected that “in that moment, I had this like experience in my body, where I, it's like this pain going into my gut”. The pain going into her “gut” came in the midst of a clinical supervision session focused on the EBP we discussed during her interview. As an important revelation about a block in her learning came to light, as Raylene was learning the EBP, and as she reflected back about what a key in her learning that was, she described it as “going into my gut”, as if entering her body. Each of the examples from Ken, Louise, and Raylene, as well as passages from other participants, lead me to further explore the experience of embodiment while learning an EBP. As Matthews (2006) noted, “to be

embodied means that living in the world comes before conscious thought about the world” (p. 56), experience is pre-reflective. Now, as Husserl (Moran, 2000) would suggest, to the participants’ experiences.

### **5.1 “But it wasn’t even conscious at the time”: Clearing a Space for a Felt Sense**

This aspect of Gendlin’s (1978) model encompasses two phases, that of clearing a space and developing a felt sense for the problem. The former was described by Gendlin as listing “the problems mentally...the major and trivial together” (p. 52), not focusing on any one in particular. The latter, developing a felt sense for the problem, is a focus on the most challenging aspects of an experience and developing a sense of “how it makes you feel in your body when you think of it as a whole” (p. 53). The driver for most participants in this research project was to become more effective at working with couples and families. While some were interested in particular clinical issues it was a general need to improve their work with couples and families that lead them to exploring the evidence-based practice I discussed with them. Ken summarised it as not about specific clinical issues but “I think just more the issue about how generally, how to be more effective as a marital therapist, couples therapist, relationship therapist”. Interestingly, across all professions – social work, counselling, psychology, and marriage and family therapy- none of the participants felt like their graduate studies prepared them to adequately work with couples and families.

Cassandra for example, a licensed marriage and family therapist in the United States, mentioned that she “didn’t feel like my master’s level course, it was just one course, and quite honestly it wasn’t the greatest course in the world, and I didn’t really feel like it prepared me to see couples”. While Kathy, a registered social worker in

Canada, described starting her private practice over 10 years into her career and the struggles she had working with couples; she reported that “like a lot of therapists, I’ve worked with couples but I’ve never felt successful with them”. This lack of success impacted Kathy’s experience of her work with couples as she discussed how she “never really enjoyed working with them”. A major contributing factor to her pre-reflective lack of joy was her sense of a lack of efficacy describing how she “didn’t feel I knew what to do and you know you get a couple, you don’t know what to do and you see them individually”. Like Ken, Cassandra and other research participants, Kathy wanted to experience herself as effective in her work with couples stating that “I think if you’re doing a job, you want to feel that you have something to offer, and I didn’t think I really had a frame of reference to operate in”. An important reflection for research participants such as Ken, Cassandra, and Kathy was to recognise that they did not know what they were doing and clear a space for new learning. What emerged from that initial desire to be effective, however, was a surprising process for the research participants.

Research participants found that it was in my questioning and their reflecting back on those questions that they noted something began to shift in them once they started learning a new approach to working with couples or families. Raylene mentioned that “now I can kind of put it together” in reflecting back about her experience of learning a key aspect of a new approach to working with couples, “in [my] own being”. She went on to describe that “it wasn’t even conscious at the time” and it was feedback from her friends and family members “noticing that [she was] showing up differently...” that contributed to her recognising how this part of her had changed. Raylene specifically

noted it as something “in” her continuing to talk about the role of learning this new therapy approach “from the inside out”.

Ken also reflected back about the impact of learning an evidence-based practice (EBP). When asked how learning a new approach to working with couples affected his practice, Ken responded “in every way” and went on to describe how “it is, it’s an attitude, a way of being, that has permeated everything that I do in my life, it’s not just in my practice”. Ken’s “way of being” and having the EBP “permeate” an imagined boundary or shield evokes a sense of the EBP sinking in and finding its way through each part of him, spreading through his body like the dye injected for a coronary angiogram finding its way through his coronary arteries and heart and blending in seamlessly once the catheter is properly positioned. This “way of being” suggests a new pre-reflective stance that affects “everything” he does in his life. While Ken experienced this new stance as something that developed as he integrated the new EBP, others described a sense of how their new learning spoke to something that was “in” them.

Louise, for example, discussed her experience with adopting her niece as one that affected the direction of her therapy practice when she returned to it after taking a few years off to focus on her family. Living with and integrating a child into her family who had had a series of dysregulating experiences during the first few years of her life exposed Louise to the importance and complexity of secure attachment. These experiences gave her a felt sense of the importance of attachment, as Louise described, “because I’ve lived it. And I see how powerful it is”. For Louise, the space in her for this felt sense to emerge was cleared by the experience with her niece. This new felt sense lead her to seek further training and supervision in an approach to working with couples



that integrates attachment theory. Her work became infused with a purpose and direction informed by the experiences with her niece and a desire for her work to be effective on a number of levels. She described it as follows:

Ah, because at the end of the day that's probably the primal theme, so it makes me ah, it's very meaningful for me, and like I said I really feel like oh my God I'm getting in there, the rubber's hitting the road, I'm doing something, I am changing the world you know because if at the end of the day someone feels more securely attached, the world's a better place, right you know.

Louise discussed the space cleared as moving her to work with a “primal theme”. She is a person with exposure to a variety of populations and understands the wide range of needs people have to have met in their lives. Primal is defined as first or most important (Oxford Dictionaries, 2014b) and Louise described her work as fundamental to survival the way one would describe water or food. Her experience and her work now focuses on working with the body at a basic sustenance level. Louise's approach evokes the research of Harlow and Zimmerman (1958) commonly known as “Harlow's monkeys” where the behavioural hypothesis that an infant would form an attachment with a carer who provided food was disproven. For Louise the part of the training that focused on attachment “just spoke to [her]” evoking the felt sense aspect of embodiment that Finlay (2011) noted.

This sense of having a part of oneself spoken to was shared by other participants. Jessica for example, felt “drawn” to her training in a new EBP in a way that “spoke to [her]”. Her knowledge of attachment theory lead her to seek further training, as she said “so o.k., let's see what this is about”. As she described, “I was really drawn to that whole

idea of that's how, how people, how you can explain, how things can get distressed in life, so that started that part of it". She went on to describe developing a new "lens" as if she had new eyes now looking at the couples and families she was working with saying that "it just seemed to really gel and really come together for me as a way of this is how things can get so off track". While describing her struggles with integrating the new EBP into her practice, Jessica also felt moved in a way she had not experienced in her prior learning, as if she was wrestling with the new therapy model. She described that "there's something quite compelling about the model that kind of keeps pushing and I never felt it before". Being "pushed" by a therapy model in a way that she has not "felt" before suggests a physical sensation. As if Jessica was describing an invisible set of hands moving her body in ways she had not experience before.

This pre-reflective push may relate to another aspect of embodying a new therapy practice, what Gendlin (1978) would describe as "finding a handle" or the "core of the felt sense" (p. 55). For some of the participants in this research project, their own lives became a key means they found for learning more about a new therapeutic approach and embodying the practice. This was true for Jessica as she described "...but in any other learning that I've done or in theory or, I don't think I applied it so directly to my own life". What follows is a further exploration of a means that participants had for learning a new approach to working with couples and families by embodying it into their own relationships and families.

## **5.2 “My personal life has been deeply, deeply, deeply impacted”: Getting a Handle**

Gendlin (1978) wrote that the key in this phase is developing a sense of the quality of the felt sense. For the research participants who described a tremendous sense of growth, personal fulfillment, or development in their therapy practice and as people, there was a certain kind of active engagement with the learning process. They found themselves, their relationships, and their lives as an integral source for learning; they were in the middle of this learning dance where, at times, it felt like they were bobbing their head to the music as I did this past summer at the Stranglers concert. While at other times, it felt like their bodies were shoved and pulled in different directions. Raylene summarised getting a handle by mentioning the improvement in her therapy work, “but not just my clinical work. My personal life has been deeply, deeply, deeply impacted. It’s impacted my relationship with my husband, my relationship with my children, my relationship with my friends...”. Being in the middle of this learning dance was not always an easy process, other research participants reported that, while it was a tremendously rewarding experience, there were challenges and costs along the way. They felt compelled or driven though as if by an invisible beat moving their bodies with the felt sense that it was right for them in some way.

Jessica for example described the impact of the training on her work with couples and families by mentioning that “there’s something that’s deeper in this [EBP] and that’s what keeps me coming back”. The mention that it is “deeper” suggests a sense that her learning is more embodied, going further into her bones and sinew as if it is a feeling that cannot be ignored. She went on excitedly to describe a new experience in her work with

couples and families where individuals were able to name their experience and communicate it to each other in a way that facilitated their therapeutic goals. For Jessica this keeps her coming back to the learning about the EBP she was integrating into her practice and she mentioned “because I think when you can see that...you can’t shy away from it so you have to continue and you have to, in some way, go with that, so that’s what keeps me coming back”. One way of understanding her description is to use Gendlin’s (1978) notion of getting a handle; Jessica is facilitating that process with the couples and families she is working with. At the same time, she has a “deeper” experience herself that provides her a handle for understanding what she is exploring in her training. This naming or getting a handle for Jessica is different from her previous clinical work and training, she described that she had not “felt that way in session in any other way”. This kind of unique experience that was compelling for some of the research participants here also presented others with challenges.

As described earlier, Louise was clear about how her experiences with adopting her niece affected her choices about clinical training. She returned to her therapy practice five years ago with a new purpose and understanding about working with a “primal theme”. She also noted that “it’s part of the reason why I find this work, it’s kind of all-consuming, you know I’m really tired at the end of the day, but I will, you know, think about a client and go read an article in preparation for working with a client”. As if prompted by the thought that she forgot something that she told herself to remember, Louise described the constant search that learning the new EBP set her on. Like those moments when we have a felt sense that we forgot something and employ a range of strategies to prompt the memory to come to the fore, our bodies unable to settle until we

do remember. We do not know why we have a felt sense that we forgot something just that it is hard for our bodies to settle until we do remember it. Louise went on to describe how “I am constantly reflecting on it. It’s a total growing edge for me”. She was uncertain if that will ever end, stating that “it will be interesting to see, will that stop... I mean yes you’ll get some expertise but my guess is that it just deepens and deepens and that’s kind of exciting really”. Similar to other participants she describes the learning as “deepens”, not simply as an acquisition of knowledge or development of skills but something that is in her that will deepen. Louise felt compelled, driven even, describing how “it’s all consuming right now right and I know that’s not healthy particularly you know. Ah, but it’s o.k. for right now cause I don’t know what else to do”. For Louise, as the learning deepened, she was compelled to explore this felt sense knowing that it reflects a part of herself and her work that is “primal”.

Ken is another research participant who described some of the struggles he experienced deep into his learning a new approach to working with couples. He described how it “certainly has been harder for me to not go into that inner critic and think I’m really stupid enough and I should really stop doing this and take on, you know become a plumber”. Ken’s “inner” critic questioned his ability to learn a new approach 42 years into his practice and one that had him learning over the years with some of the leading figures of couple and family therapy. For Ken, the experience of embodying a practice ultimately lead to some of the most exciting moments in his clinical work which will be described later in this chapter. That process, however, came with experiences of pain “in” him that were unavoidable.

As Raylene noted about learning Emotionally Focused Therapy (EFT), “you have to understand attachment in your own being and then make sense of it cognitively. But you have to really understand and get it, so it’s not an easy approach to learn, to really get good at it”. While convinced that you have to understand it “in your own being”, Raylene also notes that this makes it more challenging. She goes on to punctuate the importance of knowing in our bodies by saying that “it has to do with having the inner experience internally so that you get the experience from the inside out”. Raylene suggests that EFT must first be known by the body to be able to practice it effectively. The knowing is “inside out”, first in one’s body then in one’s head, and on to the application of it. Raylene has enough experience with that process to be confident that her integration of EFT is “going to continue to unfold, I know where I’m going”. Part of her experience included another aspect of embodying a practice, that of resonating with a felt sense or handle that is uncovered. What follows is a description of the research participants’ experiences with this aspect of embodying a practice.

### **5.3 “I had no idea what I was getting myself into”: Resonating**

Resonating, according to Gendlin (1978), is the process of checking the quality of word(s) developed from the third phase (getting a handle) against the felt sense. The participants in this research project were generous when discussing their experiences of learning an EBP, willing to share how it not only impacted their clinical work but also their personal lives. For many they found themselves slamming up against parts of their lives or parts of the EBP project that left them reflective on the one hand and angry on the other. Raylene, for example, mentioned that while first learning EFT, “I was going through a divorce of a 20-year marriage and so it was actually helpful for me, it was kind

of ah-ha for me when I experienced just the whole approach of EFT”. Here again, the first thing she related the learning to was the body of her recently ended marriage.

Raylene related her new learning about the EBP we discussed to her own lived experience and recently ended marriage and it resonated for her in an “ah-ha” moment. For others, they were left reflecting about the complexity of their clinical work that the EBP they were learning was not able to address. George addressed it by saying:

...you know we had all these smart therapists that were coming in and doing these trick therapies from and we were shaking our heads in a way and saying but that’s fine, these guys have no respect for the stickiness of change and the you know they seemed, it’s a bit car salesman approach to therapy.

Both George and Raylene describe resonating with their learning, finding a fit between a felt sense and the words to describe that experience. For Raylene it gave her the opportunity to begin to name a felt sense about her recently ended marriage that had remained unsettled for her. While for George, he felt like he was being manipulated in some way or sold something at too high a price or something he did not need. George noted this manipulation by mentioning the “stickiness of change”, a tactile way to describe a feeling that he experienced in the room with the families that he has worked with. Another way that George might convey that feeling might be by saying “but these guys have no idea what it’s like to be embodied in the room with the families that I work with”.

Resonating with a felt sense was described by the research participants here in both an exuberant manner and as a way that they were challenged to embody the work. Raylene summarised it well when she said:

I thought... that I was just going to become a better therapist this year...I had no idea what I was getting myself into. I had no idea that it was going to transform me in such a deep and profound way and transform really my world view in such a positive way.

For Raylene, being changed in a “deep” way was a positive experience with her “view” changed. Again, the experience is “deep” in her and it is not her “thoughts” that changed or her “skills” but the way she sees has been changed as if seeing with new eyes.

Exploring this part of embodying a new approach to working with couples and families with the research participants lead to their discussing two interesting aspects of learning an EBP; the challenges with learning and the challenges of the EBP project.

The challenge of committing to fully integrating a new approach into one’s practice was noted by all of the participants who went on to become recognised as having a level of proficiency in the approach they were learning. This proficiency was usually recognised with certification by a professional body that could assess the competency in a specific approach to working with couples or families. Ken for example, reported his experience of becoming a certified EFT therapist as follows: “it is by far the most difficult training and learning process that I’ve ever been in, and I’ve been a therapist for 42 years and it was, it was astounding”. While Gendlin (1978) described resonating in a manner that suggests it may take minutes to get a “fit...that the words are right” (p. 56), for the research participants here that sometimes took months or even years. As if they were stuck in the middle of their body flailing about, drawn on the one hand by a felt sense they felt was “positive” and “deep” inside them while on the other recognising that they could not identify what was there.



Jessica for example described that sense of what drew her further into her learning. She mentioned being able to:

relate so directly to some of the, if you get into the details around what the EFT looks like, especially around those messages that we carried from childhood and into adulthood, into relationships. I get it you know on a different level because they resonate, some of those messages resonate with me.

The “message” of the learning for Jessica resonated with her own lived experience. The resonating she reported was not with a theory of how to work with couples; she resonated “on a different level” because the “messages” resonate with her own lived experience. She goes on to mention that to “be able to see it that way...not just from oh I can hear it from a client, I can hear what their experiences are, but I also, can relate well, I mean not to every experience, but I get it”. Jessica’s experience of resonating with her learning about a new approach and embodying the practice shifts her experience with clients to where she can “get it”. This felt sense that Jessica describes with her clients where she can “get it” means she finds a fit between that felt sense and what she hears from or does with her clients.

Integrating a new therapy approach is not always an easy process. As Kathy so aptly puts it “when you’re first learning it it’s sort of you know, you’re not sure but you’re sort of on shaky wheels, you’re not sure where things fit in”. Focusing on how things “fit” is a key aspect of embodying a practice and the second interesting aspect of that process in relation to EBPs that research participants noted was the challenge of the EBP project. Ken for example addressed this challenge by saying that “I think there’s a lot of resentment around the fact that we’ve got to be ‘scientists’ when we are actually

artists so to speak”. Ken invokes the sterile clinical image of a “scientist” in opposition to that of an artist. Oxford Dictionaries (2014c) define a scientist as “a person who is studying or has expert knowledge” and an artist as “a person skilled at a particular task or occupation” (2014d). As if one may be a scientist on his or her way to becoming an artist or that a scientist may have knowledge about therapy but not actually know how to do it whereas an artist does know how to be a therapist. For some of the participants in this research project, a focus on EBP was a barrier to becoming an artist and to embodying a practice.

One of the participants, George, spoke at length about the challenges he had with evidence-based practices. As an experienced family therapist, George has participated in a wide variety of training over the years though he still referred back to his early experience with adapting the McMaster Family Assessment Device as the foundation of his understanding for working with families. This seminal experience also shaped his understanding of what can happen when there is too strong a focus on one approach to working with families. He described an experience where he and a few colleagues fully engaged in learning a new approach to working with families while others were more hesitant as follows:

So there was this tension...where it should be in the whole scheme of things, and so there was this, not always healthy, dialogue going on between us, who would see everybody else as antiquated, and the others, who would see it as you know blind to this new drug we were just high on...

George situated his description in the body describing a “tension” and the “new drug we were just high on” describing a felt sense of euphoria when they found something that fit

for he and some of his colleagues while others struggled with those embodying a practice. The struggle George described sounded like a team sport game where the two sides competed for “where it should be in the whole scheme of things”. On one side were a team high on “this new drug”, on the other side the “antiquated” athletes.

George went on to describe some of the challenges he experienced with EBPs over the years. Like other research participants, he too described a sense of how there is a calling or something in a person that drives them to continue to engage in the process of integrating a new practice. George, however, had a different take on this experience. He described it as having a rigidity stating that, “I mean you know there was a religious kind of sense in which these therapies are imbued, they have a certain kind of inclusive/exclusive kind of quality to them”. For George, part of what is missing in the EBP project “is a huge amount of human experience” that he feels “is not captured in evidence-based practice”. For George, the urging that some experience while learning an EBP takes him away from “human experience”. George goes on to describe how he does not “think we should be you know kind of blindly, it gets a little bit like a God that you have to obey and I don’t want to go down that route”. He continues to describe the challenge he experiences with EBPs in terms of what his body will do and where his body will go or not go. George qualifies his engagement with EBPs by stating that “I want to listen to that piece but I don’t want to let it dictate my life”. George comes to a clear understanding of how he wants to embody a practice that does not fit for him. He can hear it, he’ll resonate with what he describes as human experience, and decide what “route” to go down.

The participants in this research project described a range of experiences when resonating with a felt sense or something “in” them or as the training “deepened” and all described some part of how they resonated. For some, it was about how the practice they were learning did not fit for them or they could not find a way to make sense of their felt sense. Some of the participants however went on to describe what Gendlin (1978) described as a body shift. This shift left them with a tremendous sense of accomplishment and a feeling like they had integrated the therapy approach they were learning at a new level.

#### **5.4 “Something has shifted inside of my body”: Asking and Receiving**

The fifth and sixth movements in focusing are asking and receiving. Gendlin (1978) writes that asking involves “spending some time...staying with the unclear felt sense, or returning to it again and again” (p. 58). Receiving involves welcoming “anything that comes with a body shift...not in it, but next to it” (p. 61). One can receive without asking, a shift can happen in the body that one can link with a description without asking. The kind of embodiment that people experience when the learning that they do is “deeper” translated into how they experienced the interview as well. As Raylene noted “you know even if I’m sitting here talking to you, I mean I feel completely comfortable being totally transparent with you. Something has shifted inside of my body”. The “shift” that Raylene experienced “inside” her body came in the process of her learning about EFT and as noted earlier “deeply, deeply, deeply” impacted her personal life. That shift inside her body not only impacted her personal life however as she noted that it also “greatly affected all of my clinical practice” and she went to say that “yes all of my clinical work has been deeply, deeply, deeply, deeply impacted”. Raylene

was able to translate that “shift inside” her body across personal and professional contexts as well as the interview that I did with her. Finlay (2005) noted that this awareness of embodiment in the interview context reflects an awareness of the intersubjective bodily relationship between participant and researcher. The kind of delight that Raylene experienced with this kind of embodiment was shared by other participants in this research project.

Ken may have been one of the more exuberant research participants when he described a feeling of reaching “Everest on this issue” when describing his experience of a moment in therapy where his intervention was effective and was a strong demonstration of the approach he was learning. After months of struggling with a new approach to working with couples, Ken described how “it was gratifying to say the least to, in that moment to see oh yes, my god I’ve got it. Now I understand all of the teaching and the training you know that I’ve been given”. He went on to describe his sense of climbing while learning as if every part of his body was involved in the process:

It’s just at a new level but there’s something very contenting, exciting, something that is very, it makes all of the struggles so worthwhile in that moment because it’s like I’ve reached a level of knowledge, of wisdom that is, all come together, so something like that.

As Ken described this process, I imagined him panting at the top of a summit, every part of his body aching and heaving with a combination of excitement and exhaustion with the realisation that he had accomplished a long fought for and dreamt of goal. Every ledge he had clung to and every choice point about where to go next suddenly realised in a moment of success where he now had the expanse to see what he had accomplished.

While Ken described reaching a new level of “knowledge”, as previously noted it is the physical experience of reaching Everest that I focus on. It was Ken’s movement towards understanding “all of the teaching and training” that left an impression for me as a researcher.

Louise was another research participant who delighted in her newfound experience of the “power” of her work after integrating a new approach to working with couples. Her delight was more of a surprise to her, however, as she described, “...it’s kind of blowing me away because ah I get a lot of really positive feedback”. Here again, I interpret Louise’s description as a state of motion where she’s impressed, as in her body is moved by the experience. She goes on to describe that “it’s kind of blowing me away and I know it’s because this is the way we work with people right, I know that, I know that”. While being blown away, or moved, Louise also recognised that she has become part of the therapeutic change process she had worked so hard to learn about. Louise went on to describe the depth that she received this shift she experienced when being “blown away” with her work.

For Louise being “blown away” meant finding who she was as a therapist. She described “it’s how I work with people and I’ve been so grateful cause it’s given me, like I said, it’s given me this I now know who I am as a therapist” going on to say that “right, this is what I do”. Louise contrasted that with her training in graduate school where she was introduced to “many different approaches there are out there” which left her questioning her identity as a therapist. Learning an EBP gave her a “map” which she described as giving her “a little bit of a sense of o.k. I feel like I know, I’m on a road and I feel like I’m going somewhere”. For Louise, learning an EBP gave her both an

emotional reaction (“a feel”) and a sense of direction (a sense of “going somewhere”). Not only does she now “feel” herself as a different therapist but she also experiences her whole body as moving in a direction that reflected how she felt. For the research participants who described an experience of embodying a practice, they found that process crossing over in to other aspects of their lives.

Raylene demonstrated an embodiment by elaborating on her understanding of “learning from the inside out”. She described how she was “showing up” differently with friends and family and having “direct experiences of what it is like to be in my own vulnerability and reach to another and have them be responsive to me”. Raylene describes an experience of being “in [her] own” vulnerability as if in her own body, that she is reaching from a felt sense to the people around her and they are very responsive. The response helped her to “get it”, to understand the experiences she was trying to facilitate with the couples and families she works with. As she went on to say, “that’s what you have to do with clients, and if you can’t do that with yourself, you’re not going to be able to do that with clients”. For Raylene, this new found confidence discovered while embodying a practice helps guide her understanding that it is possible to facilitate changes with couples and families as well as give her a felt sense of what those changes are like.

Ken also spoke of a new feeling describing that he felt much more confident, more “than I ever have been”. Ken’s new felt sense of assurance emerged in other contexts outside of a therapy room as if he could not stop his body from doing anything different. He went on to describe that “when I’m not confident I can speak about that, I don’t hide that as much as I used to. And I don’t hide it very much anymore at all”.

Ken's description of not "hiding" this new felt sense as if a disfigurement he had previously covered up translated into a new significance that he described as "opening myself and allowing myself to really, just allow people in at a new level, at a much deeper level". Ken repeats the refrain shared by other research participants who experience themselves and others with a "deeper" felt sense and often elaborating their description with reference to a physical sense. Ken went on to describe how "it's no different than the child who looks at the candy, is one thing but when you get to taste the candy, wow".

Ken offers a mouth-watering distinction between savouring the taste of candy longed for in the excited manner of a child and simply looking at the candy. This wide-eyed description gives a strong flavour of receiving a new felt sense that he not only looks at but literally internalises by chewing, sucking, tasting, and swallowing. This embodied notion of experiencing the world from somewhere, specifically from our bodies, links to Merleau-Ponty's (2002) understanding of embodiment. Moran (2000) clarifies the distinction by noting that it is not that we have a body but that "I am my body" (p. 406). What follows is a brief exploration of Merleau-Ponty and Gendlin's writing about embodiment in relation to the experiences of the participants in this research project.

### **5.5 Embodied Learning: "It's something deep within me around how I see it"**

The research participants did not separate their bodies from what or how they were learning. They reflected Merleau-Ponty's (1968) notion of the body as standing "before the world and the world upright before it, and between them there is a relation that is one of embrace" (p. 271). This pre-reflective stance where the body drifts into the



background becoming part of the horizon we take for granted is how we most often experience our bodies. Like Raylene's mention that at the start of her learning EFT, the changes she later reflected in her work were not "even conscious at the time". It was only in reflecting about the questions that I asked that Raylene could talk about what had happened "inside of [her]". For therapists, there is an importance for embodied learning that translates to the work with couples and families. Churchhill, Lowery, McNally, and Rao (1998) write about how the body enables us to understand the Other empathically and therefore to listen fully to their experiences.

The full listening that the body contributes to posits the body as a form of consciousness. Merleau-Ponty argues "that the body cannot be thought of as a mere object. Instead, it is a subject: a form of consciousness" (Romdenh-Romluc, 2011, p. 62). While Merleau-Ponty offers the opportunity to explore the participants' experiences from the position of the body, Gendlin (1978) positions the body as the place where change is felt and processed. He writes that "there is a distinct physical sensation of change, which you recognize once you experience it" (p. 7). Merleau-Ponty writes of a body interacting with, impinging on, and being compelled to act by the environment while Gendlin goes into the body, describing what happens when those interactions take place. Both start with an understanding that there is a cognitive or logical process and that not all learning can take place with the use of rationality only. Finlay (2011) writes that perception for Merleau-Ponty, "is inherently participatory – an active interplay between the perceiving body and what it perceives, and between the doing body and what it does. There is a mutual relation between the self, body and world" (p. 36). Such a perception cannot rely on cognition alone nor a mind in isolation from the body or a mind that dictates to the

body. As Finlay (2011) noted, “It is impossible to separate our bodies from who we are and what we do in the world. Our body is the vehicle for experiencing, doing, being and becoming” (p. 29). From this perspective, we go “to the body” as a means to understand participants experiences with learning an EBP beginning with, as Gendlin suggests, clearing a space for a felt sense.

Clearing a space for learning a new EBP from a rationalist’s perspective may focus on how much a person needs to study, read, or focus his or her intention on learning a new approach to working with couples or families. Merleau-Ponty (2002) used the example of a man, by the name of Schneider, with an acquired brain injury to explain the limits of this approach. When asked to raise his arm by a psychologist, because of the area of his brain injury, he could not raise his arm. Schneider worked and otherwise maintained much of his life as he had before the injury and was physically capable of raising his arm and intellectually understood the request. Merleau-Ponty used this example to outline three limitations of a focus on intent: one, it does not explain why it is only abstract actions that create difficulties; secondly, Schneider’s intelligence was otherwise intact and it was not a matter of his inability to rationalise; third, it was not a matter of not having the thought to do something. To assist with understanding the limitations of a focus on intent, Merleau-Ponty makes the distinction between concrete and abstract actions. He writes that abstract actions are not, “relevant to an actual situation” (p. 118) or “movements, that is, which are not relevant to any actual situation” (p. 118). Merleau-Ponty goes on to note that “concrete movements and acts of grasping therefore enjoy a privileged position for which we need to find some explanation.” (p. 118). For the research participants in this research project, they experienced the discord

that actions that are abstract to their bodies impose. As Kathy noted prior to her learning an evidence-based approach to working with couples:

I've worked with couples but I've never felt successful with them. Never really enjoyed working with them, I didn't feel I knew what to do and you know you get a couple, you don't know what to do and you see them individually.

Kathy described how she returned to what, for her, were concrete actions. Prior to learning the EBP we discussed, Kathy would simply do what she knew how to do, see the couples she was working with individually. In therapy with couples, the focus of the work is the relationship, not individuals. With a few exceptions (e.g. abuse) it is counter-productive to work with a couple by seeing them individually. That would be akin to diagnosing a cold because you hear a cough and never examining the lungs to understand that it is cancer. Despite this challenge, Kathy found herself seeking a clearing, following her felt sense of wanting to find a way to work with couples differently.

This clearing was reflected by the research participants in this research project in two ways. First, with their intent to be more effective with couples or families, the research participants accepted that they had something to learn. Secondly, they found something that spoke to a "part" of them. Gendlin (1978) writes that "a felt sense is usually not just there, it must form" (p. 10). This forming takes place "by attending inside your body. By certain steps it can come into focus and also change. A felt sense is the body's sense of a particular problem or situation" (p. 10). When Jessica noted that she was "really drawn to the whole idea" and "found kind of a real place" that "keeps pushing and [she] never felt before", it was as if she had found an itch that could not be ignored. Jessica could no longer ignore this "place" she had found magnetically drawing

her attention and calling her to attend to the learning in a new way. Raylene may have been the most emphatic about the need to learn “from the inside out” and the limitations of focusing solely on intent when she stated that “only understanding it cognitively isn’t enough...I don’t think it’s enough really for anyone to really be effective with it”.

The call to be effective with couples and families and attending to a felt sense brought about a variety of changes for research participants. Paying attention to and listening to that call brings our body forward, no longer melted into the horizon of day-to-day life. This occurred partly by participants’ own noticing their work in a new way and partly by engaging in a learning and supervision process that involved others. As Finlay (2011) noted about being watched by an Other, when “we become aware of their regard we begin to exist in a new bodily self-conscious, unnatural way” (p.31). Much as I become aware of all the things that I do with my back when I injure it, how I use it with every movement, every cough, and how I sit or lie down, research participants suddenly became aware of their therapy practice in new and, at times, painful ways. Finlay describes this awareness as “both an altered experience of one’s body and an altered experience of the world – and that these are one and the same” (p. 33). This altered experience becomes hard to ignore, as Jessica said, “there’s something that’s deeper in this and that’s what keeps me coming back”.

Jessica’s call or invitation to return to and pay attention to what she was learning because it was “deeper” suggests an area or a project that now has her attention. Romdenh-Romluc (2011) explains this phenomenon by noting that a “perceiver perceives their environment as ‘inviting’ them to interact in certain ways, as ‘offering’ certain possibilities for action and ‘disallowing’ others” (p. 74). A number of the research

participants noted how their engagement with learning a new EBP changed as they progressed. Raylene, for example, started out thinking that it would be a few days at a workshop and then realised “but you can’t go to a weekend training and learn EFT”. She went on to emphasise that it had “to do with having the inner experience internally so that you get the experience from the inside out”. Raylene noted the opportunity to respond to her felt sense and how it altered her and her therapy world, “deeply, deeply, deeply” affecting both.

Merleau-Ponty, as noted by Romdenh-Romluc (2011), suggested that the environment “invites” therapists to engage with their learning in certain ways and disallows others. Gendlin (1978) describes this process as a “change [that] begins but seems oddly, mysteriously incomplete. It gives you the start of a shift, but you know (your body knows) a more complete shift is possible” (p. 15). The invitation from the environment that Merleau-Ponty wrote about provides the opportunity for learners to resonate with a felt sense and make meaning of it. Some of the research participants here discussed the challenges with that process both individually and in the environments they worked in. Ken noted that it was “by far the most difficult training and learning process that I’ve ever been in” while George spoke to the challenges he experienced in his work environment and how he managed those. He described how “more and more” of his colleagues were “doing things that can be programmed” as a means to respond to “government” and the “paymasters”. George went on to describe his colleagues’ efforts to address how government funding was spent by looking to “evidence-based practice”. For George this meant a “move” that would allow him to retain and attend to his felt sense about what was effective in his work with families. He described it as follows:

In some ways I have actually moved a little bit outside of mainstream because I'm getting increasingly concerned by that, fiscal restraints on health care and the exclusion of therapies that can't be proven to be effective and the shortness of treatment lengths now which are really driven by cost implications.

George's "move" is a means to understand and make sense of the push and pull of his environment. The invitations that the environments offer as a means to explore something "deep" or "inside" of the research participants, that opportunity to resonate and make sense, also lead to some of the research participants describing a powerful shift in their bodies.

This powerful shift so aptly described by Ken as feeling like he had "reached Everest on this issue" with regards to integrating a new approach to working with couples was felt in the body by the research participants in this research project. Romdenh-Romluc (2011) describes how "the exercise of their skill at something also manifests as understanding of both their surroundings and themselves" (p. 90). Ken not only experiences himself as competent but imbued his description with the exhilaration of accomplishing a long worked for goal and a celebratory environment. Gendlin (1978) describes this change process as "natural to the body" (p. 8) with the crucial move that "goes *beneath* the usual painful places to a bodily sensing that is at first unclear" (p. 8). Much as Ken described, this experience "of something emerging from there feels like a relief and a coming alive" (p. 8). Ken's exhilaration and bodily awareness points to a significance that Merleau-Ponty addressed in his work.

Romdenh-Romluc (2011) noted the importance of imbuing environments with motor significance. For couple and family therapists adding a bodily sense of what it is

like to be in the kind of relationship or family we are working with, as if we are in it, provides an important source of information. Merleau-Ponty (1964) suggests that the body is integral to the understanding of the human situation. He writes, “I perceive in a total way with my whole being; I grasp a unique structure of the thing, a unique way of being, which speaks to all my senses at once” (p. 50). Raylene reflected this way of knowing by stating that “that’s what you have to be able to do with clients, and if you can’t do that with yourself, you’re not going to be able to do that with clients”. The research participants who felt the exhilaration of knowing “from the inside out” also spoke at length about the pain they experienced along the way to integrating a new EBP. In the end though, it left them with a sense of confidence and knowing, that they felt “in” them. Ken reported that “I feel so much more confident, than I ever have been”. Reaching the peak of Everest will leave one with confidence and an understanding of one self, as Gendlin (1978) writes, “there is a kind of bodily awareness that profoundly influences our lives” (p. 32) . This shift is what Gendlin referred to as a felt sense.

With attention to a sensation, or a need to learn something new about working with couples and families, a shift begins. Gendlin (1978) described how “a felt sense will shift if you approach it in the right way. It will change even as you are making contact with it. When your felt sense of a situation changes, *you change...*” (p. 32). Paying attention to the body adds to the rational knowledge that is the starting point for learning a new therapy approach. The knowledge that the body adds however, cannot be replaced by rational knowledge. Romdenh-Romluc (2011) write that “one’s bodily self knows how to act, and it has a motor understanding of one’s surroundings that is not reducible to

conceptual knowledge” (p. 102). This may be some of the struggle when talking or writing about it, it is difficult to find words to explain everything at once.

One possible way to explain this dilemma is by asking one to think about two people that are close to them. When asked to describe the two people, there might be a series of physical characteristics or personal attributes or emotional experiences that come out but there is a struggle to fully describe the felt sense that one has about another person they know well. This may be the simplicity of the Stranglers song that started this chapter. Their call to “get a grip” on oneself, to recognise the crime of “playing rock and roll” and acknowledge “the money’s no good”, is akin to the research participants noting the shift in their bodies as they were learning and recognising their crime is trying to be more effective with the couples and families they work with. While reflecting about a song is an evocative means to explore participants’ experiences it has the potential to bring those experiences “vividly into presence so that we can phenomenologically reflect on it” (van Manen, 1997, p. 353). Bringing it back to the Stranglers and imagining them as co-investigators for a moment on this research project, they could develop a song written exclusively from the research participants’ words. Statements from participants constitute a narrative that reflects both a lived experience and an emotional engagement with the phenomenon. “As such, the use of poetic narrative does not constitute a challenge to phenomenological analysis but rather an addition to or extension of it” (Willig, 2007, p. 218). Researchers suggest that it is another means to reflect about, engage with, and create meaning of participants’ experiences (Glesne, 1997; Öhlen, 2003). What follows is such an engagement:

I think just more the issue about how generally



how to be more effective as a marital therapist,  
couples therapist, relationship therapist  
I didn't feel like my master's level course,  
it was just one course,  
I didn't really feel like it prepared me to see couples

It has to do with having the inner experience, internally  
so that you get the experience from the inside out  
there's something that's deeper in this  
but in any other learning that I've done  
I don't think I applied it so directly to my own life

I've reached Everest on this issue  
and like I said it's kind of blowing me away  
because I get a lot of really positive feedback  
it's given me this  
I now know who I am as a therapist  
all of my clinical work  
has been deeply, deeply, deeply, deeply impacted

I thought that I was just going to become  
a better therapist this year  
I had no idea what I was getting myself into

it is by far the most difficult training  
and learning process that I've ever been in  
my personal life  
has been deeply, deeply, deeply impacted

I mean you know there was a religious  
kind of sense in which these therapies are imbued  
so there was this tension  
in some ways I have actually  
moved a little bit outside of mainstream

I've reached Everest on this issue  
and like I said it's kind of blowing me away  
because I get a lot of really positive feedback  
it's given me this

I now know who I am as a therapist  
all of my clinical work  
has been deeply, deeply, deeply, deeply impacted.

## **Chapter 6**

### **“I had no idea that this shame piece was in me”:**

#### **The Experience of Shame While Learning and Using a New Evidence-Based Practice**

This chapter will be a review of the experience of shame while learning and using an evidence-based practice (EBP). This theme emerged from half of the research participants as part of their development with the EBP they were integrating into their practice (Appendix E). First, a brief introduction to the approach to shame that will be used to further interrogate participants’ experiences will be provided. As noted in Chapter 3, there are a number of theoretical approaches to the experience of shame and the understanding of shame used here is one that posits shame as a social emotion. The introduction to which theory of shame is used here helps to situate the interpretation of the participants’ experiences that follows. Following a description of the participants’ experiences, I will then discuss the impact of shame, further reflect about participants’ experiences with the assistance of social and social work understandings of shame, and finally review Sartre’s interpretation of shame and how it might apply in this situation.

As noted in Chapter 3, this theme is what Smith (2011b) referred to as evolving from a “gem” or a particular passage from a research participant. It was Raylene’s transcript in particular that evoked this theme and provided the opportunity to illuminate the experience for the group of participants as a whole. Raylene who is very experienced in the field and had done a lot of her own therapy was surprised at the challenges she experienced in learning a new therapeutic approach:

I had done a ton of my own personal work but I had no idea that this shame piece was in me. I felt responsible...I was really tapping into how ashamed I felt that I wasn't getting this model down.

Raylene used the words “shame piece” to describe an aspect of her experience of learning a new EBP five times during our interview. She also described herself as “ashamed” at some point during her learning four times during the interview and used various other descriptors such as describing herself as “shameful”, “my shame”, “filled with shame”, and “my shame experience” 14 times during the interview. The evocative passage from Raylene noted above was an entry into an experience shared with other research participants. Raylene’s descriptions were what Smith (2011b) described as a “shining” gem where there is a clear presence and description of that experience by the research participant. In fact, Raylene’s perspective about the shame that she experienced while learning an EBP evolved. She described how “the whole shame piece has been extraordinary to me”, that it illuminated an experience earlier in her own life (her sister’s suicide) that was exposed while learning an EBP. Once exposed, she was able to process and integrate the experience with the help of supervision, further training, and peers to develop a more coherent narrative which enriched not only her learning of the EBP we discussed but her life in general. With that coherence developed, Raylene offered an experience that I draw on throughout this chapter. Also contributing to this chapter is the theoretical understanding of shame as a social emotion.

Understanding shame as a social emotion emerges from a category of theories that assumes that social relationships are a basic biological need (Greenberg & Mitchell, 1983) and understand shame as a threat to the social bond (Scheff, 2000). Bowlby (1973)

for example, wrote that a child rejected by their parents “is likely not only to feel unwanted by his parents but to believe that he is essentially unwanted, namely unwanted by anyone” (p. 238). Shame can alert an individual to potential rejection and can motivate a person to prevent the rejection from occurring (Nathanson, 1987, 1992). Scheff’s approach to shame incorporates both a negative sense of the word as well as its positive intentions, for example having a sense of shame, adhering to social norms. While Brown (2006) defines shame as “an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p. 45). Each of these theoretical approaches to shame suggest that the mechanisms of shame are social which is the focus used for the interpretation in this chapter. What follows is a description of the shame and shame like experiences that the participants discussed in this research project.

### **6.1 “There’s nothing like family practice to push people into a bit of a corner”**

The nature of the training that the participants did in this research project seemed to reflect a general understanding that learning about couple and family therapy (CFT) is more personal (i.e. challenges the self-of-the-therapist) than learning about individual approaches to therapy. George who trained as a family therapist in the 1970s and has since been responsible for training and supervising others learning family therapy noted:

We had a lot of problems with residents in training, not just residents but whoever, who come up against their own personal difficulties quite quickly. I think there’s nothing like family practice to push people into a bit of a corner.

As an experienced therapist and trainer, George noted both the personal “difficulties” that arose during training as well as the image of being cornered. He evokes a sense of an

individual isolated, confronted, exposed, and stuck at the same time. George offers a picture of individuals in family therapy training confronted by their own “personal difficulties” as if long lost secrets or personal foibles that had long been hidden away rear up and snap a trainee into attention. George received and conducts family therapy training in group settings. When these personal difficulties arise, they expose an individual not only to themselves but other trainees, supervisors, and trainers. The trainers and supervisors in this case have a great deal of authority over a trainee’s future career so the possible implications for being exposed are both personal and professional.

At the same time that George paints a picture of trainees exposed and confronted, he also suggests they are isolated and stuck at the same time or backed “into a bit of a corner”. This push into a corner suggests there is nowhere to turn and they are edged deeper into a corner by their “personal difficulties”, isolated from and unable to reach for supports, resources, or other people. George went on to describe a situation with one trainee where:

We had a particular participant in one of our groups who clearly had had an abusive experience in her childhood and she’d been going along with this nicely contained. Into this family arena and the whole thing just, and she was in a mess for quite some months.

This trainee was confronted by her early in life injuries with the people she most trusted at that time. Once the abuse history was exposed, this trainee was in a “mess”, not only backed into a corner but one gets a sense of huddled and sobbing in a corner unable to see any options for sorting the experience. This kind of experience where one is flooded with overwhelming emotion leaves one isolated and feeling unwanted.

For some of the participants in this research project though, the opportunities for aspects of their families and relationships to be exposed, re-ignited, or illuminated during couple and family therapy training was not a function of previous lack of self-exploration or therapy. Raylene, for example, who is very experienced in the field and had done a lot of her own therapy, was surprised at the challenges she experienced in learning a new therapeutic approach:

I had done a ton of my own personal work but I had no idea that this shame piece was in me. I felt responsible...I was really tapping into how ashamed I felt that I wasn't getting this model down.

For Raylene, the personal difficulties she was confronted with while learning a new EBP were not a function of a lack of self-of-the-therapist work or previous personal therapy she had done. George on the other hand described how he “had done a lot of work previously on myself because of my psychotherapy training so you know it didn't really affect me quite so much”. George noted that in comparison to a trainee who “was in a mess for quite some months” he was not affected “quite so much” but this did not mean he was not also confronted. In his own words, George went to mention that “I certainly you know found myself not sure what, you know what, how to view my own family” when he had started his own family therapy training. The research participants not only discussed how they were personally confronted and exposed but also how that confrontation happened professionally while learning a new EBP.

One of the research participants, Mary, was a therapist in a clinical trial for a new approach to working with families. Part of the clinical trial was a measure of fidelity to

the therapeutic approach and a constant monitoring of her work. Mary described the process as follows:

I mean the other challenge, it has been...that feeling of being scrutinized because every single session that I do is recorded and every single session that I do...is reviewed by somebody, and that person is giving me a score, and if there's something that I'm doing that is not therapeutic or that involves another model, they will point that out to me and as much as I have been benefitting from that, somehow there's also a feeling of being exposed. So that, it was somehow difficult to adapt to that, to be so scrutinized.

In reflecting back, Mary could identify how this helped to develop her abilities as a therapist though she described how "it was somehow difficult to adapt to that, to be so scrutinized". While Mary experienced this scrutiny as helping to develop her therapeutic skills, the experience of being scrutinised is an element of learning an EBP for the participants in this research project. All of the participants had to submit to the scrutiny of supervisors, trainers, and peers during training and supervision sessions. They had to submit to the gaze of several others in person, with video of their therapy sessions during supervision, during role plays in training, some participants had live supervision, and at many other times during the process of learning an EBP.

One reaction to this scrutiny that Helen noted was the negative qualities about the trainer. Despite agreeing to do the interview and knowing the recruitment criteria, Helen had not done a lot of follow-up in her learning and was clearly struggling during the interview to discuss how she had integrated the new EBP into her therapy practice. She agreed with much of the ecological model to working with families that she was learning



but seemed to have a series of excuses for her lack of follow-up with supervision, videotaping her work, and other tasks that could have contributed to her integrating this new EBP into her therapy practice. One of the things Helen did instead, was she spoke at length about the challenges she had with the trainer, externalising her struggles, with little reference to the content, her own process of learning, and her adaptation of the information into her practice:

So the other person, so it's interesting to me... it seemed to be a lot about like, where they had travelled, a lot of names of people they had worked with, and, not that, the teaching part wasn't happening, but where I see this approach is, it's definitely telling you, it's not, it's taking you out of being an individual, and what I saw was, it was very much about an individual. From my perception.

Helen seemingly acknowledges both that teaching was happening and that she did not like the style of teaching. At no point did she go on to discuss how she integrated this information into her practice but she did return to the theme of what she found wrong with the way a person facilitated or delivered training of which she was part. In the context of the rest of her interview, Helen reflected a combination of confusion, fear, and judgment often associated with the experience of shame (Brown, 2006). Her fear of exposing herself or her work lead to a protective strategy whereby she did not have to talk about what her experience was of not being successful at integrating a new EBP into her clinical work. Other participants also discussed times where their challenges in their training lead them to experience a range of shame-like emotions such as humiliation, guilt, and anger. What follows is a brief review of some of these experiences.

## 6.2 “I could have said this, I could have said that”

Research participants discussed moments in their training and learning where they experienced shame, pain, and a general sense of themselves as bad or wrong. Cassandra for example, beautifully illustrated an experience of in-the-moment shame:

One girlfriend of mine I love what she said...she said you know I am the absolute best EFT therapist in the car driving home, you know you always have this oh I could have said this, I could have said that, I wish I would have done this, and you know, so that was painful.

Cassandra described what any therapist might do when reflecting about a session but her addition of the experience being “painful” situates the experience differently than a simple reflection. Cassandra used the word “painful” six times during the interview to describe how she was feeling during moments in her learning a new approach to working with couples. One of these moments she described how she was “really struggling with you know I know what I want to do, why can’t I do it in the moment?”. Cassandra’s experience in that moment and the “pain” she described is one where she sees herself as incapable. Not just that she does not know how to do a therapy technique but she is in “pain” because she experiences herself as flawed. The experience of oneself as flawed is central to the feeling of shame (Brown, 2006) and the process of learning an EBP for the research participants presented different opportunities for this to emerge.

Among the experiences that participants discussed of perceiving oneself as flawed, Raylene mentioned an element of learning an EBP that was shared with other participants who were more senior in their field. Raylene talked about the following:

It was already humiliating enough to be a seasoned therapist back in training and having to pay for supervision and being in these study groups with all these very young, inexperienced people that are just, they're still in school, they're like interns and it was pretty humiliating for me.

The experience of feeling humiliated because she was in learning situations with colleagues who were new or had yet to enter the field reflects an understanding she had about what it means to be a "seasoned therapist". While not a barrier for Raylene, this kind of understanding of what it means to be experienced in the field may serve as a barrier for others learning an EBP. Helen, for example, provided an example of how she shut down when challenged in her learning.

Helen reported an incident during training where she was struggling with the material and did not want to participate in the discussion being facilitated by the trainer. "If I feel like I'm being pushed, I will push back, and as much as I said I wouldn't, I did. Cause I wasn't saying anything". A possibility Helen did not mention was to ask questions, explain that she was struggling with the material, request additional information, and other options that may have facilitated her learning. She did not describe the facilitator as intimidating nor disrespectful of learners. For Helen, however, the tendency to turn inward and hide in such a moment reflects a tendency noted in the shame literature (Brown, 2006; Dearing & Tangney, 2011; Tangney, Stuewig, & Hafez, 2011), that is, she was motivated to hide or escape the shame-inducing discussion. Smith (2011b) described this as a "secret gem" where a participant "may not be consciously aware of the meaning" (p. 14) of what they have said. Other research participants had

some awareness (suggestive gem) or were very clear that they were experiencing shame as part of learning an EBP and what follows is a description of some of their experiences.

### **6.3 “Tapping into this feeling of shame”**

For some of the participants in this research project who spoke about the experience of shame, there came a time in their learning where they openly acknowledged that they did not know what they were doing. As Cassandra put it:

And then you get into a room with a couple and even if I felt like I had a decent idea of what I wanted to do you know I thought I did, at this point I realized that like what it looks like on paper and what it looks like in the room and what you’re really trying to do, that translation in and of itself takes a lot of the time.

This open and honest assessment of her ability with the new EBP she was learning belies the painful path Cassandra took to this statement. She spoke of her experience of feeling incompetent at not being able to learn a new EBP:

...tapping into this feeling of shame that I would get over and over again because I wasn’t getting the EFT and I would feel so incompetent and otherwise I felt so competent as a therapist. So it was like really hard for me and when I would tap into it.

Cassandra described her experience as if shame was on tap ready to be released into her when she struggled with her integrating an aspect of the EBP she was learning. Each time she struggled a tap opened inside of her building a fuzz of shame the way the light brown foam builds when a Guinness is first poured into a glass. For those inexperienced with pouring a Guinness and with tapping into the experience of shame while learning an EBP, it can spill over as it did for Raylene.

As previously noted, of the participants interviewed for this research project, Raylene provided the most evocative experience of shame while learning an EBP. Her experience centred around the suicide of her sister 30 years prior. Raylene described that she first started to make the connection between her struggles in her learning and the suicide of her sister during a supervision session. She said, “I left that supervision session, I was completely dysregulated, all I wanted to do was, eat sugar [laughter] and I leave but I’m, but my mind, I’m watching, I’m going wow, this is really significant. This is huge”. While “dysregulated” she was “watching”, curious, she had an awareness that there was something significant about feeling that way as she left that supervision session. Note that she does not blame the supervisor for making her feel that way nor discuss what strategies she used to stop feeling that way but is aware that all she wanted to do was “eat sugar”. Raylene later linked an earlier experience in her life with the shame she was experiencing while learning and using an evidence-based approach to working with couples and families:

And I’m just like oh my God, that’s it, that’s it, and then I begin to tell them the story about how I had put this together through my supervision, the shame piece, my sister’s suicide and me feeling responsible and this is what I was hitting inside myself and having that line-up with the emotion was incredibly powerful and it was very dysregulating. I was actually pretty disassociated there.

Raylene described the shame she experienced and the feeling of being responsible for not preventing her sister’s suicide. How was she to learn a new approach to working with couples rooted in attachment theory if she was not able to save someone 30 years prior with whom she had a significant attachment? The “shame piece” emerged from moments

of overwhelm and “dysregulation” and the desire to integrate a new approach to working with couples that required her to confront this shame. While Raylene was confronted, as other participants were, with an aspect of herself that was shame inducing, she found a means to make meaning of that experience in the midst of learning a new EBP. There were a few key resources that assisted Raylene with that process.

Like other research participants, Raylene talked about seeking connection, seeking to build social bonds as a means to deal with shame. Raylene mentioned how exchanges on a listserv began to lift the isolation and seed an understanding of what she was experiencing. “And so there was a lot of talk on the listserv which was also helpful, about shame and I went to a shame workshop...I began to understand this whole thing about shame”. She described developing a coherent narrative of the “shame piece” in the context of seeking connections. George emphasised the importance of being able to explore and discuss the “personal difficulties” that come up in family therapy training as mentioned earlier. He described the need as follows:

I think one has to have openings, people available to discuss on a personal level with trainees, encourage them to use their training group for support and help and guidance in whatever they may be going through. So, although some of it is so personal it can't be shared easily in public, you know they may need to go somewhere else for it but you have to be prepared for that. So these are the things that you know one is challenged with personally and I certainly found that when I was training.

For George, an experienced trainer, he assumed that there was a need to discuss things on a “personal level”, that learning family therapy is also about learning about one self,

one's family, and one's relationships. In addition, George's experience is that some of that learning will be with "personal difficulties" that are not "shared easily in public" or, in other words, might be considered shaming or shameful. Both Raylene and George are aware of the need for supports and connections while learning a new approach to working with couples and families based on their experiences as well as the potential for shameful experiences to be transformed.

In fact, Raylene went on to discuss part of why she chose to do an interview for this research project. "So you can hopefully help other people along the way, so they won't be so surprised [laughter] and so ashamed. It's like a journey". With the benefit of experience and the ability to reflect back, Raylene recognised that shame was a part of her learning an EBP and may be for others as well. While acknowledging that shame was part of her learning process, Raylene was able to recognise the integral part this took in her learning a new EBP, how it actually was bound up and contributed to her ability to integrate a new EBP into her practice. She did not want people to be "surprised" that they may become "dysregulated" and possibly "dissociated" while learning a new approach to working with couples and that it may very well just be part of their "journey". If shame is to be part of the learning of an EBP for some therapists, it is important to explore what the impact of shame on people is and for therapists during their clinical work.

## 6.4 The Impact of Shame

*I'm all lost in the supermarket, I can no longer shop happily*

*I came in here for the special offer, a guaranteed personality*

*And it's not here, it disappear* (Strummer & Jones, 1979).

One question to consider is why we would want to explore the experience of shame for CFTs learning an evidence-based practice. Besides the evocative nature of the theme and the experience of the researcher finding a “gem” in the data, what are some of the other considerations for exploring shame as a theme for this research project? What follows is a brief review of the research literature of the impact of shame on people in general and the limited research about the impact of shame for therapists.

Shame proneness is linked in the empirical research literature to problems with hostility, anger, aggression, and a propensity to externalise blame (Ahmed & Braithwaite, 2004; Andrews, Brewin, Rose, & Kirk, 2000; Bennett, Sullivan & Lewis, 2005; Harper & Arias, 2004; Harper, Austin, Cercone & Arias, 2005; Tangney & Dearing, 2002). The frequent experience of shame has been linked to individual vulnerability (Dearing & Tangney, 2011) as well as poor collaborative skills and conflict avoidance (Lopez et al., 1997). Dearing and Tangney (2011) point out that “the immediate action tendency when faced with shame is to hide or escape from the trigger that elicited the painful emotion” (p. 5). Other subsequent action tendencies, such as lashing out in anger or blaming others, are attempts to alleviate the discomfort associated with shame. One of the consequences of shame is the negative impact on interpersonal relationships.

Shame is negatively related to perspective taking and the focus of cognitive and emotional energy when in a shame experience is directed inwards. Leith and Baumeister



(1998) outline the impact on perspective taking as follows: “the globality of shame could make perspective taking highly aversive: if one assumes that the particular misdeed reveals oneself to be a bad person, one will not wish to contemplate oneself from one’s victim’s perspective.” (p. 7). The impact on perspective taking can be seen in this and other research projects. Brown (2006) described her research participants’ experience of shame as follows:

When the participants experienced shame...they were taken off guard, flooded with overwhelming emotions, and were unclear about what they were feeling or why they were feeling it. The shame experience often produced some combination of confusion, fear, and judgment. Closely following these feelings were often strong feelings of anger, rage, and/or blame. (p. 48)

Some of the research participants talked about the struggles to learn a new approach and the inward direction of their questioning. None of the participants spoke more clearly about their struggles than Raylene when she mentioned being “dysregulated” and “dissociated” during and after a supervision session. Other participants also spoke to experiences of overwhelm, shame, and the related secondary behaviours that come with these feelings such as anger. For example, Cassandra clearly spoke of her experience of feeling incompetent at not being able to learn a new EBP when she discussed “tapping into this feeling of shame that I would get over and over again because I wasn’t getting the EFT”. While Helen, who had spoken with a certain kind of anger about the struggles she had with a trainer, mentioned that “it was very much about an individual” as a means to reflect about her experience of integrating an EBP while completely deflecting from her own lack of efforts or inabilities. In either case, directed inwards or focused on what

the problems are with the trainer, one's attention is taking away from the content being presented, the issue being explored in supervision, or the possible learning from a video or live session review. Both of these experiences takes a trainee away from learning about an EBP or blocks them from integrating an aspect of an EBP into their practices.

Talbot (1995) writes of the need for an active approach to uncovering shame by both supervisors and therapists. "Unexplored shame begets *passivity* and *hiding*" (p. 339). The importance of a therapists' need to explore their experiences of shame is highlighted by the impact it may have on clients. "Embarrassing and shameful moments reveal unacknowledged, uncomfortable feelings of which the therapist is unaware that will likely have unknown effects on clients" (Ladany, Klinger, & Kulp, 2011, p. 307). Research participants spoke of the transition to new approaches in their practice and the lag between an idealised therapist-self and the reality of their experience with a couple or a family. As Cassandra mentioned, "what it looks like on paper and what it looks like in the room and what you're really trying to do, that translation in and of itself takes a lot of the time". Like other participants, Cassandra started her learning of a new EBP with a sense of being able to integrate a new therapy approach into her practice with more ease than she experienced. All of the participants in this research project had a minimum of a masters' degree and a sense of competency about their clinical work. Identifying therapists' shame and working through it is critical given the impact it may have on clinical work. As simple as this may sound, the research participants' experiences spoke to the tremendous challenges this presents.

As Brown (2006) noted, "shame often produces overwhelming and painful feelings of confusion, fear, anger, judgment, and/or the need to hide" (p. 46). This

experience was reflected by the participants in this research project. Raylene for example mentioned being “completely dysregulated”; Cassandra discussed “tapping into this feeling of shame”; Kathy talked about wanting to “feel like you have something to offer”; Ken reviewed how it has been “harder for me to not go into that inner critic and think I’m really stupid”; Jessica reflected that “the actual practice or implementing of the theory is a little bit harder” than she had anticipated and this led to her questioning her abilities as a therapist; and Tina relayed an experience with a supervisor who offered feedback about her work and she “felt really overwhelmed by that and I felt wow am I up to the level of expectation at this time in my life?”. These are just a few examples of shame related experiences while learning an EBP from the research participants. Underpinning all of these experiences was a great desire to be effective and the need to demonstrate this efficacy to clients, peers, supervisors, and trainers when learning an evidence-based practice. It is important to distinguish between shame and guilt, embarrassment, humiliation, and primary vs. secondary shame and what follows is a brief outline of those differences.

#### **6.4.1 Delineating shame**

Lewis (1971) suggested that the key distinction between shame and guilt is the latter focuses attention on the triggering behaviour or attribute while shame focuses more generally on the self as a whole. For example, I did something bad in a therapy session versus I am a bad therapist. The impact on a person is also significantly different. “In terms of the degree of stress, shame is more painful than guilt” (Akbag & Imamoglu, 2010, p. 671). As a result, the action tendencies of guilt tend towards wanting to make things better and in supervision or training, more likely to be brought up. As Tangney,

Stuewig, and Hafez (2011) write, shame however “often motivates efforts to deny, hide, or escape the shame-inducing situation” (p. 710). Beth discussed how her guilt was helpful in her work, making her more attentive and adaptable with the couples she works with:

I’m a bit obsessive, I’m a very, very, overly conscientious so I like to feel like, although I’m very independent-minded too, so I think that it’s a funny combination and so I have a lot of self-consciousness or guilt even though I will veer off of something if I think it’s relevant to a couple or they need more time on this than others. And so I find that that’s very helpful because it means I sort of feel like there’s a permission giving or acknowledgement that not every couple is going to proceed through this that linear way.

Beth experiences her “guilt” as motivating and it helps her to be a better therapist. For Beth, guilt has a function; it keeps her focused in her work and gives her “permission” to better attend to each couple in a way that she experienced herself as a more competent therapist. Guilt allows for other oriented empathy while shame disrupts people’s ability to connect empathically with others and leaves one absorbed in self-oriented distress (Tangney, Stuewig, & Hafez, 2011).

The tendency with guilt is to seek repair in relationships, “it appears that guilt helps strengthen and maintain close relationships.” (Leith & Baumeister, 1998, p. 2). Shame on the other hand is linked in the research literature to efforts to externalise blame, anger, hostility, and aggressive behaviour (Bear, Uribe-Zarain, Manning, & Shiomi, 2009; Bennett, Sullivan, & Lewis, 2005; Harper & Arias, 2004; Luyten, Fontaine & Corveleyn, 2002; Paulhus, Robins, Trzesniewski, & Tracy, 2004; Tangney & Dearing,

2002; Thomaes, Bushman, Stegge, & Olthof, 2008). Finally, again different from guilt, shame is linked to a wide range of symptoms including low self-esteem, depression, anxiety, eating disorders, post-traumatic stress disorder, suicidal ideation, and substance dependence (Ashby, Rice, & Martin, 2006; Brewin, Andrews, & Rose, 2000; Crossley & Rockett, 2005; Dearing, Stuewig, & Tangney, 2005; Ghatavi, Nicolson, MacDonald, Osher, & Levitt, 2002; Harper & Arias, 2004; Leskela, Dieperink, & Thuras, 2002; Luyten et al., 2002; Murray, Waller, & Legg, 2000; Orsillo, Heimberg, Juster, & Garret, 1996; Stuewig & McCloskey 2005; Tangney, Wagner, & Gramzow, 1992). In addition to clarifying the difference between shame and guilt, another distinction to make is that between shame and embarrassment.

Embarrassment is often linked to shame and can be considered on a continuum with a key difference being that embarrassment is experienced short term (Ladany, Klinger, & Kulp, 2011). Embarrassment has also been referred to as instrumental shame (Greenberg & Iwakabe, 2011), that is learned to achieve an interpersonal aim by feigning embarrassment or reflecting a cultural behavioural expectation. One example of how embarrassment might be used while learning an EBP is described by Raylene's experience with a new learning group. She mentioned her discomfort, hesitancy, and feeling of embarrassment about not knowing what to do or expect. Her co-learners were looking at each other awkwardly, feigning embarrassment, "and everyone's looking around thinking what are the rules, what's safe, what's expected of us, you know and once people learn the level of safety that there is, people are more comfortable in coming forward". Raylene described a passing experience, one where people may hide and avoid each other but it is short-lived. A more damaging experience to the interpersonal context

is that of humiliation, another emotion sometimes confused with shame and important to distinguish.

Humiliation arises from the actions of others but there is little sense of disruption to personal identity. The actions of others can be explicit or implied as it was for Raylene when she discussed being humiliated as a “seasoned therapist back in training and having to pay for supervision and being in these study groups with all these very young, inexperienced people”. The notion that as an experienced therapist Raylene was at the same level as newly trained therapists, some not even out of grad school, implied an experience of humiliation for her but not one that left her incapacitated or unable to recognise the skills and experience she did have as a therapist. Other clarifications in the research literature about shame distinguish between primary versus secondary shame.

Greenberg and Iwakabe (2011) make a distinction between primary adaptive and maladaptive shame. Primary adaptive shame “is seen as the person’s most fundamental, direct, initial, rapid reaction to a situation of diminishment” (p. 72). Adaptive shame alerts people that they are too exposed, that other people will not support them, or they have violated an important standard or code. This kind of display of shame is also intended to elicit support from others by “evoking affiliative responses, sympathy, and forgiveness from others” (p. 72). Primary maladaptive shame often evolves out of past trauma or a poor attachment history. A person internalises the experiences of being shunned or being defective; this history of being mistreated is internalised and can be activated at other times in their lives. Greenberg and Iwakabe (2011) indicate that this is the more common form of shame to appear in therapy and it must be accessed to transform it. Similarly in training and supervision, participants noted the importance of

being able to explore and understand their own experience of shame while learning as Raylene said:

That is extraordinary, when I got that piece, really it was in the middle of this year, of 2012, when the shame piece began to come up...so people began to talk about it and being able to own my own shame around learning EFT and then everybody on listserv jumped on board and went yah I feel the same way; that was huge in making everything safer.

Secondary shame on the other hand is an “emotional reaction to a primary emotion, such as feeling shamed at one’s sadness or anger” (p. 73). For example, the shame men in some cultures are taught to exhibit if they are feeling sad. Having delineated shame from other emotions and behaviour, the next section will deal with the theoretical approaches to shame used in this chapter.

#### **6.4.2 Shame as a social emotion**

Unlike the theories about shame reviewed in the overview of results chapter, Scheff (2000) defines shame as “the feeling of a *threat to the social bond*” (p. 97). There was a repeated refrain when participants talked about how they dealt with shame as it arose during training, supervision, or while trying out a new model in their work: they were soothed by other people. Raylene talked about how exchanges on a listserv began to lift the isolation and seed an understanding of what she was experiencing. She mentioned the exchanges on the listserv was “helpful” and her reaching out to and connecting with peers and discussing it further with her supervisor and husband helped her “to understand this whole thing about shame”. Of the participants in this research project, Raylene was the clearest about developing a sense of coherence with her

experience of shame while learning an EBP. The understandings about her experience with shame lead Raylene to want to connect with other therapists and offer the story about how she identified and processed those impacts in her learning. As she mentioned, so that “you can hopefully help other people along the way”. Raylene knew the threat to the social bond that the experience of shame while learning an EBP presented and she sought a way to offer her experience as a means to assist others in understanding the importance of recognising, integrating, and seeking supports to assist when one does experience shame while learning an EBP. Another approach to shame is that of Brene Brown’s (2006), who proposed shame as a psycho-social-cultural phenomena.

With over 14 million views on the internet of her 2010 Ted Talk, a series of books, a variety of television appearances, University of Houston social work professor Brene Brown may have the most popularised view of shame at the moment. Based on interviews with 215 women she developed the shame resilience theory and defines shame as “an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (Brown, 2006, p. 45). This view of shame incorporates psychological, social, and cultural components.

Brown (2006) describes the psychological component as her participants’ “emphasis on the emotions, thoughts, and behaviors of self” (p. 45). The social aspect arose out of participants discussing shame as evolving out of an interpersonal context and always linked to relationships and connections. While “the cultural component points to the very prevalent role of cultural expectations and the relationship between shame and the real or perceived failure of meeting cultural expectations” (p. 45). As George noted about his own experience with learning family therapy and now being involved with



training others, “I think there’s nothing like family practice to push people into a bit of a corner”. George commented on the potential to reflect about, re-consider, and re-experience aspects of a personal and professional self, one’s family, and one’s relationships often seem to be at hand in couple and family therapy training. Here, Jean-Paul Sartre (1956) may be of help to explore those experiences.

### **6.5 The Impact of Shame on Learning an EBP**

*In shame the phenomenon of the Other confronts me. I am ashamed when the Other sees me make an awkward or vulgar gesture. Then I appear to the Other not as a subject but as an object. This makes it possible for me to pass judgement on myself as on an object – objectively.* (Stellar, 1960, p. 37)

Joseph Stellar admirably paraphrases Sartre’s analysis of the experience of emotion and shame in particular. As Sartre (1956) writes about the experience of shame, “I recognise that I *am* as the other sees me” (p. 222). The process of learning an evidence-based practice for the research participants required one to constantly submit to the gaze of an “other”. As noted in the methodology section, participants were screened for the following criteria: they were relating their practice to a treatment manual; the clinicians received extensive training specific to a practice; the clinicians received supervision specific to an approach; and the evidence-based practice they were learning has a theory of change that clinicians are required to relate their practice to. The process required participants to begin to see themselves through an other’s therapeutic framework, “the Other is not only the one whom I see but the one *who sees me*” (Sartre, 1956, p. 228). This view from others presents unique challenges when learning a new approach to working with couples and families.

Most participants talked about how part of the learning process included their reflections about their own relationships and families, past and present. There were many “others” that became part of the process. As George noted about trainees, they “come up against their own personal difficulties quite quickly” in family therapy training. As George did when first doing his family therapy training and found himself at that time “not sure what, you know what, how to view my own family”. That experience has been repeated throughout training I have assisted with in Emotionally Focused Therapy for Couples where participants often discuss the duality of learning a new approach while reflecting about their relationships throughout the training. One participant at a recent training came up to me on the second day and said “last night I went home and told my husband we’re going into therapy”. Fortunately, her husband was amenable to the request. The training experience for this participant seemed to reflect Sartre’s proposal that in those moments, “I see myself because somebody sees me” (p. 260). Or in this training participant’s experience, she saw her marriage because someone else saw her marriage.

Generally, we equate being seen with a healthy process, that we are known, our experience is reflected, and our motives from infancy are intersubjective to attract and engage another person (Mikulincer & Shaver, 2012; Trevarthen, 2001). The other experienced by the research participants here is not first experienced as a seeing other but as a vehicle to learn a new approach to therapy, a “supervisor”, a “trainer”, a means to help us understand who we are by realizing that we are not like them (Stellar, 1960). That relationship evolves as a therapist seeks to genuinely integrate new ways of working with couples or families. As Sartre (1956) writes, the “relation to the Other is first and

fundamentally a relation of being to being, not of knowledge to knowledge” (p. 244). It may serve an important function to protect oneself or one’s ego or keep an interpersonal bridge intact to get angry at an object, blame our limitations in learning something new on an object, and deride the shortcomings of a therapeutic approach. When this happens, the people involved in training and supervision are made into objects. The dysregulating overwhelm experienced by participants also touches a place where they experience themselves as flawed therapists, not just that they do not know how to implement a new technique but they experience the notion that they are flawed therapist because they cannot learn a new approach. Helen succinctly summarised this experience as follows, “but it sort, I don’t want to say it’s confused things for me, but it makes me realize, like how you’re just at the very start”. Being at the very start is not how the masters educated participants in this research project experienced themselves as therapists. For some of the participants, there was a reckoning about being “at the very start” again in their learning about therapy with a couple or family that they could process. For those participants who spoke explicitly or implicitly about shame, the experience of themselves as flawed suggests a role for others that Sartre explores further.

The place of the other in these moments suddenly takes on a significant role that calls for a high tolerance for ambiguity and a capacity to not know oneself or not be oneself. Sartre (1956) states it this way:

Shame – like pride – is the apprehension of myself as a nature although that very nature escapes me and is unknowable as such. Strictly speaking, it is not that I perceive myself losing my freedom in order to become a *thing*, but my nature is –

over there, outside my lived freedom – as a given attribute of this being which I am for the Other. (p. 263)

Suddenly infused with objectivity, “the quality or state of being an object” (Stellar, 1960, p. 126), strategies are sought to self-regulate, re-orient, or re-organise one’s being. For some, this means lowering expectations as Cassandra described:

I had one gal, very experienced in the field, say well if you help one out of ten that’s good you know. And personally for me that’s not enough. I wouldn’t feel good about my work if I was only helping one out of ten couples.

For others, this means questioning the overall EBP project and the people involved in any capacity as Mary described:

Well, one thing is that, as I said, I’m not, in my PhD program, they really promote a critical view of evidence-based practices. So I get the sense, I haven’t been told that, but I get the sense that somehow they look at me like oh you’re betraying us, how come you’re learning about this model that is evidence-based if you know that this type of research can be oppressive or that many times this research is based on, so basically that I shouldn’t be accepting these evidence-based practices blindly, that I have to maintain a critical view of them.

Cassandra and Mary described subjecting themselves to review, scrutiny and objectivity by both those involved in the learning of an EBP as well as colleagues not involved.

This viewing by peers in learning a new EBP and colleagues not involved can leave one feeling vulnerable to scrutiny from various sources, some expected, some may not be. Sartre (1956) described how even the windows of a house can have a function of a look for someone about to break in:

What I apprehend immediately when I hear the branches crackling behind me is not that *there is someone there*; it is that I am vulnerable, that I have a body which can be hurt, that I occupy a place and that I can not in any case escape from the space in which I am without defense – in short, *that I am seen*. (p. 259)

There is potential for many windows, many crackling branches, and many vulnerable spots when learning a new therapeutic approach. There is no place to hide in learning an EBP that requires supervision, adherence to a treatment manual, video review of a therapist's work, and a demonstration of fidelity to the approach.

The example of a fidelity measure is useful for exploring Sartre's notion that when a therapist is seen in this instance, they are "seen as an object in a world that is not my world and in which everything is ordered from the viewpoint of the Other" (Stellar, 1960, p. 40). A measure of fidelity to an approach is important for establishing a therapy model as an evidence-based practice as well is used to assess progress of a trainee in some practices. A fidelity measure is a tool to assess whether treatments are distinct and ensures that the tasks associated with a particular therapeutic approach do not overlap with other approaches (Allan & Ungar, 2014; Waltz, Addis, Koerner, & Jacobson, 1993). Fidelity measures in outcome research have been described as "confirmation that the manipulation of the independent variable occurred as planned" (Moncher & Prinz, 1991, p. 247). The scrutiny of specific moments in a therapy session or particular techniques implemented over a number of sessions can be experienced as both restrictive and liberating at the same time by a therapist. As Mary noted about being part of a clinical trial for a new approach to working with families:

I mean I cannot use that here right now so the way I deal with this frustration, many times is to know that this is the way it is. I cannot, there are some rules in this game and those rules are restrictive in many areas, and that's it, I mean I accept that to play the game in this way. But, I know that I can use this model outside of research projects with more flexibility.

Mary is aware that she is cast into a world “which is revealed to me only by collective and already constituted techniques...These techniques are going to determine my belonging to collectivities...to the professional...group” (Sartre, 1956, p. 514). She is aware that on the one hand there is a “game” to be played to be a therapist in a clinical trial and on the other she sees her potential to liberate herself from those restrictions outside of the confines of a research project and the gaze of the researching other.

Further, some participants also spoke of how they dealt with the experience of shame.

While not the focus of this research project, and one that does require a focus in future research, some participants mentioned what they found supported them when they experienced shame. For example, Cassandra noted the role of her supervisor:

My supervisor was huge in terms of just helping me especially with those initial you know, that initial pain that I was going through of feeling completely incompetent at times and really struggling with you know I know what I want to do, why can't I do it in the moment?.

While Cassandra spoke of the need to connect with more experienced therapists learning the same approach:

So that was really helpful and my experience was that I really had to, in terms of getting that support, it had to be with other EFT people. Either people who are

further down the path or at the same place with me, that you know that I could talk to other colleagues who weren't learning EFT about some of those struggles, but they couldn't quite relate because I think the model itself demands so much of the therapist.

The need to connect with other learners noted by Cassandra relates to an interesting experience that emerged with the last interview conducted for this research project.

A number of the interviewees were experienced therapists who had trained with some of the leading figures in the field of couple and family therapy (e.g. Salvador Minuchin, Virginia Satir, Michael White). In some ways, it was a surprise to hear about their pain, torment, and struggles in learning a new EBP because of their extensive experience and commitment to learning. The last interview, however, was with a recent Master's in Counselling Psychology graduate who had done his master's internship at a couple and family therapy centre. When the interview was complete, I was struck by how his experience of the turbulence of learning an EBP felt normal to him. Further, he seemed to reflect Sartre's (1956) proposal that one must choose to be what one is in the face of pride, shame, hate, or fury. That to confer a more positive meaning on the experience, we "do not choose to be for the Other what I am, but I can try to be for myself what I am for the Other, by choosing myself as I appear to the other" (p. 529). When asked what helped him with the challenges of learning a new EBP, Eric described weekly gatherings with fellow students all in different internships settings as follows:

I would say the other, my fellow Master's students were also another huge piece. You know it was, we realized pretty early on in the program that when we would go out for dinner, or go out anywhere, ah that no other group of people at

restaurants was having the type of conversation we were having. The counselling students would you know get into discussions of you know applying the theories that they were learning to themselves, in a real open way...It was hilarious but also refreshing because you were all, ah willing to apply what we were learning to ourselves and discussing it in a fairly open and non- judgmental way with each other. It was just a nice group of friends to be able to do that with...Ah, but yah that was crucial, and the friendships of course that formed then I'm still in touch with many of my Master's classmates and ah you know I can have, still now, have conversations with them you know where I can easily bring up something very tender in a very kind of conceptual way and I know that it won't be, it won't be stepped on, it won't be judged, they'll kind of engage in this, you know they'll engage with their curiosity.

Eric described the norm of his peers using their own experience as one way to filter new learning, positively engaging with peers, and knowing that they were vulnerable in their learning. Similarly in training and supervision, participants noted the importance of being able to explore and understand their own experience of shame while learning. As Raylene said:

That is extraordinary, when I got that piece, really it was in the middle of this year, of 2012, when the shame piece began to come up...so people began to talk about it and being able to own my own shame around learning EFT.

Both Eric and Raylene describe how, in the face of shame, they were choosing to be vulnerable, open, learners. In other words, they were choosing to be themselves. Aponte et al. (2009) write that this "self-acceptance (not to be confused with self-pity or self-



indulgence) promotes a freedom from the tyranny of shame about their hang-ups that allows them to actively engage with their vulnerabilities in the service of their therapeutic efforts” (p. 384). The active engagement with one’s own vulnerabilities is very much the process that Raylene discussed during our interview. She had a story to tell about her experience of learning an EBP and was keen to share it because of the adaptive experience she had with engaging her vulnerabilities and the internalised sense of how important that process was for her learning the EBP we discussed.

## **6.6 Conclusion**

This chapter reviewed therapists’ experience of shame while learning and beginning to use a new approach to working with couples and families. Therapist’s shame is a limited area in the research literature (Ladany, Klinger, & Kulp, 2011) and the experience of shame while learning an EBP is even more so. The area of shame research is supported by researchers using diverse methodologies and from various fields of research (e.g. Balcom, Lee, & Tager, 1995; Brown, 2006; Dearing, Stuewig, & Tangney, 2005; Scheff, 2000, 2003; Tangney & Dearing, 2002; Tracy, Robins, & Tangney, 2007). Researchers report there is a shame associated with talking about shame; that it is often avoided and that trainees who experience unacknowledged shame may feel misunderstood (Dearing & Tangney, 2011). At the same time research participants reported that it is a common experience, as Cassandra said about learning a new approach to working with couples that a lot of therapists “go through kind of feeling some shame and pain”. While not the focus of this research project, some participants offered the strategies that helped them to cope with the experience of shame. Those involved in training and supervision can be a support during the challenging times by recognising

that the experience is to be expected and supporting a new understanding that reconciles the self as viewed by other and the self as chosen by the trainee themselves.

## **Chapter 7**

### **Discussion**

Discussion chapters in interpretive phenomenological approach (IPA) studies are sometimes the first opportunity to “place your work in a wider context” (Smith, Flowers, and Larking, 2009, p. 112). This approach starts with reporting results where “the interpretive account...is a close reading of what the participants have said” (p. 112). This research project has already discussed findings in light of theory in the analytic chapters (Chapters 4-6), which is an acceptable option within IPA research. Thus, the focus of this chapter is a further exploration of each of the super-ordinate themes that emerged from the data and the implications for clinical practice, training, and supervision.

This exploration is not exhaustive but offers further reflections in light of the Dreyfus (1986; 2004) model of skill acquisition; posits a means for embodying a clinical practice; and discusses options for therapists, trainers, and supervisors when encountering shame while learning a new clinical approach. I will then offer personal and epistemological reflections as suggested by Willig (2008). A note about the words used to describe research participants which include supervisee, trainee, and therapist; the choice to use each of these words reflects an idiographic perspective. Each of these words reflects different aspects of the research participants’ experiences while learning an evidence-based practice (EBP). They were a trainee while in a workshop or a course learning the EBP, a supervisee while receiving supervision about the EBP they were learning, and a therapist while working with a couple or family using the EBP that we discussed. Starting with the supports and challenges for learning an evidence-based practice, the following further discusses EBPs in light of the Dreyfus model of skill

acquisition and an alternative to empirically supported treatments that is sometimes proposed, the common factors approach.

## **7.1 “In life...there’s always a growing edge for me”: To EBP or Not to EBP**

Research participants discussed a number of factors that supported and challenged their learning an EBP. Some of these factors were the need to learn from the “inside out”, to have opportunities for trial and error learning, the role of context, the need for supervision and support to deal with personal issues that arise, and Flyvberg (2001) would add the willingness to use “judgment...common sense, [and] intuition” (p. 23). In terms of research participants’ experiences with learning and using an EBP and what influenced their decision to learn a new therapeutic approach, the intent to improve their work with couples and families was central while the process of learning and using an EBP provided a focus and an intent that organised these experiences. What follows is a further exploration of the Dreyfus (1986; 2004) model of skill acquisition and whether EBPs were necessary for the research participants to improve their couple and family therapy practice. An exploration of the common factors approach (CFA) is also in this section. The CFA is important to mention because it is posited in the research literature as an alternative to empirically supported treatments and the CFA is an evidence-based approach to working with couples and families.

### **7.1.1 Common factors**

Sprenkle, Davis, and Lebow (2009) wrote that change in psychotherapy occurs “predominantly not because of the unique contributions of any particular model of therapy or unique set of interventions...but rather because of a set of common factors or mechanisms of change that cuts across all effective therapies” (p. 2). They reviewed a

large body of research literature and concluded that “there are typically only modest differences in the results achieved by very disparate therapies that independently have been shown to be effective” (p. 7). These conclusions lead researchers to develop a common factors approach to psychotherapy in general (Lambert, 1992; Lambert & Ogles, 2004) and couple and family therapy in particular (Sprenkle et al., 2009). Common factors are considered evidence-based by virtue of the research that has been done on these factors in the various research projects that had one or more of the factors in the therapy approach being researched. The aim of the CFA is to identify the elements that different effective therapies share with the goal of creating an approach based on these effective elements (Blow & Sprenkle, 2001).

The different conceptualisations of a CFA either focus on specific therapeutic techniques or a broader view that sees “common factors as including other dimensions of the treatment setting—like client, therapist, relationship, and expectancy variables” (Sprenkle et al., p. 9). Laska, Gurman, and Wampold (2013) for example, identified the following shared elements as necessary and sufficient for change in therapy:

- (a) an emotionally charged bond between the therapist and patient, (b) a confiding healing setting in which therapy takes place, (c) a therapist who provides a psychologically derived and culturally embedded explanation for emotional distress, (d) an explanation that is adaptive (i.e. provides viable and believable options for overcoming specific difficulties) and is accepted by the patient, and (e) a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is positive, helpful, or adaptive. (p. 3)

Alternatively, Sprenkle and Blow (2004) take a broader approach and consider the therapeutic relationship, expectancy effects, client factors, therapist effects, and nonspecific treatment variable such as: “behavioral regulation, emotional experiencing, and cognitive mastery...[and] allegiance effects and the organization or coherence of the model employed” (Sprenkle et al., 2009, p. 31). The CFA is not intended to replace EBPs or be used as a clinician’s sole treatment model but specific therapeutic approaches are intended to be “vehicles through which common factors operate” (p. 5).

The layering of a CFA with EBPs offers another set of rules for clinicians to consider as part of an evidence-based approach to working with couples and families. The purpose of this research project is not to explore the merits of one approach over another but focus on the therapist’s experiences with learning an EBP. There are many similarities between the understanding of a common-factors and an empirically supported approach to couple and family therapy. Sprenkle et al. (2009), proponents of a CFA approach, wrote that both a CFA and EBPs “use the same elements but in very different ways” (p. 9). That similar elements are used in both a CFA and EBP approach points to the shared limitations of each of the approaches as reflected by the participants in this research project. I will now return to the Dreyfus (1986; 2004) model of skill acquisition to further elaborate on these limitations.

### **7.1.2 Knowing how vs. knowing that**

Evidence-based approaches to working with couples and families tell us how to work with typical cases, not a particular case or cases in general. EBPs and the CFA provide lists of rules for how to work with couples and families. Husserl (Husserl & Welton, 1999) argued that concepts (e.g. EBPs and the CFA) are hierarchies of rules

which contain other rules within. Husserl used the example of learning about dogs whereby the rule for recognising dogs contained a subrule for recognising dog fur. Husserl wrote that “If we are once attuned to apprehension of the universal...each part, each particular moment in an object, furnishes us something to apprehend conceptually as general; every analysis will then go hand in hand with a general predication” (Husserl & Welton, 1999, p. 288). This focus on rules, on the particulars that fit a concept that we have of a clinical issue or family, sits well with both evidence-based approaches such as the CFA and empirically supported treatments.

For example, we know that: a parent who involves a child in an argument with his or her spouse is triangulating (Bowen, 1978); a spouse who goes silent or removes him- or her-self from meaningful discussion with his or her partner in an attempt to reduce conflict is using an avoidant attachment strategy (Johnson, 2004); a child or adult who struggles with emotion and emotion regulation likely has a mood disorder (American Psychiatric Association, 2013); and from a structural perspective that the parental hierarchy is out of order if a child is ruling the household with his or her bad behaviour (Minuchin, 1974). Similarly, depending on one’s clinical approach, we know that it is important to work with parents to help them understand the impact of involving them in a conflict with their spouse and how to manage conflict with their spouse; to attune with the client who sometimes uses an avoidant strategy to develop coherence of that strategy and help them reach from a vulnerable place to their partner; to work with and find resources that support emotion regulation; and to re-install the parental hierarchy in an effort to reassure the child that they can rely on their parents.

We know these rules and what the rules are for responding to them because of clinical experience and the research that has been conducted over the years and the range of evidence developed to help understand these rules. EBPs are about “learning a lot of facts and rules for relating them” (Dreyfus & Dreyfus, 1986, p. 4). If we are to attune and be helpful with the couples and families that we work with however, couple and family therapy is a skill akin to knowing how to find one’s way about a couple or family, what it is like to be in those relationships. That kind of attunement requires a “basic understanding...a knowing how rather than a knowing that” (p. 4). “Knowing that” is learning the rules as outlined in an empirically supported treatment or the CFA while “knowing how” incorporates a variety of other ways of knowing such as embodying a therapy practice and attending to the experiences that emerge in our learning an EBP such as shame. Whether on an empirically supported treatment list or a CFA, each of these are about “knowing that” and not a “knowing how”.

Another way to understand “knowing how” is Merleau-Ponty’s proposal “that perception and understanding are based in our capacity for picking up, not rules, but flexible styles of behaviour” (Dreyfus & Dreyfus, 1986, p. 5). The complexity of couple and family therapy tasks and the complexity of couples and families that present for therapy is what Dreyfus refers to as unstructured tasks. These tasks present a “potentially unlimited number of possibly relevant facts and features and the ways these elements interrelate and determine other events is unclear” (p. 20). Unstructured tasks require a high level of skill and the kind of intent and focus that the research participants discussed here who made strides incorporating a new EBP into their clinical practices. As previously noted, we have a view from somewhere, a personal intent to be a more



effective therapist with couples and families was an essential view for the participants in this research project.

The research participants' view or position was also essential for dealing with the learning challenges and more importantly helped to navigate the paradox of learning an EBP. That is, that it is an important step but not the final step because EBPs "are fixed and explicit"; however, they do not "mirror the uncertain, nonstationary, unstructured world in which we live" (Dreyfus & Dreyfus, 1986, p. 44). The complexity of the tasks that couple and family therapists perform require an intent, a focus, and the accumulation and understanding of a lot of rules or skills. As Sprenkle et al. (2009) note, "therapists need models to give their work coherence and direction" (p. 5) but it is a direction not an end point. This direction requires substantial skill development that EBPs can be one means of providing because "...despite any problems raised by the existence of perspective, the indisputable fact remains that human skill level increases when tasks are approached from a point of view" (Dreyfus & Dreyfus, 1986, p. 48). Learning about an empirically supported treatment or common factors are both research-based ways to accumulate skills as a couple and family therapist but neither can sustain the ongoing development of a therapist. The question of whether to explore and learn an EBP is not as relevant as deciding what our view is, where we view from, and what our intent is for our work with couples and families. Learning an evidence-based practice can be an important means to support the development of couple and family therapists though cannot be the only resource that therapists use in their development. Moving to the experience of embodying a practice, the next section will explore the role of self of the therapist work.

## 7.2 “Little bastard...little priest”: Embodiment

The experience of embodying a practice and the related challenges was one of the super-ordinate themes that emerged in this research project. Participants discussed something “in” them or a felt sense (Gendlin, 1978) that compelled them in their learning an EBP. As Jessica mentioned, “it’s something deep within me around how I see it”. Jessica’s sense of something “deep within” her was shared with other research participants discussing their experiences of learning an EBP. While the experience of embodying a practice was compelling and the research participants felt drawn to a felt sense that they wanted to explore, this was not an easy process.

As George and other participants noted, learning couple and family therapy challenges more of the person of the therapist. Our own relationships, families of origin, children, parents, and so on are brought into the training room and sifted through the model we are learning. I have witnessed this experience on a number of occasions in the training with which I have assisted. For example, one participant learning the Social Ecological Approach approached me halfway through a four day training and reported that she had completed the Child and Youth Resilience Measure (Ungar & Liebenberg, 2011) with her two daughters the previous evening. The results surprised her. As a child psychologist she thought that she had been very careful to establish similar rules and expectations for the children with the children’s father for each household after they had separated. This participant went on to report how she was integrating the learning of the model in relation to her own family and the changes she was planning to make in her own parenting approach.

The way our own families and relationships are evoked in couple and family training added to the complexity of the learning and integrating of an EBP. This knowing from the “inside out” was also painful at times for research participants as previously noted. A few of the research participants even had a visceral reaction to the EBP project in general. George for example noted how EBPs are “becoming the new religion, people want to, I see more and more of us doing things that can be programmed”. George reports this programming as if he is becoming automated, a machine calibrated to respond in specific ways. He went on to say that “we’re talking about the way that the soul has been left out of therapy”. George suggests that learning and integrating a new EBP is not only a personal challenge but a spiritual challenge as well. In some ways, the challenges - personal, spiritual, and otherwise - are a necessary ingredient for learning an EBP.

Coyle (2009) described how struggling during learning is “not optional—it's neurologically required” (p.43) and that the most effective learning takes place when we are focused on the edge of our abilities and understanding. Coyle described it as the “bittersweet” spot of learning and used the example of babies learning to walk to illustrate the point. He reported research that demonstrated that the babies who learned to walk more quickly were the ones that tried more often. Coyle asked readers to imagine what deep practice felt like and he wrote the following:

It's the feeling, in short, of being a staggering baby, of intently, clumsily lurching toward a goal and toppling over. It's a wobbly, discomfiting sensation that any sensible person would instinctively seek to avoid. Yet the longer the babies remained in that state—the more willing they were to endure it, and to permit

themselves to fail—the more myelin they built, and the more skill they earned.

The staggering babies embody the deepest truth about deep practice: to get good, it's helpful to be willing, or even enthusiastic, about being bad. (p. 94)

The challenges involved with embodying a practice such as re-experiencing our relationships and families and staggering through our therapy practice bring the self of the therapist (SoTT) to the fore. To embody a practice, a therapist cannot hide and this requires the incorporation of SoTT issues in training. That is, to embody a practice we must consider the person of the therapist in the training. While an area that emerged in this research, SoTT was not the sole factor that contributed to learning an EBP for the research participants here. It is important to explore SoTT issues, however, when discussing the embodiment of an EBP. What follows is an exploration of one model of SoTT and the related experiences of the research participants.

Aponte et al. (2009) developed a model for training the person of the therapist in an academic setting. Here they focus on the concept of the signature theme.

The philosophy behind the term [signature theme] is that we all live with our very own unique-to-each-person signature struggles with ourselves and with life. Our biology, our family histories, our gender, race, ethnicity, cultures, and spirituality, along with the effects of the choices we have made in life, all shape who we are today. (p. 384)

Aponte et al. contend that the degree to which therapists commit to exploring the challenges in their lives and engage in personal growth and development is proportionate to the ability to relate to clients' efforts to deal with their challenges. The notion of a

signature theme was reflected by the research participants as well as in my own experience as a supervisor.

I have one supervisee who I have been working with for 13 months now. Her sister committed suicide 15 years ago and the related sadness, inability to prevent her sister's suicide, and blocks in therapy when she does feel helpless with her clients has come up in supervision a few times. Similarly, another supervisee will always introduce the couples she is working with by mentioning her ability to connect with the withdrawing partner and challenge with connecting with the pursuing partner. When I gently inquired further about this, she described her own experience of being a pursuer in her relationship, how painful that can be, and that she herself has never had that aspect of herself reflected or validated, thus making it hard to offer that to her clients. Research participants spoke to a few different aspects of signature themes that emerged during their training.

Jessica talked about how the model she was learning somehow linked to a signature way of understanding herself and her work:

It's a fit and not only spoken from a professional stance, but it's a fit from a personal stance. So it's been a really personal journey as well and I've learned oh a whole lot about myself, my relationships, and not just my partner relationship, but whole family relationship dynamics and it has explained things that I hadn't really understood before. So because that fit as well, it just kind of seals it for me. Jessica's learning "a whole lot" about herself and her relationships is central to Aponte et al.'s (2009) notion of working with a signature theme. While she did not name what her signature theme was, Jessica does convey the importance of this aspect of the EBP she

was learning and how important it was for that “fit” to “seal” her interest in further integrating the approach into her clinical work.

Sally discussed the importance of the training in an ecological approach to working with families for validating her approach to her work which can sometimes be at odds with the system she works in. In this instance, the training supported a fundamental way she has of understanding and working with families and provided the opportunity for that theme to be explored in her workplace:

I think, it validated what I did...And I think because I came from a school psychology background, it was, we were used to having to pull in resources, and it wasn't, just individual, cognitive-behaviour therapy. I was used to having to, pulling in resources, and build a team around people. And that consultation-collaboration model, that I learned from there. So I think, doing the social-ecological approach just validated, ok, all that time I spend pulling together the resources in the school, and talking with the family doctors, and talking with moms, counsellors, pulling everyone together around this family, really, despite...and I can't count it in my stats, it's still really valid for what the kid needs right now.

While Sally's approach to her work was reinforced with the training, other participants discussed how signature themes emerged during training or they knew that the training was raising challenges beyond the assimilation of new material.

For example, Ken was very clear about what his signature theme was and how that related to learning a new attachment-based approach to working with couples:

I think that what made it so difficult is that, see I came from an orphanage, a foster home background because I was given up at birth so, and my, and I went into a foster home at about five years of age that, but I wasn't adopted until I was 16. And my parents kind of had, I guess what you could call a subsidized adoption until I was 16. And this encapsulates the whole thing, the attachment issue very well. When I was about in my 30s, late 30s I found out from my sister-in-law that my dad's nickname for me was his little bastard and my mother's nickname for me was her little priest.

For Ken, learning about attachment contributed to his developing coherence about his childhood. Now in his mid-sixties with 40 years of experience as a therapist, Ken easily identified his signature theme during training as he reflected back on the experience. Eric on the other hand, planned ahead, anticipating that personal issues would become part of his learning:

I had asked her for a referral when I was starting my practicum as I knew that learning and practicing couples work would trigger a lot of my own stuff and I needed to have somebody to work that out with as it was coming up. So I was actively engaged in working through my triggered responses in the work and that was hugely helpful.

Eric knew in advance that working with couples would “trigger responses” that he would need assistance “working through”. George noted the role of this kind of exploration both from his own experience of learning family therapy and from training students who were learning family therapy:

So family therapy I think is a powerful opener up of those kinds of issues and those are the things that are quite challenging in a training program. So you know you have to, I think I, you know I think one has to have openings, people available to discuss on a personal level with trainees, encourage them to use their training group for support and help and guidance in whatever they may be going through.

George speaks to the role of support that Aponte et al. (2009) note as providing therapists the freedom to explore signature themes, grappling with them in a supportive environment and opening “us to viewing these personal wounds as portals through which we can reach beyond our usual limitations to new insights and new behaviors” (p. 384). The person of the therapist, the little bastard and the little priest alike, has an opportunity to experience the kind of reflection, validation, exploration, challenge, and support that a therapist might then offer to their clients in turn. There are a number of SoTT models and one was reviewed here to further illustrate SoTT related work and explore participants’ experiences with this aspect of their training. To embody a practice, a trainee may require the opportunity to explore their bodily and felt sense experiences of learning a new therapeutic approach in the context of SoTT work. Another experience that may emerge while learning an EBP is that of shame. In the next section a means of working with shame as it emerges while learning an EBP will be explored.

### **7.3 “I look like a deer in the headlights”: Shame**

The experience of shame while learning an EBP was described as a gem of a theme evoked by the experiences of one of the research participants (Raylene) which helped to illuminate the experience as discussed by other participants. Ladany, Klinger,



and Kulp (2011) define therapist shame as “an intense and enduring reaction to a threat to the therapist’s sense of identity that consist of an exposure of the therapist’s physical, emotional, or intellectual defects that occurs in the context of psychotherapy” (p. 308). The desire to hide or get angry at anyone exploring those exposures is a common reaction when experiencing shame; as Talbot (1995) noted, “shame is associated with the hidden parts of ourselves, buried deeply enough to avoid scrutiny by others and, in many cases, by ourselves” (p. 339). For couple and family therapists there are a number of potential sources of shame.

Talbot (1995) reported these sources in psychotherapy as the shame that: evolves from the relationship between therapist and clients, that arises from the therapist’s fears or experience of not being approved by a supervisor, and are inherent in discussing personal material in a supervisory session. The options for exploring the impact of shame for a therapist are further complicated by the cultural norms and action tendencies when in shame. For example, Dearing and Tangney (2011) report that the word “shame” is often avoided, that the action tendency of shame is to hide, and that therapists inadvertently avoid discussing shame related issues. The focus of therapists’ experience of shame to date has been while they are providing therapy, not while they are learning. The research literature has noted that the progression that therapists go through in their development may expose a therapist to the experience of shame.

Ward and House (1998) for example, report that supervisees progress “through a sequence of definitive stages while experiencing increased levels of emotional and cognitive dissonance” (p. 23). This dissonance can lead some to feelings of guilt while others experience shame. Guilt however leads to a reparative action while shame does

not (Smith, Webster, Parrott & Eyre, 2002). Talbot (1995) noted that “interpersonally, shame is the emotion associated with the humiliating revelation of personal failure to another” (p. 339). It is difficult to imagine a learner or supervisee who experiences shame finding a means to explore that experience. As Chao, Cheng, and Chio (2011) report, “one’s self-image is questioned in a state of shame” (p. 203). An important goal for a therapist learning a new EBP while experiencing shame is “to seek an effective means of buttressing a threatened social self or bolstering self-esteem” (p. 203). What follows are guidelines for a supervisor to consider when working with a trainee or supervisee who is experiencing shame.

### **7.3.1 Intersubjectivity and attunement**

The supervisory relationship is a central factor to develop for successful supervision (Todd & Storm, 2014) and takes on a greater emphasis when dealing with a supervisee in shame. The importance of taking an intersubjective stance that provides safety and support for a supervisee or trainee facilitates possibilities for exploring shame related experiences. While there are various approaches to defining intersubjectivity (Gillespie & Cornish, 2010), the understanding drawn on here is the embodied nature of intersubjectivity which posits an implicit behavioural orientation towards others (Coelho & Figueiredo, 2003; Merleau-Ponty, 2002) and the interactional and performative nature of intersubjectivity (Goffman, 1959; Scheff, 2006).

As Kaufman (1985, 1989) noted, shame is triggered interpersonally by disappointed expectations of mutuality or breaks in the interpersonal bridge so the focus needs to be on re-building that bridge one platform at a time. If a supervisor or trainer wants to assist with processing experience(s) of shame, they need to know the inner

experience of a supervisee not overcome them with information or an emphasis on cognitive distortions. The safety in a supervisory relationship assists with “cognitive, social, emotional, psychological, and behavioral functioning” (Hughes, 2011, p. 19). It is in this safety that a supervisee can begin to explore disorganised or disowned parts of their therapy work and life in general that provide onramps, one might say, to experiences of shame. This kind of intersubjective sharing assists supervisees to develop coherence of their experiences and thrive in therapy without losing their uniqueness. When supervisors communicate intersubjectively, it assists supervisees to develop their uniqueness and further identify strengths and resources. This is a complicated task as Raylene noted about such an experience during a supervision session: “in that moment, I had this like experience in my body...I look like a deer in the headlights”. A deer in the headlights is stunned, frozen, incapable of movement, and unable to prevent themselves from being run over or attacked. Another example is a supervisee with whom I am currently working.

This supervisee works with adolescents and their families in a public mental health setting. She mentioned that she was becoming increasingly aware of how an event that took place in her life 15 years prior was affecting her work with adolescents. Her sister had overdosed and killed herself and at the time she was a key support to her sister. When her sister overdosed and died, this supervisee was a young mother, working full time and her sister lived in another part of the country. Her sister had called this supervisee seeking assistance the night that she had overdosed and died. It is a call that she replayed several times in her head over the years wondering if there was something else she could have done or said. As tears streamed down her face, she mentioned to me

during a supervision session “how the hell am I supposed to help the teens I work with if I could not help my sister!”. I validated her fears and worked hard to attune to what those moments in her therapy work with teens who express suicidal ideation must be like. It is in those moments of feeling attuned that a supervisor can share a coherent and organised narrative that enables the supervisee to begin to organise, makes sense of, and develop his or her own coherence and sense of self along with a meaningful sense of events that relate to shame related experiences. This process is intersubjective and reciprocal, that is, the subjective experience of one contributes to the other and vice-versa.

For supervisors, taking an intersubjective stance requires that they experience what a supervisee is discussing themselves and then communicating that experience to a supervisee so that the supervisee can experience it again through the eyes or felt sense of the supervisor. As a trained and credentialed supervisor (I am an approved supervisor with the American Association of Marriage and Family Therapy, the Canadian Counselling and Psychotherapy Association, and the International Centre for Excellence in Emotionally Focused Therapy), I can attest to the limited training supervisors get for developing an attuned, intersubjective supervisory relationship. There is a lot of focus on supervisory contracts, learning goals, and what to do if there is a disagreement, but not about how to attune to each other. At times, supervisors and therapists alike are encouraged to remain neutral without understanding that being “neutral” is a stance in supervision and therapy. Being intersubjective means that we maintain a nonjudgmental stance, value supervisee’s autonomy, and accept different experiences of an event, but we are not neutral about our own feelings and experiences during a supervision session.

The goal is to create an opening to re-experience those moments that bring up shame for a supervisee. When left alone with shame, a supervisee is likely to dysregulate, hide, possibly get upset with the supervisor, or get rigidly focused on controlling or avoiding emotions. Each of these profoundly affects the ability to reflect and develop a coherent narrative. Within an intersubjective stance, we draw on Rogers' (1961) unconditional positive regard; thus safety is enhanced by the supervisor's nonjudgmental stance and exploration is encouraged for a supervisee. Three factors need to be present for intersubjectivity to exist (Hughes, 2011): the supervisee's affect regulation is involved; there is joined awareness; and the supervisor and supervisee have complementary intentions. These three factors will now be explored in more detail.

The co-regulation of affect involves conveying empathy and understanding as a supervisee manifests emotion. When conveying empathy, the focus is to communicate an understanding of the purpose of that emotion and to communicate what the supervisee is feeling and how strongly he or she is feeling it. This understanding helps to dissipate the affect which allows them to explore underlying factors associated with the emotion (Hughes, 2011). Supervisees are more likely to be regulated when their affective expression of emotion is matched. For example, with the supervisee that I described earlier, I conveyed an understanding of the sadness she was experiencing in the room with me, validated the challenge that the experience of her sister's overdose presented at times with her clients, and as she came out of her sadness, I shared those moments in my work that similar challenges arise and how I make sense of them. In essence, we focused on developing an understanding of these experiences as rich sources of experiential knowledge that we can draw on as strengths in our work. Alternatively, telling the

supervisee not to cry or handing her the Kleenex when she did start to cry would not have been the antithesis of an intersubjective reaction that focused on corregulating emotion. We are more able to reflect and re-experience an event when we are regulated and this corregulation creates safety and facilitates exploration through enhanced reflective functioning. The next aspect of an intersubjective approach is a joint focus of attention.

To be intersubjectively present, we need to be focused on the same content whether it is a past or present event (Hughes, 2011). When two people are focused on the same event, two perspectives are brought to that experience. This shared focus helps a supervisee to realise that his or her experience of the event can change, not the event itself however. A supervisee can be influenced by a supervisor's experience of it that is created by intersubjectivity. This collaborative approach within an intersubjective stance means that all experiences are equal. The third and final aspect of intersubjectivity is the need to want to focus on the same thing during a supervision session or complementary intentions (Hughes, 2011). The supervisor's focus is to get to know the inner life of the supervisee and do so in a safe manner, to facilitate intersubjective experiences, and keep momentum going in a supervision session. The supervisor's intent is not to "fix" supervisees but to focus on getting to know them and building an understanding of their uniqueness and strengths. These guidelines for working with a supervisee experiencing shame are a starting point that requires further research and development. This brief exploration of a possible option for supervisors working with the experience of shame furthers the discussion of the super-ordinate theme that emerged in this research project. What follows are further reflections by the researcher about this research project.

#### **7.4 Epistemological Reflections**

Willig (2008) described epistemological reflexivity as engaging questions about the research, how it was defined, how it could have been investigated differently, and to what extent this might have led to a different understanding of the phenomena. “Thus, epistemological reflexivity encourages us to reflect upon the assumptions...that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and its findings” (p.10). There are two key experiences with the research project that emerged for me in reflecting about the process. One is the topic of therapists’ experiences in the research literature and the second is a newfound conviction for research participants’ experiences and I will start with the former.

As previously noted, the experiences of therapists themselves have rarely been the focus of research. This was a particularly curious note that emerged for me in this research, that is, why has there not been more research focused on therapist’s learning? This is not the focus of this research project but does warrant brief attention. What follows is an exploration of the paradoxical nature of this reality in the couple and family therapy field and more generally, in the psychotherapy field.

While there is research literature exploring the experience of self of the therapist (Aponte et al., 2009), little research has explored the experience of students or trainees learning couple and family therapy. For example, Nel (2006) did an extensive literature review of qualitative research about students’ views of family therapy training and identified two studies (Dowling, Cade, Breunlin, Frude, & Seligman, 1982; Green and Kirby-Turner, 1990). Other reviews of research that explores the training of couple and family therapists have been few and repeat the refrain of the limitation of the research in

this area (Avis & Sprenkle, 1990; Knistern & Gurman, 1979, 1988; Sori & Sprenkle, 2004; Street, 1998, 1997). Sandberg, Knestel, and Schade (2013) suggest “this is because of the long-held belief that change in therapy comes at the prompting of specific therapy techniques” (p. 38). Similar shortcomings have been identified in the research literature about supervisors as well (McCandless & Eatough, 2010, 2012). Given the focus of this research project it is both important to mention why a focus on the therapist in training is needed and perplexing at the same time that there is a need to mention it at all. As Raylene noted about her own process about learning a new approach to working with couples, “you’ve got to get the internal terrain. So the personal work has been the key piece for me to really get it”. The research literature also reflects the importance of a therapist both understanding their own internal terrain and the ground that includes the therapeutic relationship.

Orlinsky, Rønnestad, and Willutzki (2004) note that over 1,000 research findings demonstrate a positive therapeutic alliance is one of the best predictors of outcome. The person of the therapist is a critical factor for therapy outcomes regardless of their theoretical orientation. As Skovholt and Starkey (2010) write, “just as carpenters have their hammers, screwdrivers, and other tools, therapists need to rely – almost exclusively – on one tool: the self” (p. 126). Yet little is known about therapist development and how that influences change both in and outside of the therapy room (Angus & Kagan, 2007; Obegi, 2008). While some research about models of training that focus on the self of the therapist identify the need for further clarification about both personal and professional development of therapists (Aponte et al., 2009; Orlinsky & Rønnestad, 2005), the focus remains on a model of training and not therapists themselves. So, if one of our best



predictors of therapy outcomes is the therapeutic alliance, and the key to therapeutic alliance is the therapist, why is so little research focused on how they learn and develop? As previously noted, this is not the focus of this research project though one of the questions that emerged from it for the researcher.

The second main area that emerged for the researcher is a newfound epistemological conviction for the experiences of the research participants. There have been several healthy exchanges on the IPA listserv dealing with the challenges of discussing research that has a commitment to idiography and is interpretive. As noted in the methodology chapter, the nod within health service fields such as CFT “to favour a positivistic research paradigm and, by extension, quantitative methods” (Ungar, 2001, p. 18) places a variety of stressors on qualitative researchers seeking to get their work published, funded, and accepted for conference presentations. These pressures not only exist within quantitative research camps but among those who favour qualitative approaches as well. For example, Glaserian grounded theory (Glaser, 2003, 2007; Glaser & Strauss, 1967) has been widely adopted as a “scientific methodology” (Age, 2011) drawing on a positivist paradigm. The tensions noted among qualitative researchers by colleagues on the IPA listserv bring to the fore the challenges of one size fits all understandings of value in qualitative research.

The experience with interviewing participants, analysing the data, and endlessly engaging in a reflexive process whereby every experience in my life became a means to further explore and understand participants’ experiences developed a stronger commitment to and understanding of the importance of both an idiographic and interpretive approach. In some ways, it was a beginner’s mistake to not hold to on an

epistemological conviction about the sample size. This experience highlighted the importance of thinking from the data outward and holding the participants' experiences as central with an understanding of the depth, time, and extraordinary commitment required to do the analysis and develop a narrative based on those experiences. This has been a helpful development in my learning about IPA and qualitative research in general.

## **7.5 Personal Reflections**

Another important area of reflection is personal reflexivity. Willig (2008) wrote that personal reflexivity:

involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. It also involves thinking about how the research may have affected and possibly changes us, as people and as researchers (p.10).

The dissertation itself could have been a lengthy personal reflection; steeped in the topic or in the middle of analysing an interview, I found myself often reflecting about the research and the participants. I will focus here on three areas including: my experience with asking interview questions as a therapist; a reified conviction about supervision and training; and having the experience of shame highlighted for me. Starting with reflections about asking interview questions, what follows are some personal reflections about this research project.

I spend much of my work life asking questions, listening to people, and being curious. As a therapist, supervisor, and teacher with a collaborative and intersubjective approach, I am constantly seeking to understand what is happening for the people I work with and what they are feeling and thinking. As a "researcher", I focused on description.

I followed the edicts of phenomenology paying attention to what I brought to the shared horizons with interview participants and worked hard to allow “participants to tell their own stories, in their own words” (Smith et al., 2009, p. 57). This focus on description brought up a number of experiences for me during and after interviews as I reflected about them. For example, if I feel something in my body as a participant described a situation, do I share that with the participant? And if they resonate with my offering, do I follow that up asking them more about that felt sense? Alternatively, when I felt like a participant was talking around their experience instead of directly about it should I use the gentle confrontation that is a hallmark of therapeutic change by pointing out that dissonance? Occasionally, I gently inquired further, asking permission to stay with the topic and explore it further. Often, I noted how the different questions of “research” and “therapy” came to the fore for me as I wrestled with where to go next.

If IPA research is “committed to the examination of how people make sense of their major life experiences” (Smith et al., 2009, p. 1) then where does the line fall between asking someone to describe that experience and a client-centred experiential therapeutic approach to working with mental health issues? The latter draws on a variety of techniques including reflecting on feeling that “leads to reprocessing of experience” (Rice, 1974, p. 289). Do I not ask research participants to reprocess their experience as we explored how they made sense of their experience of leaning an EBP? While a therapist is responsible for the therapeutic alliance, to be congruent in the relationship, and to communicate “to the client quite explicitly an empathic understanding of his [or her] internal frame of reference” (p. 289), a researcher using IPA methodology on the

other hand may be encouraged to bring an awareness of the intersubjective bodily relationship between participant and researcher (Finlay, 2005).

Accordingly, a researcher may attend to the comfort of participants and attempt to make discussion about their experiences safer. Is an interview in IPA most akin to the assessment phase of a client-centred experiential approach to therapy? Or does a therapist conducting research need to shut off all their tendencies to follow the indicators they get about unexpressed or unsettled emotion and thoughts and stay focused on eliciting description? These and other questions emerged and evolved with each interview completed, as I analysed data, and reflect further now about my experience with IPA. A second area of personal reflection is the clarity about the role of training and supervision that came with discussing participants' journeys with the EBPs we discussed.

My experience is that it is not a popular view in my field in this geographic area to promote the need for engaged, focused, and sustained training and supervision in a therapeutic approach to working with couples and families. Practitioners from various professions are more likely to claim an "eclectic" approach drawing on experience without a coherent model of therapeutic change. These same practitioners are often reluctant to discuss the specifics of their practice or demonstrate their work by showing video of it for example, and are more likely to focus on perceived shortcomings of therapeutic approaches they have introductory knowledge of if these new therapeutic approaches challenge their work in some way.

The participants in this research project who had had a substantial engagement with learning a new EBP repeated the refrain of how challenging their learning was as well as how rewarding it can be. They reached Everest on an issue; had their lives and

clinical practice deeply, deeply, deeply impacted; were drawn to something deep inside them; were working with a primal theme; and were going to learn a new EBP come hell or high water. I have had some of those experiences, noting a substantial growth and development in my clinical practice as I engaged in substantive training and supervision. This research project has changed me as a teacher, trainer, and supervisor. I can no longer ignore that perspective that knows what the potential is for a therapist when he or she engages in focused, deep, and engaged learning with the intent to improve their work with couples and families. The excuses for not videotaping one's work or not taking the time to conceptualise a case in the context of a model a therapist is learning are now experienced differently by me. With this more reified conviction also comes a deeper appreciation for the experience of shame while learning a new therapeutic approach.

As I reflect about the experience of shame, I am reminded of a supervisor earlier in my career as I was working towards becoming a Clinical Fellow with the American Association of Marriage and Family Therapy (AAMFT). The second time we met, he asked how I came out to the couples and families that I worked with. His position was that from a systemic perspective and reflecting therapist congruency, that I was responsible for coming out to my clients as a means for setting the tone for a systemic orientation that included addressing variety of identities and issues of power. At the time I was stunned at the question and whether it meant that to get AAMFT supervision I would suddenly have to come out to all of my clients. I have come out to family, friends, in local and national media when I did community-based HIV work, to countless colleagues, and again as I write this. This is a complicated topic; I do not want to minimise the importance of it nor suggest that there is a single way for a therapist to

manage issues of identity. The purpose for raising it here is a reflection about a time that I experienced a “deer in the headlights” moment in my own work.

At that time, my supervisor’s perspective was to maintain the headlights on full waiting to see what the supervisee (me) would do. As I listened to research participants talk about their experiences of trainers and supervisors who recognised moments of shame and worked with them to develop coherence of an experience that lead to feelings of shame, I went on to reflect about my own experiences as a trainee and supervisee where the opportunity to develop that coherence was not offered. I feel an unsettling in my stomach and a general unease in my body; I race with ideas about identity, the conservative and small town nature of the Maritimes, the therapist’s role, what kind of therapist I am, and so on. I also begin to experience greater empathy for those moments in supervision when a supervisee feels overwhelmed, uncertain, guilt, and even shame.

The expansion of experiences of shame in learning and supervision of a new therapeutic approach leads me to consider the spectrum of experiences that trainees or supervisees may have from guilt to shame. Those moments when supervisees are uncertain about their work and look to me for immediate and specific answers to questions that are sometimes complex and layered not only with a need for knowledge about a therapeutic technique but also the need for “being with another that both [supervisors and supervisees] have the potential for new learning and growth” (Finlay, 20011, p. 165). The opportunity to explore those moments that can lead a supervisee to experience themselves as incapable or clients as unwilling to change are critical junctures in a supervisory relationship. The fuller appreciation of the experience of shame, and expanding that reflection to consider the spectrum of experiences that supervisees or

trainees may have from guilt to shame, has been another personal reflection from this research project.

## **Chapter 8**

### **Conclusion**

#### **8.1 Summary of findings**

This thesis has presented findings from a phenomenological exploration of couple and family therapists learning an evidence-based practice (EBP). The research aimed to understand what happens for therapists as they undertake learning a new couple or family therapeutic approach that is evidence-based. It also aimed to get a better understanding of what influenced couple and family therapists to learn an EBP. I was interested in developing an account of therapists' experiences and how they made meaning of integrating a new EBP into their practices. Couple and family therapists are rarely the subject of research themselves and the focus on their experiences was a unique opportunity for some to discuss a rich learning and supervisory journey they considered successful while other research participants discussed the struggles in their learning.

The thesis began by providing a review of evidence-based practices, the field of couple and family therapy, and the practice considerations for couple and family therapists. There are a number of benefits, challenges, and social justice conversations for EBPs that I reviewed. The lack of consensus about the role of EBPs may be most poignant in the couple and family therapy field among mental health professionals. EBPs have the potential to provide therapists: a professional reputation and legitimacy; a knowledge base for practice; we have an ethical responsibility to ensure our interventions are as beneficial as possible; the potential to promote researcher-practitioner alliances; and there is increased pressure to allocate resources on an explicit rational basis. Some of the challenges with EBPs include that they: favour a medical model not always relevant



to the phenomena under study; have potential to decrease the quality of psychotherapy training; may give even greater power to third-party payers as de facto untrained “supervisors” (e.g. insurance companies, employee assistance programs); actually discourage empirical research in some areas (such as personality disorders, co-morbidities); disseminate results of limited true value that may work against consumers best interests; and entrench an outdated research paradigm that focuses on a narrow epistemic band (e.g. positivism). From a social justice perspective, non-English and qualitative research is rarely considered while there are few measures available to begin the research with a number of populations.

The field of couple and family therapy evolved from a series of leaders promoting their models to the present day where there are a variety of approaches including evidence-based practices. Couple and family therapy is itself interdisciplinary drawing on many different theoretical roots such as communications theory, psychology, attachment theory, ecology, biology as well as other academic fields. I then went on to outline the methodology reviewing the theoretical underpinnings of interpretive phenomenological analysis which are phenomenology, ideography, and that it is interpretive (e.g. hermeneutics). This led to the three themes that emerged from the participants’ experiences which were: the challenges and supports with learning an EBP, embodiment of an EBP, and the experience of shame while learning an EBP. A major influence for the research participants who learned an EBP was a desire to improve their work with couples and families, to be more effective.

The supports and challenges with learning an EBP were buttressed with an exploration of the Dreyfus model of skill acquisition. Research participants noted the

importance of an “inside out” learning, the opportunity for trial and error, the role of context, a need for supervision and support to deal with personal issues that arise, years of experience, the opportunity to practice, and the development of intuition. With consideration of the Dreyfus model, a paradox emerged about the role of EBPs in the development of couple and family therapists. The paradox is that continued adherence to an EBP may impede therapist development over the long term particularly what Dreyfus referred to as the proficient performer and expert stages. These stages of learning require greater use of embodied knowledge and intuition and the adherence to rules as outlined in an EBP impede therapist development at the proficient performer and expert stages.

The body emerged as an integral source of knowledge and a central means for therapists learning an EBP to process their experiences. Drawing on Merleau-Ponty’s notion that we all have a view from somewhere and the body is a form of consciousness, the second theme explored in this thesis described how participants explored something “in” them. The felt sense was variously described as visceral, learning from the inside out, drawn to something in me, a feeling, and a part or piece inside of me. The body emerged as an important form of knowledge that some participants drew on as a means to guide their learning and better understand where they were struggling. As is often the case for me, music came to the fore as a metaphorical means to further relate to the experience of the body while learning an EBP. In this case, the Stranglers conviction to follow a calling to play rock and roll fit as an apt means to evoke further reflection about the role of embodiment for the research participants.

Finally, the experience of shame while learning an EBP shone through as a gem of a theme. The evocative nature of a passage from one of the research participants

illuminated the experience for the group as a whole. Shame was posited as a social emotion in this thesis which suggests that the tendency for a person experiencing shame is to hide and there is break in the interpersonal bridge. The role of supervisors and trainers was highlighted as a key support for therapists learning an EBP as well as peer learners. The next section will explore the potential for researching therapists' experiences of learning an EBP.

## **8.2 Significance of the Study**

As previously noted, much of the research about evidence-based CFT approaches have focused on the outcome of an intervention and occasionally on the experience of the patients themselves. The experience of the therapist has historically been located behind closed doors with someone designated as a supervisor or teacher when that resource is pursued or made available. There are a number of potential implications for this research, not the least of which is that CFTs “must attend to the results of RCTs for clinical, ethical, and legal reasons” (Persons & Silberschatz, 1998, p. 126). This research project may contribute to improving care for the couples and families who seek the service of a CFT.

While historically driven by the empirical sciences, the focus on evidence-based practice is growing across all fields. Public funding and consumer interest is often influenced by what is deemed as an evidence-based practice at any given moment. CFTs may increasingly be asked to link their approach to evidence-based practices as a means to account for their work from an ethical and legal perspective, minimising risk to themselves, their practice, and their employer. Understanding what the experience is of

learning an evidence-based practice may provide insights to that process that are helpful for the training, development, and supervision of CFTs.

Couple and family therapists themselves may be seeking a better understanding of the process of learning an evidence-based approach. The opportunity to better understand an approach that has demonstrated some kind of effectiveness or efficacy may provide insight for their own practice. Evidence-based approaches may provide us with hints about how to proceed, be a guide or knowledge base for our practice, and engage us with research in general. However, “as practitioners, we apply a broad range of experiential knowledge and strategies that are hardly mentioned in the text books” (Malterud, 2001, p. 398). The present study promotes a research culture by engaging CFTs who are interested in and exploring the results of research in their own practice. This would contrast the research-practice gap that “plagues all clinical fields... (and is) particularly prevalent in [CFT]” (Sprenkle, 2002, p. 11). This gap has been noted as a combination of clinicians’ interest in a “charismatic individual” (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002, p. 76) who develops a model with little evidence to support it becoming popular on the workshop circuit and researchers who “sometimes disdain clinicians, fail to listen to the wisdom of good clinicians, and typically do not work hard at making their work clinically accessible” (Sprenkle, 2002, p. 11). This research project may promote an engaged research culture whereby clinicians see the results of research as relevant to their practice while promoting an approach whereby researchers understand engaging CFTs as central to their research.

### **8.3 Limitations of this Study and Opportunities for Further Research**

This study has proposed important linkages between therapists learning an EBP, the role of embodiment, experiences of shame, and the limitations of EBPs. The small scale of the research, however, does not permit more general conclusions about couple and family therapists experiences of about evidence-based practice. A variety of methodological approaches is best to approach each of the experiences outlined in this thesis. Kvale and Brinkman (2009) for example, discuss how survey techniques can be used to link with qualitative methods. A multi-pronged approach would further enhance the understanding of experiences of shame while learning an EBP, the strengths and limitations of EBPs for couple and family therapists, and further develop an understanding of the role of embodiment as a therapist is learning and using an EBP in their practice. The multitude of possibilities might even include some of the strategies used to research couples and families such as Gottman's "Love Lab" where among other research methods employed was the tracking of couples' heart rates as they engaged in difficult conversations (Gottman 1991, 1993, 1994, 1999).

The focus of this research project can be seen as both a limitation and strength. Exploring therapists' experiences has developed an understanding of what happens when learning an EBP. The process of integrating an EBP, however, can be considered ongoing and long term. While challenging, it may be useful to examine and build on other longitudinal research about the development of therapists (e.g. Ronnestad & Skovholt, 2003). Another possible benefit of prolonged research is the opportunity for multiple contacts with research participants and building a trusting relationship where participants feel comfortable with increased disclosure (Flowers, 2008).

The findings may also have been affected by the characteristics of the participants. It is possible that volunteers differ from a larger sample and some populations are weary of research in general (Yancey, Ortega, & Kumanyika, 2006). Volunteers may be drawn to discuss a particular aspect of their experience, positive or negative. I do draw some solace from the diverse experiences discussed; the sample did not repeat a singular experience. Further, research participants noted a variety of reasons for participating including being of help to other therapists, wanting to participate in research leading up to their own research project, and it was an interesting topic for the participants. There are characteristics of the research sample not outlined for reasons of confidentiality that are important to consider. These include but are not limited to socio-economic status, ethnic and racial identity, and sexual orientation. These limitations lead to areas for further research for me that have emerged from this project.

The question of identity and how that intersects with and is affected by learning an EBP is an area that comes to the fore. While the identities of couples and families have been the topic of important research (e.g. Boyd-Franklin, 2003; Falicov, 2013; Laird & Green, 1996; McGoldrick, 1998), considering how therapist's identity intersects with learning an EBP is an area for further exploration. Age, years of experience, location of therapy practice, socio-economic status, racial identity, ethnic identity, sexual orientation, gender, theoretical orientation, a specific therapy practice, and profession are but a few of the possibilities for beginning to explore further with specific filters in mind. The potential to continue to build narratives of experiences that therapists themselves can relate to is an important aspect of the EBP project.

Another aspect of this research project that sits in my near horizon as I consider evolving this work is the experience of shame. As previously noted, I did not ask specifically about participants' experiences with shame while learning an EBP. The experience of shame itself has a variety of approaches in the research literature (Mills, 2005) and of greatest interest for me are social and interactional understandings of the experience of shame (e.g. Brown, 2006; Scheff, 2000; 2003). Given the tendency in shame is to hide or lash out (Dearing & Tangney, 2011), neither are useful while learning and integrating a new therapy practice though the situation itself may be one prone to evoke the experience of shame. The two areas noted here for further research are the start of contemplating what seems like an endless series of possibilities for further research. To conclude this thesis, I will offer final reflections.

#### **8.4 Final Reflections**

The conclusion of this research brings to an end the dialectical process of reflexivity whose beginning was outlined in the methodology chapter (Finlay, 2008). While there is limited research about the experiences of therapists learning and using an EBP, this research project touches on a small part of what could potentially be a vast and growing area of academic research. It is surprising to see to what degree therapists are ignored in the research literature on the one hand and how they are posited as objects that will assimilate an EBP on the other. Exceptions to each of these is the research about Self-of-the-Therapist models (e.g. Aponte et al., 2009). Considering therapists as subjects as opposed to objects in training, supervision, and research requires epistemological approaches that have the agility to construct more than one reality at a time and meaningfully engage with lived experiences.

My experience with interpretive phenomenological analysis (IPA) is my most substantive engagement with a phenomenological approach to research. Being an important first, it likely will leave an indelible mark on my research life. It also leaves me with a number of questions. Phenomenological research is not a singular entity, it is more appropriate to refer to the various phenomenologies that can inform a research project (e.g. Ahmed, 2006; Goldberg, Ryan, & Sawchyn, 2009; Heidegger, 1962; Husserl, 1927; Merleau-Ponty, 2002; Sartre, 1956). In the mental health field for example, there was an exchange between two of the leading figures in phenomenological approaches to psychological research discussing the shortcomings of different phenomenological approaches to research sometimes discussing as if there is only one approach (Giorgio, 2010, 2011; Smith, 2010). My interests in phenomenological research are emerging more with the way a hermeneutic of suspicion is engaged with the research process (Ricoeur, 1970). IPA for example makes room for “theoretical perspectives from outside...to shed light on the phenomena” (Smith et al., 2009, p. 36) with an emphasis on finding a middle ground between descriptive and interpretive work “as long as it serves to ‘draw out’ or ‘disclose’ the meaning of the experience” (p. 36). While the double hermeneutic- empathy and suspicion- are clearly laid out, the research literature tends to favour the former. This limitation leaves me with the desire to continue to engage with the meaning that people make of an experience and a craving for more clarity about how to further the IPA methodology’s use of a hermeneutic of suspicion.

Finally, having further developed my research in the lap of IPA did provide important developmental milestones for my work. IPA’s interpretive range provided



(Larkin, Watts, & Clifton, 2006) a solid framework to do the research while I developed a better understanding of my convictions about research. The focus on meaning making expands my clinical, supervision, and teaching work to the research realm. Further incorporating felt sense, emotion, and embodiment (Finlay, 2011) while exploring topics (e.g. evidence-based practice) traditionally researched by those with a more positivist approach will provide me opportunities to engage with human sciences more on the human side of that spectrum. I feel privileged to have explored with the research participants their experiences of learning an evidence-based couple or family therapy practice.

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## Appendix A

### Interview Guide

1 - Can you tell me about your therapy practice in general?

Possible prompts (PP): Which degrees do you hold and what additional training do you have?

2 - Can you tell me about how you became a couple/family therapist?

PP: How did you develop the CFT aspect of your practice?

3 - Can you tell me about a CFT evidence-based approach that you have learned about?

PP: Which approach specifically?

4 - What influenced your decision to learn about that CFT approach?

PP: Were there clinical issues that you were dealing with that led you to explore that approach specifically? Did your work place suggest or insist you have to learn that approach? Who paid for your learning?

5 - What was your experience of learning that CFT approach?

PP: How did you learn that practice? Were you supervised? Did you attend course(s) or workshop(s)? Did you video yourself? Did you refer to the treatment manual?

6 - Can you tell me about what you enjoyed about learning that new CFT approach?

What you found challenging about learning that new CFT approach?

PP: Who supported you? How did you deal with challenges in learning that new approach? Did your work place provide support?

7- Are there clients with whom the EBP does not work?

PP: Why is this? How does culture, context, and resources play a role in the effectiveness of an EBP?

8 - What metaphor would you use to describe the process of learning that EBP?

9 - How has learning that new approach affected your clinical practice?

PP: Has it affected your clinical practice? Did it lead to new opportunities? Did it change how you work with couples or families?

10 - Did learning an evidence-based CFT practice affect how other people viewed you? Professionally or personally.

PP: Did it have any impact on your referrals? Were you sought out by colleagues or people in your life in any different way?

11 - What do you see as the role of evidence-based CFT approaches in the future of your clinical practice?

PP: Will you continue to learn and explore the approach we have been discussing? Do you see yourself learning additional evidence-based CFT approaches in the future?

12 - Are you aware of any controversy with evidence-based CFT practices in general? If yes, how do you cope with the controversy?

13 - How does your profession view EBPs?

PP: Does your profession promote training in an EBP? See EBPs as integral to identifying with that profession?

14 - How does your workplace view EBPs?

PP: Do they hinder or support your exploration of a CFT EBP? How?



15 - Do you use practice based evidence or indigenous knowledge in your practice? If yes, what do you think about these other sources of expertise in relation to EBPs?

Practice –based evidence is information gathered from service providers and families used to identify effective interventions and areas for program or practice improvement (Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003; Lucock, et al., 2003).

16 - Anything we've covered that you would like to add to? Anything we've not covered that you would like to mention?

## Appendix B



### **Information Letter- Consent Form**

Research Title: Phenomenological exploration of couple and family therapists learning and using an evidence-based practice

Principal Research Investigator: Robert Allan, Robert.allan@dal.ca

Thesis Supervisor: Dr. Michael Ungar, Killam Professor of Social Work, Co-Director, Resilience Research Centre

#### Introduction

We invite you to take part in a research study being conducted by Robert Allan who is a graduate student at Dalhousie University, as part of his Interdisciplinary PhD Program. Your participation in this study is voluntary and you may withdraw from the study at any time. Your employment performance evaluation will not be affected by whether or not you participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort which you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Robert Allan or his thesis advisor, Dr. Michael Ungar.

#### Purpose of the Study

The purpose of the research is to explore the experiences of couple and family therapists learning about and using an evidence-based practice. Like other professions, couple and family therapists are choosing to or being asked to learning evidence-based practices. This research will contribute to the knowledge of what helps couple and family therapists learn an evidence-based practice.

#### Study Design

This research is phenomenological which means I'm interested in what your experiences have been. Information will be gathered via up to 20 interviews that will be audiotaped which will be transcribed and then reviewed looking for themes and issues identified in the interviews.

### Who Can Participate in the Study

This research is open to therapists who have at least a masters degree and are currently, or have been, actively engaged in learning about and using an evidence-based couple or family therapy practice that includes the following elements:

- the evidence-based practice has a treatment manual;
  - you received training specific to that practice;
  - you received supervision specific to that approach; and
- the evidence-based practice has a theory of change that you are required to relate your practice to.

### Who Will Be Conducting the Research

Robert Allan will be conducting the research. A transcriber may assist Robert in transcribing the audio files of interviews and meetings. The transcriber will not know your name or have access to your personal information.

### What You Will Be Asked to Do

You are being asked to complete a 60-90 minute interview with Robert Allan. Also, if I have any brief questions of clarification after the interview, I would like to follow-up with you and ask those questions. This will take less than 30 minutes. I can only follow-up with you within six months of the interview.

### Possible Risks and Discomforts

The risks associated with participation in this study are minimal. Participants may not like some of the questions they are asked during the interview. Participants do not have to answer those questions they find too distressing. Participants may withdraw from the study at any point. If someone withdraws they may withdraw any information collected from them as well.

### Possible Benefits

This research may contribute to helping other couple and family therapists learn about and use an evidence-based practice. The results of the research may improve training and supervision of couple and family therapists learning an evidence-based practice.

### Compensation

Participants will not be compensated for participating in this research project.

### Confidentiality and Anonymity

Participants will not be personally identified in any reports or publications. No personal information will be shared with the transcriber. All the data collected, including audio files, will be stored on the researcher's computer and a backup hard drive located in his home. Both the computer and backup drive data will be password protected and only Mr. Allan will have the password. Whatever data is transferred to the transcriber's system will not contain personally identifying information and will also be deleted from the transcriber's system as soon as it is no longer needed. Data will be securely maintained on the researcher's computer or a comparably secure university server for seven years, post publication.

### Questions

If there are any questions about this study, please contact Robert Allan at 902-494-6693 or <[robert.allan@dal.ca](mailto:robert.allan@dal.ca)>. If there is any new information that could affect your participation in this study you will be notified by e-mail as soon as possible.

### Problems or Concerns

If you have any questions or concerns, you may contact me at either the phone number or email address listed in the previous section. This project was reviewed by and received ethics clearance through the Dalhousie University Research Ethics Board. If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, [ethics@dal.ca](mailto:ethics@dal.ca). Please feel free to phone collect if you are calling from outside the Halifax area. If your concerns are of a personal nature, you may contact the Bayers Road Community Mental Health Services at (902) 454-1400 or the Mental Health Mobile Crisis Team at (902) 429-8167.

### Signature Page - Consent Form

Research Title: Phenomenological exploration of couple and family therapists learning and using an evidence-based practice

Consent:

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

I consent to have interviews audio-recorded. Data derived from my participation may be used in reports and any further studies related to this research.  Yes  No

I consent to the use of substantial direct quotes without personal identification.  Yes  No

I consent to being re-contacted so that I may receive information related to study results and publications.  Yes  No

I consent to being re-contacted within six months for questions of clarification about my interview.  Yes  No

Researcher: Robert Allan, Robert.allan@dal.ca, 902-494-6693

Date: \_\_\_\_\_

(Participant's signature) \_\_\_\_\_

Participant (PRINT name and e-mail address): \_\_\_\_\_

Date: \_\_\_\_\_

(Researcher's signature) \_\_\_\_\_

## Appendix C

### Research Recruitment Letter

Hi - My name is Robert Allan and I am researching therapists' experience of learning and using a couple or family therapy approach that is evidence based. This research will help fulfill the requirements for an Interdisciplinary PhD program that I am in at Dalhousie University (REB # 2012-2819).

I would like to interview therapists who have at least a masters degree in a mental health field, such as counselling, psychology, social work, or marriage and family therapy, and have, or are in the midst of, learning and utilising an evidence-based couple or family therapy approach that includes the following elements:

- the evidence-based practice has a treatment manual;
- you received training specific to that practice;
- you received supervision specific to that approach; and
- the evidence-based practice has a theory of change that clinicians are required to relate their practice to.

The interview will take 60-90 minutes and we can schedule the interview at a time and location that is convenient for you. For those people at some distance from the Halifax area, I also have the option to conduct the interview on-line using a secure web-based service called BlackBoard Collaborate.

Your participation in this study would be completely voluntary and you may withdraw from the study at any time. I hope that this research will contribute to the knowledge of evidence-based practices and the experience that therapists have in learning them. Participating in the study might not benefit you, but I might learn things that will benefit others. Participants will not be identified in any reports or publications.

If you have any questions or are interested in participating in this study, feel free to phone or email me at the contact information listed below.

Thanks,  
Robert Allan  
Interdisciplinary PhD Program  
Dalhousie University  
902-494-6693  
[Robert.allan@dal.ca](mailto:Robert.allan@dal.ca)

## Appendix D

### **Description of Research Participants**

The following is a description of each of the 14 participants in this research study. The comments below include the researcher's brief reflections about the interview and how it may have influenced the approach to the data. All of the names of the research participants have been changed and they have been given pseudonyms. A few notes about the terminology used to describe participants' professions. The word "Counsellor" is used for what is variously described in Canada and the United States as Counselling Therapist, Clinical Counsellor, Psychotherapist, and Licensed Professional Counsellor. The abbreviated "MFT" will be used to describe those participants who are registered or licensed as Marriage and Family Therapists. The term "Social Worker" will be used to describe both clinical and non-clinically trained social workers. Finally, the term "Psychologist" will be used to describe those who are registered psychologists.

To protect confidentiality, the specific therapy approach that was discussed in the interview will not be mentioned in the following descriptions. Of note, there are participants that could be identified as part of a small group of less than 10 if the specifics of the approach and how they were engaged in the learning were mentioned. One option would be to name the therapy approaches that the other participants discussed during the research interview and not report about those who come from the smaller group. This would leave a process of elimination however, where one could identify those participants not linked to a therapy approach and make the connection. The following are the descriptions of the research participants.

## **Jessica**

Jessica is a Counsellor who is now primarily in private practice and has been in the field for seven years. In her forties, Jessica chose to meet me at her private practice office. Her therapy practice consists mainly of referrals from employee assistance programs with clients also coming from other publically funded programs and some people self-referring. Jessica appeared nervous about the interview; as if there was something she was supposed to know. On the one hand, she had an eloquent description of what drew her to the EBP she was leaning. On the other hand, she experienced a lot of uncertainty because of the struggles she had with integrating this new EBP. It was in discussing the struggles that Jessica appeared more nervous with her experiences and at times would swat her hand across as if to swat away a question about those struggles. She stated that she was uncertain about how she was going to continue with the EBP we discussed while at the same time clear that she was very drawn to the approach.

## **Ken**

Ken is a Social Worker in private practice with over 40 years of experience. Ken was very generous with his interview, sharing many aspects of his learning. He is now in a private practice with his wife and part of his journey in life in general, as well as the learning of a new EBP, is to explore these new learnings with his wife. Ken has trained with some of the leaders in the field of couple and family therapy over the years including Virginia Satir, Salvador Minuchin, and Michael White. He took on learning a new EBP in his 60s and started out thinking he might integrate it into his robust practice and experience with ease and quickly discovered that it was to be some of the most difficult therapy-related learning he has done in his life. We met via BlackBoard



Collaborate and he had developed a coherence of his learning experiences that leant well to exploring the various aspects of his integrating a new EBP. Ken is in his mid-sixties and was open, warm, and keen to talk about what it was like for him to learn a new EBP.

### **Cassandra**

Cassandra is in her forties and both a licensed MFT and Counsellor in private practice while she is completing a PhD. Like a few of the interviewees who were also PhD students while practising, she was close to the research literature in her day to day life and we had a lively discussion weaving our way between her experience of learning an EBP and her making sense of the research about EBP. We completed the interview via BlackBoard Collaborate. Cassandra was both comfortable and curious about the topic as she was about to begin her own PhD research. She was able to talk about the varied ways that she was challenged while learning an EBP while reflecting about her intent for learning- to improve her work with couples and increase potential for her practice. Being able to offer an approach that is “evidence-based” was a priority she set for her own practice and she also saw it as a selling point for potential clients.

### **George**

George is a mental health professional in his sixties. His profession is not specifically named for confidentiality purposes because he is the only research participant from that profession. We completed the interview in his office at an adolescent day and residential treatment facility. George was the research participant with the most experience in training others in family therapy. With both the experience of learning and using an EBP in his work over the years and helping others to learn family therapy, George reflected about both experiences throughout the interview. My experience during

the interview is that as I tentatively tried to follow-up on general offerings he made about the impact of the learning on the self of the therapist, he would quickly stiffen and either move the topic away from himself or not respond to my questioning. Being in the medical field, George had long been dealing with EBPs in one form or another and at this point in his career, he described himself as outside the norm that looked to EBPs as the answer for everything and my sense was that he had some choice about what he wanted to do in his practice.

### **Kathy**

Kathy is a Social Worker in private practice who met me on the university campus to do the interview. In her sixties, she moved to private practice about 20 years ago after working in public and non-profit organizations as a social worker. Kathy is an experienced therapist who is comfortable with her practice and an understanding that it will continue to evolve. She seemed the most comfortable of all the interviewees in reflecting back over her learning process. This may be due in part to discussing an EBP she had started to learn over 12 years prior to the interview. We met across a table in a small meeting room in a university building, it was the most formal setting of the interviews that I did in person. For Kathy, part of the struggle in discussing one particular EBP is her experience of having integrated the practice into an evolving self and that she is currently focused on learning another approach to working with individuals at the time of the interview

### **Louise**

Louise is a lively and energetic Counsellor in private practice with a bubbly presence. She approached me having seen the recruitment letter and we completed the

interview in her private practice office. In her forties, Louise had started practice 15 years prior, took a break from the work for eight years and returned to private practice three years prior to doing the interview. She is a voracious learner who is both keen to grow her practice while also developing as a therapist. Unlike other interviewees, she was clearest about not viewing herself as having completed all the training that she would like to do to become the therapist she would like to be. She very much had a sense of herself as a work in progress despite a number of years of counselling experience, substantial life experience, and previous related training and work experience prior to entering the counselling field. This was due in part to discovering a new approach to working with couples and families while she was on leave from the work. This may have contributed to the lack of coherence that sometimes crept into her interview. She had run on sentences, repeated words, and varied her answer as it came out at times.

### **Beth**

Beth is a Psychologist in her late thirties who works in a university counselling centre and in private practice. She is very knowledgeable about evidence-based practices in general and was very engaged in the topic. The interview took place in her office and she was warm and engaging throughout the interview. Like some other interviewees, she bristled somewhat when I tried to explore self of the therapist issues that emerged in the learning of the EBP we discussed. The interview had more of a cognitive feel to it and, at the same time, she was quite insightful about her experience and the role of EBPs in general. Beth offered me additional resources about approaches to working with couples that I was not familiar with at the end of the interview.

### **Helen**

Helen is a Social Worker in her forties who works for a government adolescent mental health and addiction program. We met in a family therapy room at one of the sites of the government organisation to complete the interview. Helen arrived to the interview with the treatment manual for the approach she wanted to discuss with sticky notes marking certain pages. She had reviewed the manual prior to the interview and came prepared as if we were going to discuss the therapy approach itself. This may have been somewhat of a defensive move on her part because as the interview proceeded it became clear that she had done limited follow-up reading, training and no supervision from her initial training. At times during the interview, questions about her experience of learning an EBP lead her to wanting to refer to the manual and read me passages from it, talk about the challenges she had with the trainer, and refer to other one or two day workshops she had attended where she liked that trainer's approach more. Helen is a thoughtful, reflective social worker who had come out of an anti-oppressive program during her Masters studies and struggled to discuss herself as a therapist. She would often refer to ideas she had heard in a workshop or writers she had read but struggled to situate the learning of an EBP in her own experience.

### **Sally**

Sally is Psychologist who works in a government mental health setting. In her forties, Sally appeared bright and engaged during the interview which took place in one of the treatment rooms at her workplace. While she came from a school psychology background, she was now working in a public mental health setting with a range of clinical issues and families. Sally was able to draw strategically from her learning about the EBP we discussed. She reported about the need to navigate the varied demands of

her work place which were at sometimes at odds with her own approach to working with families. Part of her excitement about the EBP we discussed during this interview was how it supported some of her own approaches to working with families. While the support and reinforcement the EBP offered her is an important aspect of learning an EBP, she too had limited engagement with the actual follow-up and direct attention to the elements of the EBP she was learning.

### **Raylene**

Raylene is an MFT in her sixties and we completed the interview via BlackBoard Collaborate. She currently maintains a private practice and has trained in a variety of therapy approaches over the years. Raylene had a story to tell about her experience of learning an EBP and she was determined to tell it regardless of the questions that I asked. The coherence she had about her own narrative made for a very rich interview that was evocative at times as she shared stories about moments in supervision when the suicide of her sister 40 years prior came to the fore as part of her challenge in learning a new EBP. She had started to learn the EBP we discussed eight years prior to the interview and only focused her learning with supervision, advanced training, and video of her work within the previous year. Raylene was able to recount the many challenges she faced along the way regarding her own fears of having peers view her work on video or exploring the places she felt stuck in her development and how that connected to previous events in her life. After introductions and basic questions about her practice, I asked one question about learning an EBP and that lead her into the story she came to tell in the interview about her experience with learning the EBP we discussed. Part of her interest in sharing her story was to offer it as help for other therapists who are struggling in their learning.

## **Mary**

Mary was a PhD student when we completed the interview and an MFT. In her thirties, Mary was involved with a clinical trial for an approach to working with families that included supervision and a measure of adherence to the therapy approach. We completed the interview via BlackBoard Collaborate. Mary had a number of perspectives about EBP as someone currently working as a therapist in a clinical trial and as a PhD student who engaged in dialogue with her peers about the role of EBPs in the practice of MFT. She had enough experience with the close scrutiny of a therapy session that is required in a clinical trial to be reflective about the benefits and challenges of such an approach to learning. Mary was engaged throughout the interview and had a sense of passion about her work.

## **Tina**

Tina was the second interviewee who had come from a health care background and changed careers to become an MFT later in life. In her forties, she now maintains a full-time private practice and we were able to complete the interview in her office. Like other interviewees, Tina had trained in other approaches to therapy, both individual and couple/family, and maintained a curiosity about the field where she anticipated continuing to learn about other approaches to working with couples and families. She was well versed in the EBP we discussed having done extensive training and supervision with the founders of the approach. Interestingly, like other MFTs, she sought out the training because she did not feel her graduate education adequately prepared her for couples work. Tina was somewhat tentative when talking about her experiences; she was not necessarily all that comfortable discussing places of challenge in her learning.

**Peter**

Peter is an MFT in his early fifties who recently completed a PhD. He maintains a private practice where he sees clients who have insurance coverage and is involved with a clinical trial of an approach to working with families. Peter mentioned his interest in mindful-based approaches and he reflected that in the interview, pausing to think about his answers. We completed the interview via Blackboard Collaborate and had some technical difficulties at the start of the interview; he had to change the computer he was on for us to be able to hear each other properly. Peter is a seasoned therapist with a wide range of experiences in different countries over the span of his 25 year career. He was thoughtful about the clinical trial he was working in as a therapist and realistic about EBPs from his private practice perspective.

**Eric**

Eric is a Counsellor in his thirties who had graduated six months prior to doing the interview. He was fortunate (his words) to have completed a master's internship where he was introduced to an evidence-based approach to working with couples. We completed the interview via BlackBoard Collaborate. Of all the interviewees, Eric rambled the most and struggled to answer the questions with coherence. It was the longest interview at just over one hour and forty minutes and had I been willing to carry on a conversation about other topics it would have gone on much longer. Eric clearly had an understanding of the EBP we discussed and part of the struggle for him in the interview may have been the early stage he was at in his career. He wavered between making efforts to appear erudite with reference to current research literature and

discussing the struggles he was having establishing his practice having recently moved back to his home town after the master's degree.



Appendix E

Table 3

*Frequency of occurrence of super-ordinate themes across participants*

Theme	Jessica	Ken	Cassandra	George	Kathy	Louise
Supports and challenges with learning an EBP						
a. Novice	A	A	A	A	A	A
b. Advanced beginner	A	A	A	A	A	A
c. Competent	A	A	A	A	A	A
d. Proficient performer	B	A	A	A	A	A
e. Expert	C	A	A	A	A	A
A role for the body in learning an EBP						
a. Clearing a space	A	A	A	A	B	A
b. Getting a handle	B	A	B	A	B	A
c. Resonating	C	A	B	A	B	A
d. Asking and receiving	C	A	B	A	B	A
The experience of shame while learning and using a new EBP	B	A	A	B	B	B

Key: A- Substantial discussion by participant    B- Present    C- Barely mentioned

Theme	Beth	Helen	Sally	Raylene	Mary	Tina	Peter	Eric
Supports and challenges with learning an EBP								
a. Novice	A	A	A	A	A	A	A	A
b. Advanced beginner	A	C	A	A	A	A	A	A
c. Competent	A	C	C	A	A	A	A	C
d. Proficient performer	A	C	C	A	A	A	A	C
e. Expert	B	C	C	A	A	B	B	C
A role for the body in learning an EBP		C	C	A	B	C	B	C
a. Clearing a space	C	C	C	A	B	C	B	C
b. Getting a handle	C	C	C	A	C	C	C	C
c. Resonating	C	C	C	A	C	C	C	C
d. Asking and receiving	C							
The experience of shame while learning and using a new EBP	C	B	C	A	B	C	C	C

Appendix F

Table 4

*Super-ordinate themes with quotes from participants*

**“So I feel like I’m getting it and then sometimes I think OK, no I’m not”:  
Challenges and Supports while Learning an EBP**

a. Novice

Name	Quote	Page, box
George	when I started out I remember I’d just get sucked in in the early stage and just get lost	12, 70
Jessica	So I feel like I’m getting it and then sometimes I think OK, no I’m not, I need to refer back to it to find out where I’m at. Because it is a very directive type approach and so, you want to make sure that you are following the intent of the theory so I refer back a lot.	6, 42
Eric	Ah well the bits that really stand out to me were in, I remember distinctly the role plays in that fundamentals course...They left a mark on me, in terms of I just loved when I got to role play as counsellor.	4, 20
Helen	So, I haven’t read the complete manual, but I do review it. So currently looking at the family work that I do do, I do refer to it. I’m, in particular it’s caused me to take a look at my model of practice, and I’m looking at my, my case conceptualization, and really, it’s causing me to, in a good way, maybe not question is the word, to be curious about what do I stand for, what are my beliefs	12, 74

b. Advanced Beginner

Name	Quote	Page, box
Peter	But the challenge has been that myself, knowing where I want to go, I am sometimes ah [pause] kind of rushing to get to the third landmark or to the goal, and not as much taking the time to focus on where I am. And I think the other, other therapists have had a similar experience.	6, 32
Raylene	It was personal supervision helped. It was all about personal because the cognitive stuff I mean, you know, that part I’m already good at, that’s not what was getting in my way.	17, 30
Mary	But it is about having live supervision, continuous live supervision, and having had so much attention that I think I am really improving my clinical skills	4, 29
Sally	So, the social-ecological approach gave me the framework for seeing that’s where I’m stuck. We need to go back, we have not really come up with a solid contract.	10, 100

### c. Competence

Name	Quote	Page, box
Tina	In life that there's always a growing edge for me. I find that it's always, you know it's different for every person in terms of how they emotionally process things	10, 58
Cassandra	And so, so I got serious and I thought well if I really want to start creating change for couples, I'm just going to do this, come hell or high water	5, 8
Peter	Sort of self-talk in my mind, do we, did I ask everything here? Did I look at it from enough points of view? Have I heard them say what I need to have them say? And did they say it with the right affect?	7, 34

### d. Proficient Performer

Name	Quote	Page, box
Beth	So the experiential learning was great and I think it makes the learning curve way better	15, 80
Tina	well we do tend to emulate our mentors that's true, and that can be a good thing, but you know I think I also have an individual style as well	5, 30
George	So ah, you know getting to the point where you manage your own affect and manage your own cognitive understanding of what's going on, come to a kind of new level of understanding and use that to move the family forward without compounding the problem or becoming involved in it.	10, 60

### e. Expert

Name	Quote	Page, box
Ken	takes maybe you know eight years altogether, you know type of thing. By the time you really learn it, really master it and can teach it, get certified and all that stuff and then integrate it into the rest of you know what I've known already.	18, 80
Kathy	I think it's being able to make the space for you to do what you need to do and I think, I think any theory if you become skilled enough, you can do that.	13, 46
Louise	It's been really fun again through my supervisor, seeing what's you know what's out there. Thinking oh o.k. so it's not just a matter of you get certified and you go off to your lonely corner, and you know but that there's lots more.	31, 140

## “Oh this is what it feels like”: A Role for the Body in Learning an Evidence-Based Practice

### a. Clearing a Space for a Felt Sense

Name	Quote	Page, box
Cassandra	didn't feel like my master's level course, it was just one course, and quite honestly it wasn't the greatest course in the world, and I didn't really feel like it prepared me to see couples	4, 8
Kathy	I think if you're doing a job, you want to feel that you have something to offer, and I didn't think I really had a frame of reference to operate in	10, 33
Jessica	I was really drawn to that whole idea of that's how, how people, how you can explain, how things can get distressed in life, so that started that part of it	3, 20

### b. Getting a Handle

Name	Quote	Page, box
Ken	certainly has been harder for me to not go into that inner critic and think I'm really stupid enough and I should really stop doing this and take on, you know become a plumber	6, 24
Jessica	because I think when you can see that...you can't shy away from it so you have to continue and you have to, in some way, go with that, so that's what keeps me coming back	28, 170

### c. Resonating

Name	Quote	Page, box
George	we were shaking our heads in a way and saying but that's fine, these guys have no respect for the stickiness of change and the you know they seemed, it's a bit car salesman approach to therapy	12, 78
Raylene	I thought... that I was just going to become a better therapist this year...I had no idea what I was getting myself into. I had no idea that it was going to transform me in such a deep and profound way and transform really my world view in such a positive way.	21, 36

### d. Asking and Receiving

Name	Quote	Page, box
Louise	it's kind of blowing me away and I know it's because this is the way we work with people right, I know that, I know that	28, 124
Raylene	direct experiences of what it is like to be in my own vulnerability and reach to another and have them be responsive to me	15, 24

**“I had no idea that this shame piece was in me”: The Experience of Shame While Learning and Using a New Evidence-Based Practice**

Name	Quote	Page, box
George	We had a lot of problems with residents in training, not just residents but whoever, who come up against their own personal difficulties quite quickly. I think there’s nothing like family practice to push people into a bit of a corner	17, 104
Mary	I mean the other challenge, it has been...that feeling of being scrutinized because every single session that I do is recorded and every single session that I do...is reviewed by somebody, and that person is giving me a score, and if there’s something that I’m doing that is not therapeutic or that involves another model, they will point that out to me and as much as I have been benefitting from that, somehow there’s also a feeling of being exposed. So that, it was somehow difficult to adapt to that, to be so scrutinized	10, 63
Cassandra	tapping into this feeling of shame that I would get over and over again because I wasn’t getting the EFT and I would feel so incompetent and otherwise I felt so competent as a therapist. So it was like really hard for me and when I would tap into it.	11, 20
Helen	If I feel like I’m being pushed, I will push back, and as much as I said I wouldn’t, I did. Cause I wasn’t saying anything	20, 158
Jessica	the actual practice or implementing of the theory is a little bit harder	6, 42
Eric	also refreshing because you were all, ah willing to apply what we were learning to ourselves and discussing it in a fairly open and non-judgmental way with each other	12, 42
Raylene	I had done a ton of my own personal work but I had no idea that this shame piece was in me. I felt responsible...I was really tapping into how ashamed I felt that I wasn’t getting this model down.	8, 16