A QUALITATIVE STUDY OF HOW MARRIAGE AND FAMILY THERAPISTS MAKE CLINICAL JUDGMENTS

by

PETER J. JANKOWSKI, B.S., M.A., M.S.

A DISSERTATION

IN

MARRIAGE AND FAMILY THERAPY

Submitted to the Graduate Faculty
of Texas Tech University in
Partial Fulfillment of
the Requirements for
the Degree of

DOCTOR OF PHILOSOPHY

Approved

Accepted

December, 1998

ACKNOWLEDGMENTS

I would like to express my appreciation and gratitude to David C. Ivey, Ph.D., who chaired my dissertation committee. His consistent encouragement, support, and enthusiasm for my project and interest in me as a person, kept me motivated and focused throughout the entire dissertation process. I have valued our conversations and desire to model my interactions with others based on the experiences I have had with him. Our conversations allowed me to clarify my own thinking about my dissertation and gave me the strength I needed to forge ahead with my ideas. I look forward to continuing our relationship as we move from an advisor-, supervisor-, mentor-, student relationship to that of colleagues, peers, and friends.

I would also like to thank each of the members of my dissertation committee which included Gwen Sorell, Ph.D., Stephanie Shine, Ph.D., Mindy Stombler, Ph.D., and Susan Kashubeck, Ph.D. Their thought-provoking questions and comments, and interest in and support of my ideas, encouraged and motivated me. I owe a special thanks to each committee member: Gwen Sorell for her class entitled "Theories of Human Development," our fascinating conversations about adult development, and the numerous articles/books she sent my way, all of which helped with the conceptual pieces of this study; Mindy Stombler for our conversations about research methodology and the resources she provided which helped formulate and clarify the methodology of this project; Stephanie Shine for her questions which forced me to clarify my thinking about therapy and communicate my thoughts about therapy so that non-clinicians would understand; and Susan Kashubeck for her questions and comments stemming from her clinical experience and knowledge which made me think about how my values and assumptions about therapy influenced my conceptualization, method, and findings, as well as her insights about the studies' implications for clinical practice.

I would like to make specific reference to my dissertation defense because of the apparent uniqueness of my experience. My defense was a positive, supportive learning experience. My interaction with my committee was conversational, collegial,

and mutual. I did not, as the term "defense" implies, experience my defense as adversarial, antagonistic, or critical. I was once again reminded about the constitutive nature of language when it comes to human experience. My anxiety surrounding my defense centered around the negative connotations and images invoked by the term "defense." I am grateful to my committee for making my defense thought-provoking, educational, informative, and perhaps most of all, enjoyable.

Lastly, I would like to thank my wife JoAnne for her love, patience, support, encouragment and constant reminders about what really matters in life. There were many occasions where I became a recluse, locked myself in the computer room, and many times when I felt anxious, exhausted, and overwhelmed in my attempts to balance course work, clinical work, and my research; all to the neglect of that which is most important to me, my relationship to her. I am grateful for her understanding throughout the entire dissertation process. I look forward to spending the time, as well as the cognitive and emotional energy which has been freed up by the completion of this project, on our relationship.

TABLE OF CONTENTS

ABSTRACT

Within the field of marital and family therapy (MFT), there is growing recognition among research-practitioners that the advancement of MFT as a viable treatment option rests upon research-practitioners' ability to provide consumers with descriptions of the clinical processes of MFT. However, a research focus on clinical processes is being neglected. Thus, understanding the process of clinical judgment is an essential component of advancing the practice of MFT as a viable treatment option.

The traditional approach is based upon the information-processing model and focuses on the internal, subjective judgment processes of the clinician to the neglect of the influence of context and therapist-client interaction on the judgment process. The purpose of this dissertation was to describe the judgment process of clinicians from a contextual assumptive framework. This dissertation moves the research area of clinical judgment into the realm of MFT and attempts to initiate a paradigmatic shift within the broader research community's already existent interest in clinical judgment.

A grounded theory approach was used to answer the research question, "how do marriage and family therapists diagnose or arrive at a problem definition during the first session of therapy?" In answering the question, the process which emerged involved, in varying combinations: (1) comparing and contrasting knowledge that existed in the mind of the clinician prior to meeting the client with information obtained from the client during the session; (2) using an understanding of how larger contextual factors affected client and therapist experience during the session; and (3) having an awareness of what is happening between clinician and client, and determining how information from, and the experience of, the client fit with clinicians' previous experiences. Clinicians engaged in two meta-level judgment processes. The distinction between internal and conversational judgment processes was that the clinicians engaged in conversational judgment processes: (1) made overt their judgments and incorporated them into the therapeutic conversation; and (2) relied upon client input about what would or would not be helpful when constructing their judgments.

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Qualitative dissertation proposals often include an autobiographical account of the motivation behind the research interest (Marshall & Rossman, 1995). Initial research questions often come from the lived experience and personal theory of the researcher (Marshall & Rossman, 1995). My interest in clinical judgment began much earlier in different contexts before I became familiar with the psychotherapy literature. In this introduction I provide an autobiographical context for the research questions by discussing my experiences within my family-of-origin, subsequent educational experiences, and more recent clinical experiences. A rationale is also provided of the need for the study and its place within the psychotherapy literature.

An Autobiographical Situating of the Research Interest

I was raised in a family that had a long conservative, religious tradition. As a part of this tradition, I attended a host of churches while growing up and heard many people give interpretive accounts of biblical passages. Based on this experience, one of the questions I consistently asked as an adolescent, which never seemed to be adequately answered, was "how could two, or more, seemingly knowledgeable, professional people arrive at different conclusions of the same biblical passage?" I remember hearing people, and hearing stories about people, who would disagree about the "True" meaning of biblical passages. In fact, they would argue so vehemently that discussions would result in masses of people leaving churches, people refusing to converse with one another, people being called heretical for their views, and having people make judgments about the spiritual condition of other people.

The question remained with me throughout my college experience and was a key motivational factor in my decision to pursue a theological graduate education. During my seminary experience, I focused on the study of hermeneutics which referred to the study of the interpretation of ancient literary texts, in particular the bible in its original languages of Greek and Hebrew. By studying hermeneutics I was presented a

framework for answering the question and making sense of the disparate interpretations of persons reading biblical texts. In fact, hermeneutic assumptions were integrated into my personal paradigm and became central to the way I conceptualized my own experience as well as those of others.

During my seminary experience, I decided that I wanted to pursue a career in counseling and began to seek out graduate programs in the field of counseling. During my search, I stumbled across the field of marital and family therapy and found myself interested in the course descriptions which were a part of the curriculum. As I pursued an education in marital and family therapy, I found myself asking essentially the same question once again, this time with a slight variation. Conversations I had with other therapists and observations I made while watching other clinicians work led me to ask the question "how could two, or more, seemingly knowledgeable, professional people trained in the same therapeutic tradition arrive at different conceptualizations of families and how to intervene with those families?"

I had some personal ideas about how to answer the question primarily based on hermeneutic assumptions, but wondered if they applied to marital and family therapy. I searched the MFT theoretical and research literature and found myself drawn to constructivist and social constructionist models of therapy. The assumptions of constructionist therapies seemed consistent with my personal assumptions which had emerged during my seminary education. My search also led me to the qualitative research literature and I again found a fit between my personal assumptions and the philosophical assumptions of qualitative research. More recently, I discovered that there was a research literature within the broader psychotherapeutic community that focused on the judgment processes of clinicians. However as I familiarized myself with the research literature, I realized that the philosophical assumptions of the clinical judgment research differed from my own personal assumptions. I had a difficult time making sense of the research findings and found it difficult to apply the theoretical conceptualizations of clinician judgment to my personal practices as a clinician. Out of this experience I began to formulate an alternative framework for conceptualizing the clinical judgment process of clinicians.

Clinical Experiences

Within the clinical judgment literature, I found that the term clinical judgment referred to cognitive processes such as diagnosis, prediction, prognosis, hypothesis testing, perception, attributing causation, and interpretation. I became particularly interested in the aspect of diagnosis. I realized that not only did I have difficulty making sense of the traditional conceptualization of clinical judgment on an assumptive and theoretical level, but also on a practical level. The way I thought about and went about the process of diagnosis during therapy sessions seemed quite different from the descriptions of the process within the traditional literature. My own emerging theory of therapy was based on a collaborative process of diagnosis. In contrast, the traditional approach rested on a hierarchical process which was based solely on the expertise of the therapist.

A collaborative process of diagnosis or problem definition involves beginning the therapeutic process by understanding the client's view of the problem from within his or her own language (Anderson & Goolishian, 1988). I have always understood this process to be similar to a phenomenological study that attempts to gain an understanding of a person's experience from her or his point of view. The starting point of a collaborative approach to diagnosis is phenomenologically understanding the client's experience through the use of questions which stem from a genuine curiosity about the client's experience. The therapist essentially becomes a phenomenological researcher, bracketing her or his preconceived ideas and assumptions about problems and change, and focusing on the experiential world of the client. Bracketing for the therapist refers to being aware of his or her agenda for therapy and contrasting that with the emerging understanding of the client's experience. My understanding of the traditional approach to diagnosis is that it requires the therapist to use his or her expertise and knowledge of pre-existent diagnostic categories by placing the experience of the client into one of the categories. In qualitative data analysis terms, this process would be akin to forcing the data into the researcher's pre-existing assumptions and ideas about the phenomenon of study. In contrast, a collaborative

diagnosis process allows for the categories to emerge from the data. In therapy language, the diagnosis emerges from an understanding of the client's experience.

In my experience, the collaborative process of diagnosis evolves from an initial phenomenological process to a conversational process. Problem definition or diagnosis occurs as a result of and product of the mutual, reciprocal give and take that occurs between members of the newly created system. The therapist becomes a member of the therapist-client system which forms as a result of joining with the client. Joining occurs as the therapist begins to understand the client's experience and the client feels as though he or she is being heard and understood. One of the assumptions I make is that understanding is never complete, thus there is always something more to learn from the client as the conversation proceeds. In fact, diagnoses become fluid and open to revision. The word conversation implies that therapy becomes more egalitarian with the client taking more and more responsibility for the emerging definition of the problem.

There is a need for the flattening of the hierarchy to occur that exists because of the ascribed power given to therapists which places them in a hierarchical position in relation to the client. I find myself asking questions such as "what are the consequences for someone who consistently looks toward others to tell him or her what her or his problem is, and what to do about it?", and "what are the consequences for someone who relies on others to interpret his or her own experiences?" I believe that a person's sense of personal agency, and sense of competence are central to problem resolution. I also believe that the ascribed expertise of the therapist and his or her hierarchical position prevent clients from experiencing personal agency and competence in the resolution of their problems. In fact, it has been my experience that most clients come to therapy feeling and believing that they are powerless, and incompetent to deal with their experiences. I assume, along with others (Adams-Westcott, Dafforn, & Sterne, 1993; Durrant & Kowalski, 1990), that the experience of powerlessness and incompetence can be replicated when the client takes a one-down position in relation to the expertise and power of the therapist.

I believe problem definition or diagnosis can be conceptualized differently than it has been in the predominant clinical judgment literature. In a collaborative process view, problem definition becomes a joint activity between therapist and client. The process starts off with the therapist assuming a position of genuine curiosity and continues to evolve to a mutual conversation about the concerns and struggles of the client to be addressed in therapy. The problem definition is a product of the mutual and reciprocal interaction that has taken place between therapist and client.

Assumptions Based on the Autobiographical Account

There are a number of assumptions that carry over from my clinical experience into this research project. First of all, I believe that diagnosis and problem definition are a part of every therapist's experience with a client over the course of therapy. It may be that the process is not overtly conceptualized by the therapist, and it may be that the therapist does not even explicitly attempt to arrive at a formal definition of the problem. However, I believe that there is a point, or are points, at which every therapist has a sense of what is going on in the life of his or her client and what the central issue is, or issues are, that need to be addressed in therapy. I expect that therapists will differ in their ideas about their role in the defining of the issue and how to resolve it, but I firmly expect to observe therapist and client engaged in some type of problem definition process.

Secondly, I also believe that every therapist will be able to describe the process that he or she went through in arriving at that point where he or she had some idea as to what brought the client to therapy. This assumption stems from a constructivist assumption that I make about people actively trying to make sense of their experiences. Not only do people in general actively try to make sense of their experiences, but I believe therapists actively try to make sense of their clinical experiences. I do not believe that every therapist goes about the sense-making process the way I do or as actively as I do, but I do believe that therapists engage in some type of reflective process about what they do in therapy. Since reflexivity is central to my work as a therapist and I believe that the degree of reflexivity on the part of

clients and therapists is a key component of successful therapy, I would expect other therapists to be able to reflect upon their clinical work. Not only do I think that therapists would be able to reflect on their work, but I also believe that they would be interested in thinking about their clinical work. In this study, interviews will be conducted in order to obtain descriptions of the reflective process of therapists about how they make judgments about problems in therapy sessions.

Last, I make the assumption that marriage and family therapists who have been trained in systems theory are inclined to focus on and be aware of the interactional processes that occur in therapy sessions. I do not believe that every therapist concerns him or herself with a second-order systems perspective of therapy as much as I do, but I do believe that marriage and family therapists will be able to reflect on the interactional process between themselves and their clients. I am curious about how therapists conceptualize and describe the process that occurs between themselves and their clients and this has been a motivational factor in pursuing this line of research.

Need for the Study

In the broader psychotherapy community, the task of demonstrating the effectiveness of psychotherapy treatment has become an area of increased concern (Falvey, 1992). In order to provide evidence for the effectiveness of psychotherapy, research-practitioners have attempted to answer such questions as "what specific interventions work for which client problems under what circumstances?" and "what skills or characteristics of a clinician facilitate positive client outcomes?" (Falvey, 1992, pp. 458-459). As a way of answering the question concerning clinician factors associated with effectiveness, researchers have examined the area of clinical judgment (Falvey, 1992).

Within the field of marital and family therapy (MFT), there is growing recognition among research-practitioners that the advancement of MFT as a viable treatment option in the larger health care system rests upon research-practitioners' ability to provide consumers with descriptions of the clinical processes of MFT and evidence of the effectiveness of MFT (Sprenkle & Bailey, 1995; Pinsof & Wynne, 1995). Since

many marital and family therapists have been reluctant to conduct research on the process of their clinical work (Pinsof & Wynne, 1995), there is a significant knowledge gap concerning the processes of clinician practices in the MFT literature. As evidenced by the October 1995 issue of the Journal of Marital and Family Therapy, the research focus seems to be leaning toward conducting outcome studies to ascertain the effectiveness of MFT for a wide variety of presenting problems. An understanding of clinical processes is being neglected. Without the discovery-oriented, model-building potential of process research, as well as the detailed descriptions and observations of clinician processes in their natural context, the field of MFT risks not becoming a viable treatment option (Greenberg, Heatherington, & Friedlander, 1996).

Many practitioners have recognized the importance of the clinical judgment process to the practice of psychotherapy (Falvey, 1992), yet the discipline of marital and family therapy has not included a discussion of clinical judgment within its professional discourse. One of the assumptions of this dissertation is that understanding the process of clinical judgment needs to be an essential component of the efforts being made to advance the practice of MFT as a viable treatment option. A second assumption of this dissertation is that the traditional approach to clinical judgment which rests on mechanistic philosophical assumptions does not adequately describe the judgment process of clinicians. The traditional approach is based upon the information-processing model and focuses on the internal, subjective judgment processes of the clinician to the neglect of the influence of context and therapist-client interaction on the judgment process. An approach to clinical judgment based on contextual philosophical assumptions incorporates the traditional approach into its framework, but also allows for a consideration of how contextual factors and interactional processes influence clinician judgments. Clinicians must consider the influence of context on family experience and make sense of multiple interacting variables in their work (Gilgun, 1992). A contextual framework for understanding clinical judgment allows researchers and clinicians to more thoroughly and comprehensively describe the clinical judgment processes of clinicians.

Overview of the Proposal

This dissertation represents a continuation of my pursuit to answer questions about how people arrive at the conclusions they do. In an attempt to bracket my personal and clinical experience, the literature review contains a hypothetical description of an alternative perspective of clinical judgment. The alternative reflects an integration of the literature from disciplines such as hermeneutics, constructionist therapies, philosophy of science and adult development. A common thread among the divergent disciplines is the concern with which each of the disciplines has had with advancing knowledge about, and advocating for the use of, contextual philosophical assumptions in research and psychotherapeutic practices. The chapter following the literature review contains a description of the qualitative methodology used in this dissertation project. Grounded theory research methods consistent with contextual philosophical assumptions and appropriate to exploratory and descriptive research purposes were utilized in order to arrive at a tentative, initial description of the clinical judgment process of marriage and family therapists.

Research Question

The purpose of this dissertation is to describe the judgment process of clinicians from within a contextual assumptive framework. In doing so, this dissertation moves clinical judgment into the realm of marital and family therapy and initiates a paradigmatic shift within the broader research community's existent interest in clinical judgment. The research question which guides this dissertation is: How do marriage and family therapists arrive at a problem definition in the first session of therapy?

CHAPTER II

LITERATURE REVIEW

Traditionally in quantitative research projects, the literature review chapter provides the rationale for the unique contribution your study will make to the field and a basis for the testing of models and hypotheses (Gall, Borg, & Gall, 1996). Since no hypotheses nor models were tested in this study, following traditional quantitative outlines and purposes of a literature review seem inappropriate. Traditionally in qualitative studies using grounded theory methods, the review of the literature occurs near the end of the data collection and analysis process (Glaser & Strauss, 1967; Strauss & Corbin, 1990). According to the traditional grounded theory approach, avoiding a review of the literature prior to starting the project allows the researcher to interpret the data without prior theoretical frameworks forcing the data into pre-existing categories. However, a problem arises for therapists-as-qualitative researchers because they already have a sense of the clinical phenomenon under study because of their previous clinical training and experiences with and exposure to the phenomenon (Chenail & Maione, 1997). It would seem that following traditional grounded theory guidelines concerning the literature review is inappropriate for this present study.

Coupled with the fact that this literature review does not fit into traditionally accepted guidelines, Morse (1991) has stated that there is no single accepted outline for qualitative research projects in general. Thus, I have modified the literature review section to fit with my ideas about research and the unique problems created by being a therapist-as-researcher. Because forcing data into pre-existing categories is a legitimate validity problem and because I have some pre-conceived ideas about the clinical judgment process, the literature review is a means of bracketing my ideas and assumptions. Bracketing refers to the process of making assumptions and pre-conceived ideas explicit and known beforehand in an attempt to become aware of how they will impact data analysis and to provide a point of contrast with the emerging categories and theory (Knaack, 1984).

The review of the literature offers a tentative description of an alternative theoretical framework for understanding clinical judgment based on my pre-conceived ideas and assumptions about the process of clinical judgment. The framework represents an integration of the theoretical and research literatures on worldview assumptions, hermeneutics, and the philosophy of science. A brief review of the existing clinical judgment literature is also presented which describes the underlying philosophical assumptions of the traditional approach to understanding the clinical judgment process.

An Overview of Research within the Historical and Predominant Approach to Clinical Judgment

Historically, the term clinical judgment has referred to the subjective cognitive processes of clinicians (Holt, 1988). A number of internal processes have been conceptualized as comprising the subjective clinical judgment process of clinicians. Researchers have used the term clinical judgment to refer to cognitive processes such as diagnosis, prediction, prognosis, hypothesis testing, perception, attributing causation, and interpretation (Einhorn, 1988; Garb, 1996; Garb & Schramke, 1996; Gardner, Lidz, Mulvey, & Shaw, 1996a; Jordan, Harvey, & Weary, 1988; Lopez, 1989; Salovey & Turk, 1988; Snyder & Thomsen, 1988; Smith, 1988).

The origin of the systematic scientific study of the subjective processes of clinicians can be attributed to Meehl's (1954, 1957) comparisons of subjective cognitive processes (clinical judgment) versus objective statistical processes (actuarial judgment). The first decade of research following Meehl (1954, 1957) has been concerned with studying the subjective cognitive processes of prediction and diagnosis. Research results have consistently supported the superiority of actuarial judgment over clinical judgment in terms of predictive and diagnostic accuracy (Goldberg, 1968; Goldberg & Werts, 1966; Meehl, 1954; 1959; Sawyer, 1966). Besides research which has shown the superiority of actuarial judgment, research during this time period also demonstrated that the subjective judgment of clinicians was no better than the accuracy of secretaries (Goldberg, 1959), and that trained clinicians performed slightly

better than chance and no better than untrained persons in terms of diagnostic accuracy (Oskamp, 1965).

Despite the fact that research and discussion comparing actuarial and clinical judgment has persisted to the present (Dawes & Corrigan, 1974; Dawes, Faust, & Meehl, 1989; Garb, 1994; Gardner et al., 1996a; Gardner, Lidz, Mulvey, & Shaw, 1996b; Kleinmuntz, 1990; Werner, Rose, & Yesavage, 1983), a second focus of research emerged during the second decade of clinical judgment research. Research from the second decade through the present has involved a shift away from outcome comparisons to attempts at understanding how clinicians gather and integrate information. With the emergence of the information-processing model as the predominant means of conceptualizing clinical judgment (Falvey, 1992), researchers have focused on identifying clinician heuristics and biases assumed to cause the consistent research finding that clinicians make inaccurate and inferior judgments.

The term heuristics has been defined as the cognitive rules which clinicians use in order to simplify information and make decisions (Falvey, 1992). Three of the most common heuristics used by clinicians are the availability heuristic and representative heuristic (Tversky & Kahneman, 1974), as well as the anchoring heuristic (Kahneman, Sloveic, & Tversky, 1982). The availability heuristic refers to the clinician's assigning of a diagnosis by recalling prototypical and stereotypical instances of that diagnosis (Garb, 1996). The representative heuristic refers to the clinician's estimation of correspondence between client symptoms and diagnostic categories (Falvey, 1992). Finally, the anchoring heuristic refers to the tendency to rely on preliminary information to guide subsequent judgments (Falvey, 1992). Recently, Garb (1996) has described the past-behavior heuristic used in clinical predictions. The past-behavior heuristic refers to making future predictions based on clients' past behaviors (Garb, 1996).

Heuristics, while being effective in some instances, often result in inaccurate diagnoses and predictions. Studies of the anchoring heuristic, for example, have indicated that clinicians form diagnostic impressions very early in the intake process and that subsequent disconfirming evidence is ignored in favor of retaining the initial

diagnosis (Friedlander & Stockman, 1983; Strohmer, Shivy, & Chiodo, 1990). Other sources of error in clinician judgment which have been identified include illusory correlation, confirmation bias, ego-centric bias, selective attention, attributional bias, and transient mood states (Jordan et al., 1988; Salovey & Turk, 1988; Snyder & Thomsen, 1988; Turk & Salovey, 1985).

Apart from a focus on the internal subjective cognitive processes of clinicians, researchers have also looked at various external factors which contribute to the inaccurate and inferior judgments of clinicians. The client variables of gender, race, social class, age, mental retardation, ethnicity, religion, and residential location have been studied to ascertain their influence on clinician judgments (Lopez, 1989). Lopez (1989) categorized sixty studies in terms of whether or not the results of the research indicated an overpathologizing bias, minimizing bias, overdiagnosis bias, underdiagnosis bias, or a lack of clinician bias. The results suggested mixed findings for the influence of client variables on clinician judgments with some studies providing evidence of clinician bias and others providing no evidence of clinician bias (Lopez, 1989).

Philosophical Underpinnings of the Traditional Approach

The traditional conceptualization of clinical judgment rests on mechanistic philosophical assumptions (Holt, 1988; Sarbin, 1986). The term mechanism is drawn from Pepper's (1942) conceptualization of four world hypotheses or root metaphors which represent various ways of making sense of the world and persons' experiences within the world. The term mechanism is also used to refer to a paradigm or worldview which consists of a set of ontological, epistemological, and anthropological axioms. The root metaphor of the mechanistic worldview is that the world is like a machine which can be reduced into its parts and understood in isolation from the whole. Mechanism rests upon the ontological assumption that the universe is composed of discrete, and inherently stable and isolatable parts. The parts are assumed to be linearly related in a series of cause-effect interactions. Mechanistic epistemology asserts that reality is external to the knower, and that the relationship

between knower and reality is characterized by objectivity and separation. An objective relationship to the reality guarantees that what a person comes to understand is an exact mental representation of reality. Anthropologically, persons are assumed to be reactive, passive, determined by their environment and yet, separate from their environment.

Similar philosophical axioms can be found in conceptualizations of the positivist research paradigm (Lincoln & Guba, 1985), rationalist cognitive therapies (Mahoney, 1988), and modernist psychotherapies (Anderson, 1996; Hoffman, 1990). Lincoln and Guba (1985) suggested that the positivist research paradigm assumes the following: a single, tangible reality "out there" that can be broken down and studied independently; a separation of the observer and the observed; the contextual and temporal independence of observations; linear causality; and that adherence to the scientific method guarantees that the results of an inquiry are free from researcher bias. Mahoney (1988) has described rationalist cognitive therapies as assuming that: a single, stable, and external reality exists; knowledge is validated through logic; knowledge and change are the product of linear causality; mental representations are accurate copies that correspond to the external reality; and that there is a basic dualism between the body and mind. Finally, modernist psychotherapies assume an objective, external reality; a separation between the therapist and client; and linear causality.

Numerous therapists (Amundson, Stewart, & Valentine, 1993; Anderson, 1996; Gonzalez, Biever, & Gardner, 1994; Hoffman, 1990; Loos & Epstein, 1989; Mahoney, 1988; O'Hanlon, 1993) have outlined practical implications of psychotherapies which rest on modernist assumptions. Modernist therapy represents an attempt at discovering objective truth and the underlying or "real" problem. The underlying problem which must be corrected is understood as an inherent, hidden structural deficiency within the person or system. Furthermore, problems within a modernist therapy are seen as dysfunctions, pathologies, or deviations from some normative standard. Emotions, especially negative emotions, are seen as problems to be eliminated or controlled (Mahoney, 1988). The process of psychodiagnosis is at the core of modernist therapies with the assumption that mental disorders are entities which can be

objectively measured and are accurate descriptions of a person. Finally, modernist therapies seek causal explanations for problems which are derived from the expert knowledge of the therapist.

The therapist is seen as an expert in a hierarchical position of power with privileged knowledge. The therapist operates from a position of privacy, separateness, neutrality, or objectivity. In other words, the therapist operates from a first-order perspective and does not consider the dynamics of the therapist-client system on the process of therapy (Amundson et al., 1993). For example, clients who don't "get it" are seen as "resistant" without any consideration from a second-order perspective of the therapist-client system. The therapist assumes responsibility for taking charge of therapy sessions, setting the direction for therapy, and focuses on teaching, explaining, and disseminating "expert knowledge." In fact, the therapist may use treatment jargon to sell "expert knowledge" to the client (Amundson et al., 1993). A proper methodological procedure or technique is assumed to allow the therapist to obtain an accurate picture of the problem and to prescribe a proper corresponding intervention strategy.

Evidence of Mechanistic Assumptions

Despite Holt (1988) and Sarbin's (1986) attempts to offer criticisms of, and alternatives to, the predominant approach to clinical judgment, theoretical writings and research efforts continue to represent a commitment to mechanistic philosophical assumptions. According to Turk and Salovey (1988), a fundamental expectation of clinicians is that they will observe pathology in their clients. This expectation is assumed to result in reduced accuracy of judgment and a tendency to overestimate pathology (Turk & Salovey, 1988). Holt (1988) demonstrated that research on clinical judgment has been guilty of the same bias used to characterize and criticize clinician judgment. Holt (1988) also demonstrated that clinical judgment research was guilty of the attributional bias of explaining behavior intrapsychically which seems so prevalent in clinician judgment. Clinical judgment research has focused on identifying errors in,

and attributing causation to, the internal subjective processes of clinicians to the neglect of the role of situational factors in judgment (Holt, 1988).

Researchers' emphasis on finding deficits in the clinician processes of diagnostic and prognostic predictions, hypothesis generation and testing, as well as the emphasis on intrapsychic causal attributions, reflect the underlying assumptions of a mechanistic paradigm. An understanding of the context within which the vast majority of research has been conducted provides one way of making sense of researchers' adherence to mechanistic assumptions. The field of medicine can be given credit for initiating research interest in clinical judgment (Falvey, 1992), while the discipline of psychology, particularly the specialized disciplines of clinical psychology, cognitive psychology, neuropsychology, and social psychology, can be said to have built upon and advanced the knowledge of clinical judgment (Lopez, 1989; Garb & Schramke, 1996; Turk & Salovey, 1988). It is generally accepted that psychology was established out of a determination to apply positivist assumptions to the of study human beings (Slife & Williams, 1997). Thus given the historical allegiance to positivism, it is not coincidental that clinicians and researchers trained in psychology conduct research and psychotherapy from within a mechanistic framework.

A significant aspect of research within a mechanistic paradigm has involved the use of various editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for determining the judgment accuracy of clinicians and identifying heuristics and biases in the process of diagnosis (e.g., Blashfield & Haymaker, 1988; Cantor & Genero, 1986; Ford & Widiger, 1989; Garb, 1994; 1996; Gardner et al., 1996; Grove, 1987; Livesly, Reiffer, Sheldon, & West, 1987; Loring & Powell, 1988; Matarazzo, 1983; Morey & Ochoa, 1989; Pavkov, Lewis, & Lyons, 1989). The DSM rests upon the biomedical model which has as its foundation the mechanistic assumptions of reductionism and linear causality (Wynne, Shields, & Sirkin, 1992). The biomedical model assumes that a disease can be reduced to measurable biological processes (Engel, 1977, cited in Seaburn et al., 1993) and it is the physician's task to isolate and treat the single disease causing element (Seaburn et al., 1993). Thus, the DSM

represents a categorization system of psychiatric disorders based on the assumption of isolatable intrapsychic and/or biological causes for persons' experiences (Wylie, 1995).

The information-processing model which remains the primary conceptual framework for research on clinical judgment can be categorized as mechanistic (Ivey & Scheel, 1997; Mahoney, 1988; Miller, 1993). In the information-processing model, the root metaphor of humans as machines has been replaced with the more modern root metaphor of humans as computers (Miller, 1993). One of the most basic assumptions of the information-processing framework is linear causality. The model assumes a linear flow of information from the environment and subscribes to the idea that knowledge is a product of sequential processing (Ivey & Scheel, 1997; Mahoney, 1988; Miller, 1993). The information processing model also assumes an objective external reality and that cognitive processes which are free of error can obtain an exact mental representation of that reality (Ivey & Scheel, 1997; Mahoney, 1988).

Although efforts have been made to conceptualize the person as information-processor as an active seeker, creator and user of information (Turk, Salovey, & Prentice, 1988), cognition is still understood as a linear "outside-in" process (Mahoney, 1988). Furthermore, despite attempts to conceptualize therapist-client interaction as reciprocal (Turk et al., 1988), the traditional conceptualization of transference and counter-transference rests on the mechanistic assumptions of the objectivity and separation of the observer from the observed. The term transference, for example, refers to the client's projection of significant others onto the objectively neutral clinician (Turk et al., 1988). Not only is the clinician characterized as objectively neutral, but the fundamental task of the clinician is to remain objective when everything inherent within the therapy process mitigates against objectivity (Cantor & Kihlstrom, 1982, cited in Turk et al., 1988). Consistent with the focus on deficits, the interaction between clinician and client is also understood to be a source of error in clinical judgment (Turk et al., 1988).

The mechanistic assumption of objectivity can also be seen in the definition of the process of perception which is often used to study clinical judgment. The process of perception refers to the clinician's ability to synthesize information to obtain an

accurate mental representation of the client (Smith, 1988). Smith's (1988) definition is consistent with an information-processing perspective on the cognitive processes of clinicians. In perceiving the client, the clinician attempts to ascertain the "structure" of the client and to arrive at neutral, objective descriptions of the client (Smith, 1988). The term "structure" refers to the cluster of attributes or properties which define the person (Smith, 1988). The search for "structure" is consistent with psychotherapies based on mechanistic assumptions (Anderson, 1996; Hoffman, 1990).

Mechanistic philosophical assumptions are also evident in the clinical judgment process which has been described by researchers within the traditional approach. The process is referred to as the scientific model of interviewing and is said to be more immune from error than are other less rigorous models of clinical judgment (Strohmer et al., 1990). According to the scientific or positivist model of interviewing, the clinician observes the client, makes inferences concerning the client's current status and related causal factors, and then develops a testable hypothesis about the client. The clinician proceeds to test the hypothesis against additional independent observations of the client. The process continues until the clinician has developed an accurate hypothetical model of the client. Finally, the hypothetical model serves as the basis for predictions to be made regarding treatment and intervention. Some of the mechanistic assumptions which can be found in the model include the foundational assumption that the clinician is an objective outside observer, as well as the assumptions that the clinician is in a hierarchical position of expertise for developing inferences, and that adherence to the scientific method of hypothesis construction and testing enables the clinician to obtain accurate diagnoses of the client.

Clinical Judgment in the Field of Marital and Family Therapy

Despite the fact that interest in clinical judgment can be traced throughout the history of psychotherapy, there is an absence of a research interest in the field of marital and family therapy (MFT). The few studies which have been conducted reflect the mechanistic assumptions of the traditional approach to clinical judgment. Outcome research has focused on the negative effects of therapist factors on clinician

perception, prognostic predictions, and diagnosis. Therapist factors found to result in deficient judgments include beliefs about the consequences of maternal employment, and personal family history (Ivey, 1995, 1996); and values about sex outside of marriage, gender stereotypes concerning sexual activities, sex, and religiosity (Hecker, Trepper, Wetchler, & Fontaine, 1995). Zygmond and Denton (1988) found that the gender of the therapist influenced which client characteristics were used to formulate outcome predictions, whereas the gender of the client had no effect on prognostic ratings. McCollum and Russell's (1992) survey of 107 family therapists found no evidence of mother-blaming by therapists in the process of diagnosis. Finally, Leslie and Clossick (1996) found that therapists who had received training in gender issues did not differ from those who did not receive training in terms of the levels of sexism and feminism in their clinical decision-making processes.

The evident absence of a research interest in clinical judgment within MFT can be thought of as due to the incongruence of paradigms between the predominant approach to clinical judgment and the field of marital and family therapy. A brief history of the development of MFT provides an understanding of the incongruence between paradigms. The founders of family therapy emerged in the 1950's in reaction to, and out of, the predominant psychotherapeutic approach of the time, which was psychoanalysis (Nichols & Schwartz, 1991). In fact, Nichols and Schwartz (1991) have characterized the founders of family therapy as "disillusioned psychoanalysts" (p. 82). The pioneers of family therapy were reacting to some of the mechanistic philosophical assumptions of psychoanalysis such as linear causality and the resultant overemphasis on intrapsychic causal factors to the neglect of contextual factors, as well as a pathological view of people (Nichols & Schwartz, 1991). Psychoanalysis has been referred to as the "first wave" of psychotherapy and has been characterized as pathology-focused and dominated by psychodynamic theories and biological psychiatry (O'Hanlon, 1994). The assumption of "expert knowledge" and the hierarchical position of clinicians within the "first wave" of psychotherapy resulted in diagnoses becoming absolute, objective, and external truth (O'Hanlon, 1994). The process of diagnosis became a central tenet of the "first wave" of psychotherapy.

Family therapy emerged in opposition to the "first wave" of psychotherapy and took a polarized position. The "second wave" of psychotherapy abandoned linear causality in favor of circular causality, and moved away from a search for ultimate and intrapsychic causes (O'Hanlon, 1994). The concept of personality as an intrapsychic and isolated phenomenon was replaced with an understanding of the influence of family and social relationships on personality (O'Hanlon, 1994). Psychotherapy models such as Haley 's (1976) problem-solving therapy model; Minuchin's (1974) structural family therapy model; and Bowen's (1978) emotional systems theory took extreme polemical stances against traditional psychodiagnosis, intrapsychic causation, and working from a conceptualization of the individual out of context. The extreme oppositional stance of the early family therapists resulted in a distinctive movement away from disciplines such as psychiatry and psychology. The movement was far enough and the "us versus them" mentality strong enough that there remains a definitive gap between the fields of psychology and marital and family therapy (Nichols & Schwartz, 1991). The disciplines of psychiatry and psychology are seen by many MFTs as part of the establishment remaining unenlightened by the systemic revolution (Nichols & Schwartz, 1991). Research in clinical judgment has a firm foundation and historical connection with the disciplines out of which MFT emerged, thus there remains a separation and isolation between the disciplines. The same mechanistic assumptions that MFT's reacted to and moved away from are the foundation of the traditional approach to clinical judgment.

Even though the field of marital and family therapy attempted to move away from, and criticized the "first wave" of psychotherapists for holding mechanistic assumptions, the "second wave" psychotherapies maintained some mechanistic assumptions (Nichols & Schwartz, 1991). Later critiques of the "second wave" revealed that the root metaphor of individuals as machines had essentially been replaced with the root metaphor of families as machines. The cybernetic metaphor which was used to introduce such ideas as circular causality, homeostasis, and feedback loops was essentially mechanistic (Nichols & Schwartz, 1991). In 1968 von Bertalanffy offered a systems metaphor based on the root metaphor of the world as an

organism (Nichols & Schwartz, 1991). Despite the influence of the organismic systems metaphor, the early family therapy models remained inherently mechanistic (O'Hanlon, 1994). Regardless of the systems metaphor utilized, mechanistic assumptions remained such as a search for underlying structural flaws, the hierarchical and expert position of the clinician, and the separate and objective position of the clinician in relation to the client.

O'Hanlon (1994) has suggested that in the 1980's the field of psychotherapy slowly began to move historically into the "third wave." Within the field of marital and family therapy, the "third wave" challenged the philosophical roots of MFT in the form of constructivism and the feminist critique (Nichols & Schwartz, 1991). The "third wave" of psychotherapy represents a complete shift in philosophical assumptions away from mechanism, however the philosophical assumptions of the "third wave" have had little influence on the day-to-day practice of clinicians (O'Hanlon, 1994). Not only has the influence of the "third wave" and change come slowly in the practice of psychotherapy, researchers have been slow to adopt alternative philosophical assumptions (Slife & Williams, 1997). Not unlike a lot of other areas of research, research in the area of clinical judgment remains committed to the philosophical assumptions of mechanism. The research in MFT on clinical judgment can be thought of as being a part of "second wave" psychotherapy practices. The concern with the influence of gender on the clinical judgment process (Hecker et al., 1995; Ivey, 1995; 1996; Leslie & Clossick; 1996; McCollum & Russell, 1992; Zygmond & Denton, 1988) represents an attempt at considering the influence of the larger social context on clinician and client. A concern with the influence of family history (Ivey, 1995; 1996) on clinician judgment also reflects a consideration of context on judgment. Thus, MFT research on clinical judgment could be considered the "second wave" of research with its focus on the individual in context. However, mechanistic assumptions, such as a focus on clinician bias, as well as a concern with the inaccuracy and deficiency of clinician judgments, still pervaded the research approaches utilized and the conceptualization of clinical judgment.

Philosophical Assumptions of An Alternative Paradigm for Conceptualizing Clinical Judgment

This dissertation provides an alternative set of philosophical assumptions to guide research in the area of clinical judgment and to describe the clinical judgment processes of clinicians within the alternative perspective. The alternative conceptualization of clinical judgment rests on contextual philosophical assumptions (Holt, 1988; Sarbin, 1986). Holt (1988) and Sarbin (1986) introduced alternative philosophical assumptions to the field of clinical judgment a decade ago, yet the assumptions have had little influence on research practices and the conceptualization of clinician judgment.

The term contextualism is drawn from Pepper's (1942) conceptualization of four world hypotheses or root metaphors which represent various ways of making sense of the world and persons' experiences within the world. The term contextualism is also used to refer to a paradigm or worldview which consists of a set of ontological, epistemological, and anthropological axioms. The root metaphor of the contextualist worldview is that the world is like a rope consisting of textured layers like the strands of a rope woven together. Contextualism rests upon the ontological assumption that reality consists of textured layers constructed by observers. The layers are assumed to be related in a series of interdependent interactions. Contextualist epistemology asserts that reality is internal to the knower, and that the relationship between knower and reality is characterized by subjectivity and relativism. Anthropologically, persons are assumed to be proactive, creative, influenced by their environment and embedded within their environment.

Adult Cognition and Philosophical Assumptions

Research in the area of adult cognitive development has led to further conceptualizations and clarifications of the contextualist paradigm. Pepper (1942) described four world hypotheses, however research in the area of adult cognition has indicated that Pepper's (1942) four world hypotheses can be categorized into two distinct paradigms (Botella & Gallifa, 1995; Johnson, Germer, Efran, & Overton,

1988). Within the adult cognition literature, Pepper's (1942) two analytic world hypotheses of formism and mechanism have been combined into one paradigm (Botella & Gallifa, 1995; Johnson et al., 1988; Kramer, Kahlbaugh, & Goldston, 1992). Similarly, Pepper's (1942) two synthetic world hypotheses of contextualism and organicism have been combined into one paradigm (Botella & Gallifa, 1995; Johnson et al., 1988). Research has indicated that the contextualist paradigm is comprised of a constructivist epistemology, while the mechanistic paradigm is characterized by a positivist epistemology (Berzonsky, 1994; Botella & Gallifa, 1995).

The mechanistic paradigm represents an integration of the formism and mechanism world hypotheses. Formism is based on the root metaphor of similarities among entities and assumes the existence of universal forms or types that allows for the discovery of real or core essences. The contextualist paradigm represents an integration of the organicism and contextualism world hypotheses. Organicism is based on the root metaphor of the world as a living organism and understands the world as system of complex, interrelated processes.

The integrated contextualist/organicist paradigm results in a synthesis of Kramer et al.'s (1992) relativist and dialectical worldviews. The relativist worldview understands reality as unpredictable, indeterminate, and entirely dependent upon an individual's context. Reality is utterly unique to each person's subjective perspective, experience, and situation. Also referred to as contextual relativism (Perry, 1970), knowledge is to be understood in relationship to the context within which it is situated. There is a radical element to the constructivist nature of reality and the relationship between knower and known. Each individual constructs his or her own unique interpretation of reality based upon his or her interaction with the social context, however the extreme relativistic or radical element means that all that can be known is one's own reality.

In order to arrive at an integrated contextual/organicist paradigm, the previous description of the relativist worldview must be combined with Kramer, et al.'s, (1992) description of the dialectical worldview. The dialectical worldview understands the relationship between knower and known as dialectical and embedded. The knower operates from a position of reflexivity (Kitchener, 1983) with an awareness of one's

place in the social context and the reciprocal influence of one's self on the context and the context's influence on the self. Furthermore, the reflective component involves reflections on the limits of knowledge, the certainty of knowledge, and the criteria for knowing (Kitchener, 1983). The knower is aware of his or her personal constructions of reality and the inherent biases and assumptions of those constructions. The internal personal constructions of knowledge are understood to be created through a dialectical process of integrating seemingly contradictory knowledges into an integrated whole (Labouvie-Vief, 1994).

Contextual Philosophical Assumptions

Similar philosophical axioms can be found in conceptualizations of the post-positivist research paradigm (Lincoln & Guba, 1985), constructivist cognitive therapies (Mahoney, 1988), and post-modernist psychotherapies (Amundson et al., 1993; Anderson, 1996; Gonzalez et al., 1994; Hoffman, 1990). Lincoln and Guba (1985) suggested that the post-positivist research paradigm assumes the following: realities are multiple, constructed, and holistic; observer and observed are interactive and inseparable; only context and time bound observations and conclusions are possible; entities are in a process of simultaneous and mutual shaping so that distinguishing cause and effect is impossible; and that adherence to method does not guarantee bias-free research, in fact research is bias-based. Mahoney (1988) has described constructivist cognitive therapies as assuming that: realities are individual and social constructions; knowledge and change involve cognitive transformations toward increased cognitive complexity; mental representations are constructions that determine and interpret experiences; and that body and mind are inseparable and interdependent. Finally, post-modernist psychotherapies assume multiple constructed realities and an interdependent defining and influencing interaction.

Numerous therapists (Amundson et al., 1993; Anderson, 1996; Gonzalez, Biever, & Gardner, 1994; Hoffman, 1990; Loos & Epstein, 1989; Mahoney, 1988; O'Hanlon, 1993) have outlined practical implications of psychotherapies which rest on constructivist or post-modernist assumptions. Post-modern therapy represents an

attempt at generating alternative truths and multiple descriptions of the problem. Problems and solutions are co-constructed, not relying solely on the expert diagnosis and interventions of the clinician. Problems may be understood as developmental discrepancies between the person's current adaptive capacities and contextual demands (Mahoney, 1988). Post-modern therapy involves discussion about exceptions to the problem and a focus on client strengths, competencies and resources. Emotional experience, expression, and exploration are seen as essential to the process of change (Mahoney, 1988).

The therapist is seen as a learner, co-researcher and participant observer. The therapist assumes a "not-knowing" position which is characterized by curiosity and a belief that the therapist does not have access to privileged knowledge. The therapist assumes that he or she can never entirely understand a client and that there is always something more to learn. Therapy is characterized by a collaborative organization relying on the expertise of all participants. The therapist is "public" with assumptions and thoughts and operates from a second-order perspective and considers the dynamics of the therapist-client system on the process of therapy (Amundson et al., 1993). For example, when it seems that a client doesn't "get it," it may be that the therapist hasn't asked the kinds of questions that make a difference to the client. The therapist avoids treatment jargon and uses the client's own language. Finally, post-modern therapy fosters independence, a sense of self-competence and personal agency in the client.

A Hypothetical Description of Clinical Judgment Based on Contextualist Philosophical Assumptions

Mechanistic philosophical assumptions have provided the foundation for clinical judgment research as well as the practice of psychotherapy which has been studied by researchers. In this section of the literature review, a contrasting and hypothetical description is offered of a contextual clinical judgment process. The alternative does not abandon the contributions of the traditional approach, rather the alternative is consistent with its dialectical assumption of integrating apparent opposites into a whole. The alternative conceptualization of the clinical judgment process is informed

by the field of hermeneutics. Perhaps the greatest contribution to the discipline of hermeneutics was Hans-Georg Gadamer's (1960) Wahrheit und methode in which Gadamer broadened the scope of hermeneutics from the interpretation of literary texts to the process of interpretation in the human sciences (Bontekoe, 1996). Gadamer challenged the positivist assumptions of the natural sciences which were being utilized in the discipline of hermeneutics (Bontekoe, 1996). Gadamer also argued that truths arrived at in the human sciences were as legitimate as the truths arrived at in the natural sciences (Bontekoe, 1996).

Prior to Gadamer, hermeneuticists were focused on finding the "inner meaning" of the text whether it was in the form of authorial intent or the underlying structure of the text (Gergen, 1994). The traditional approach to hermeneutics assumed that meaning originated in the individual mind of the authors or the individual mind of the reader (Gergen, 1994). The traditional approach also believed that a rigorous method based on the separation of the reader from the text could guarantee understanding of the objective meaning of the text (Bontekoe, 1996). In contrast, Gadamer asserted that the interpretation of a text was essentially like a conversation, a conversation which involved a mutual exchange of opinion (Bontekoe, 1996). Gadamer also claimed that there was an infinite number of legitimate interpretations of a text and that the assumption of interpretive objectivity needed to be abandoned.

Bontekoe (1996) has provided a detailed description of Gadamer's hermeneutic approach which stems from the presupposition that interpretation is a conversation between text and reader. Interpretation rests in the relationship between the reader and the text and the process of a fusion of horizons. The term horizon refers to the contexts in which both reader and text exist. The reader's horizon is comprised of a fore-structure of pre-conceived ideas, assumptions, values, and beliefs about the world. It is the fore-structure that is the starting point of interpretation and influences the direction the process proceeds. In the process of arriving at a mutual understanding, interpretations are offered tentatively and changes are made as the text informs the reader. The constant task of interpretation is to be informed by the text. According to

Gadamer, the reader is unable to move out of his or her horizon to an external, objective position.

The text also has a horizon comprised of presuppositions, assumptions, and values. Understanding results from the fusion of the reader's horizon with the text's horizon. The interpretation which results from the fusion of horizons is a product of mutual collaboration, and co-construction. The interpretation never remains fixed or stable for long because the process of fusion is continually going on as the person interacts with the text and the world as a whole. The hermeneutic process or conversation can be shut down when one of the parties refuses to let the other inform his or her fore-structure and the emerging interpretation. The conversation between reader and text has been described as a dialectic of question and answer with questions taking a central role in the process of co-constructing an interpretation. The interpretation does not represent an understanding of the text in an absolute, objective sense, rather the interpretation is a product of the context bound interaction between reader and text. Hermeneutic reflection never loses sight of the reader's own situatedness within the world and the influence of context on the process of interpretation. The process of hermeneutic reflection results in the reader constructing new understandings of self, as well as the co-constructed understanding resulting from the interaction between text and reader.

Adult Cognition as a Supplement to Gadamer

Within the field of adult development, there has been a growing number of researchers who have attempted to answer the question, "does cognition continue to develop through qualitatively different stages across adulthood?" (Kramer et al., 1992). In an attempt to address this question, many researchers (Basseches, 1984; Benack & Basseches, 1989; King & Kitchener, 1994; Kitchener & King, 1981; Kitchener, King, Wood, & Davison, 1989; Kramer & Woodruff, 1986; Martin, Silva, Newman, & Thayer, 1994) have drawn upon Perry's (1970) foundational study on the development of epistemic and ethical assumptions among college undergraduates. Presumably following Perry's (1970) lead, one of the trends which has emerged in the literature is

an apparent reliance upon Piaget's proposition that the different stages of cognitive development can best be understood by examining the underlying epistemic assumptions of each stage of development (Labouvie-Vief, 1992).

Some researchers have answered the question in the affirmative by drawing upon their own empirical work which suggests that there is indeed a qualitatively different stage of cognitive development than that of formal operational thinking (Basseches, 1984, 1989; Benack & Basseches, 1989; Kramer & Woodruff, 1986). These researchers have relied upon the evidence which indicates that as adults age, they tend to believe a different set of epistemic assumptions and display a corresponding thinking process distinctly different than the epistemic assumptions and thinking processes associated with adolescence and formal operational thinking. Others have suggested that cognition continues to develop into adulthood, however they have abandoned the notion of a stage model altogether (Charney, Newman, & Palmquist, 1995; Martin et al., 1994; Newman, 1993). As opposed to a stage model which implies that people function according to a predominant set of epistemic assumptions, Charney et al. (1995) and Newman (1993) have found that persons operate from an epistemological style which may be comprised of elements of different and seemingly incompatible epistemologies. According to Charney et al. (1995), different sets of epistemic assumptions develop in parallel fashion, mixing together in varying concentrations to form epistemological styles.

Recently King and Kitchener (1994), drawing upon previous research (Kitchener & King, 1981; Kitchener et al., 1989), have suggested that cognition does develop in a series of stages through adulthood, but that their Reflective Judgment model refers to a different intellectual domain than Piaget's formal operations. King and Kitchener (1994) have developed a stage model for the domain of ill-structured problems or problems that involve uncertainty as opposed to the domain of logical problems. Reflective judgment is considered to be a distinctly different thinking process than hypothetico-deductive reasoning processes (King & Kitchener, 1994). Solving ill-structured problems requires a different set of epistemic assumptions than the assumptions required for solving logical problems (King & Kitchener, 1994).

Reflective thinking, as represented in stages six and seven of King and Kitchener's (1994) model, refers to a judgment process based on the active constructive process of the knower and the assumption that knowledge is uncertain and must be understood in relationship to context. Alternative perspectives and interpretations from a variety of sources are considered and incorporated into the judgment process. According to King and Kitchener (1994), ill-structured problems force the person to search for shared meanings across contexts. Judgments are offered tentatively with the understanding that new information, experiences, and perspectives often lead to new constructions.

Baxter Magolda's (1992) description of contextual knowing is similar to King and Kitchener's (1994) reflective thinking and Gadamer's hermeneutic approach and provides further evidence of the viability of a contextual framework for clinical judgment. Contextual knowing refers to a judgment process based on the assumption that knowledge is context bound and thus, judgments are situated in particular contexts and are not transferable to different situations. Judgments continuously evolve based on new information and new contexts. The knower is viewed as an active constructor of knowledge with the task of integrating the ideas and opinions of others with their own. The phrase "self-responsibility within community" (Baxter Magolda, 1992, p. 188) refers to judgment being completely dependent on existing knowledge and context.

King and Kitchener (1994) and Baxter Magolda (1992) do not emphasize the co-constructive or social constructionist (Gergen, 1985) nature of the judgment process as much as a hermeneutic conceptualization. However, reflective thinking and contextual knowing processes do reflect a contrast to the mechanistic assumptions of the traditional approach to clinical judgment. Judgment as defined by reflective thinking or contextual knowing is not solely an isolated, intrapsychic process based on the independence and objectivity of the knower. Both King and Kitchener (1994) and Baxter Magolda's (1992) descriptions include the idea that there is a social, communal, and contextual element to the judgment process, and thus offer support of Gadamer's (1960) assertion that interpretation is an interdependent and relational process between

knower and known. The fusion of the horizon of the knower with the horizon of the known results in an integrative judgment.

Application of Gadamer's Hermeneutic to Clinical Judgment

Clinical judgment within a hermeneutic framework no longer focuses primarily on the internal subjective processes of the clinician. The advantage of the hermeneutic approach is that it moves beyond the internal subjective processes of clinicians and conceptualizes judgment as an interactional, relational, co-constructive process. Thus, judgments are dynamic concepts rather than static objective truths. A hermeneutic framework incorporates the concepts of heuristics and biases from the traditional approach such that heuristics and biases are conceptualized as a part of the clinicians' horizon. Clinical judgment becomes a process of fusing horizons through conversation in which the judgments of the clinician remain open to change, are offered tentatively, and are constantly being informed and confirmed by the client. Since judgments are dynamic, clinical judgment is no longer conceptualized in terms of predictive or diagnostic accuracy. Judgment is something that occurs *between* clinician and client, and thus is based on the socially constituted nature of knowledge (Gergen, 1985). Judgment is not the product of building and testing hypotheses, rather judgment is the result of an active, cooperative effort between persons in relationship (Gergen, 1985).

Psychotherapy within a hermeneutic framework reflects the practical implications described earlier (Amundson et al., 1993; Anderson, 1996; Gonzalez et al., 1994; Hoffman, 1990; Loos & Epstein, 1989; Mahoney, 1988; O'Hanlon, 1993). Psychotherapy becomes a collaborative process of co-constructing problems and solutions out of a genuine stance of curiosity, not-knowing, and a willingness to learn. In a hermeneutic psychotherapy, questions become the primary means of generating alternative knowledge. Both client and clinician are understood to exist in a particular context and the influence of this context on the judgment process is reflected upon and made aware. No longer is context limited to the family as it was with the "second wave" psychotherapies, "third wave" psychotherapies include conceptualizations of clients, problems, and solutions which recognize the influence of the larger social

context on the therapeutic process (O'Hanlon, 1994). In a hermeneutic approach, validity is not determined by the degree of correspondence between clinician judgment and an objective standard, rather validity is a matter of pragmatic utility. Validity of a clinical judgment is determined by the co-constructed answer to the question "is the client experiencing resolution of the presenting concern?"

Statement of the Problem

There is a significant absence of a research focus on clinical judgment in the field of marital and family therapy and a need for an alternative conceptual framework based on contextual assumptions. Psychotherapy practices, referred to in this review as "third wave" psychotherapies, are beginning to reflect the philosophical shift which is taking place in different disciplines simultaneously. Disciplines such as adult development (Josselson & Lieblich, 1993, 1995); literary and art criticism, hermeneutics, philosophy, and history (Bontekoe, 1996); as well as education (Slife & Williams, 1997) have incorporated the philosophical assumptions of contextualism into their broader intellectual practices and discourse. However, the research area of clinical judgment has been slow to integrate the various post-modern assumptions into its practices and discourse. Holt (1988) and Sarbin (1986) were ahead of their time in terms of adopting the philosophical assumptions of post-modernism and applying them to clinical judgment. This dissertation represents another step toward incorporating contextual assumptions into the conceptualization of clinical judgment, and an initial step toward conducting clinical judgment research based on contextual philosophical assumptions.

CHAPTER III

METHODS

The method utilized in this dissertation was driven by the research question, "how do marriage and family therapists arrive at a problem definition during the first session of therapy?" The question was essentially one of describing the judgment process of clinicians. A qualitative methodological approach, in particular a grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1990), was used because of the appropriateness for research questions which are process oriented (Rafuls & Moon, 1996). Furthermore, since the research question was open-ended, broad, and exploratory, grounded theory methods allowed for additional research questions to emerge and become refined and more focused as analysis occurred (Rafuls & Moon, 1996). The research question was exploratory because a process view of clinical judgment based on contextual philosophical assumptions is absent from the research literature. Grounded theory methodology was used because of the appropriateness for generating an inductive tentative theory in an area where there has been an absence of systematic study (Rafuls & Moon, 1996).

Role of the Researcher and Related Concerns of Validity

In grounded theory approaches, the researcher becomes the primary instrument of data collection and analysis (Strauss & Corbin, 1990). It was vital, for this researcher, that the method reflect the researcher's own philosophical assumptions and the assumptions of the alternative paradigm which has been tentatively offered for conceptualizing clinical judgment. Grounded theory has been categorized as post-positivist and contextualist because it shares the following three assumptions of contextualism: (1) realities are constructed; (2) knower and known are interactive and inseparable; and (3) adherence to method does not guarantee bias-free research, in fact all research is bias-based (Guba, 1990; Rafuls & Moon, 1996).

Consistent with qualitative methods as a whole, and consistent with this researcher's own assumptions, making one's preconceived ideas and assumptions overt

and explicit is fundamental to the validity of grounded theory approaches (Rafuls & Moon, 1996). In essence, what has been written in Chapters I and II of this dissertation has already been an attempt to make my preconceived ideas and assumptions explicit. A problem for therapists-as-qualitative researchers is that they already have a sense of clinical phenomena because of their previous clinical experiences with and exposure to the phenomena (Chenail & Maione, 1997). Two methods which have been suggested to manage the validity problem of having the researchers' preconceived ideas and assumptions force data into pre-existing categories and theoretical frameworks were used in order to enhance the validity of this study.

First of all, the process of bracketing has been suggested as a way to enhance validity. Bracketing is derived from phenomenological and hermeneutic approaches to qualitative research. Recall the hermeneutic assumption that therapists, and in this case therapist-researchers, approach a phenomenon with a horizon or fore-structure already in place and that this fore-structure is the starting point of interpretation or research. Bracketing refers to the process of making the assumptions and preconceived ideas of one's fore-structure explicit (Knaack, 1984). By making one's fore-structure explicit, the themes or categories, and theory which emerge from the data can be compared and contrasted with the pre-existing assumptions and ideas of the researcher. In doing so, I was able to determine where the emergent categories and theory diverged and converged with my own previously implicit categories and theory about the phenomenon. Bracketing also allows the reader of the study to adopt the viewpoint of the researcher and determine whether the descriptions and interpretations offered are consistent with the data. It should be noted that bracketing does not mean that by making one's fore-structure explicit that research becomes bias-free. Bracketing is simply one way of providing a reader of the study with a context for making sense of the researcher's initial understanding of the phenomenon and the assumptions which guide the research process.

A second means of enhancing validity concerned the use of self-reflexivity (Chenail & Maione, 1997) on my part throughout the research process. Within the context of this study, the reflexive component was incorporated into the memo writing

process of the grounded theory approach. The reflexive component focused on my reflections of my own experience with and understanding of the phenomenon, my sense of the participants' understanding of the phenomenon, and my own sense-making process concerning the study itself (Chenail & Maione, 1997). According to Chenail and Maione (1997), "As researching therapists begin to make sense of the data which is generated from the study, they will then carefully juxtapose these new sense-makings of theirs with those they had previously constructed of the phenomenon" (p. 3). The process of juxtaposing new sense-makings is similar to the process of bracketing where the researcher compares and contrasts the emerging categories with his or her pre-existing ideas and assumptions. Essentially what Chenail and Maione (1997) have suggested is that the bracketing process, which usually takes place at the outset of the study, continue throughout the course of the entire research process.

Reflexivity has become a central tenet of feminist (Fonow & Cook, 1991), phenomenological (Boss, Dahl, & Kaplan, 1997), and ethnographic (Hertz, 1996) approaches to qualitative inquiry. Reflexivity is necessary because of the assumption that researchers are active constructors of knowledge and not passive, objective participants in the research process (Hertz, 1996). Through the process of reflexivity, the self of the researcher is included in the research process. Reflexivity allows the researcher to become more aware of how preconceived ideas and assumptions impact all aspects of the research process (Hertz, 1996). Thus, the process of reflexivity enhances validity by allowing the researcher to be aware of how emerging categories from the data may be forced into pre-existing categories and assumptions throughout the research process.

Self-Reflexivity

Before describing the data collection and analysis processes, I want to illustrate the process of self-reflexivity and provide a brief description of my experience during the data collection and analysis phase of the dissertation. First of all, there were some pragmatic constraints that I ran into which were not anticipated. I had a much more difficult time recruiting participants than I had initially expected. In fact, a couple of

sites which were to provide participants fell through for a variety of different reasons. Additionally in order to recruit some of the participants, I had to go through another Human Subjects Committee approval process which was extremely time consuming and at times frustrating. The pressure to try and recruit participants actually became counterproductive to the analysis process at one point as I experienced discouragement and a loss of motivation to move forward with the dissertation.

A second issue that came up during the analysis phase was early saturation of categories and the influence of preconceived theories on the analysis process. I did have a difficult time coding the first two observations/interviews because of a rigid adherence to the grand dichotomy of contextualism and mechanism I proposed in chapter two of the dissertation. I was essentially trying to fit the observations and interviews into the dichotomy. Thus, I made a shift in the way I conducted the analysis of the interviews by separating my prior knowledge from the coding process. The shift was made possible by moving away from the labelling and relabelling of line-by-line and paragraph-by-paragraph codes to thinking about the initial research question. In an attempt to more clearly conceptualize the process of clinician judgments and to organize the codes in a manner consistent with a process conceptualization, I began mapping the codes by drawing circles and arrows. Mapping helped me to not think so much in terms of the dichotomy, but more in terms of the process I was observing from the sessions and hearing in the interviews. I also began utilizing the observation data more than I was initially using and this also allowed me to think more about the process occurring during the sessions. I really felt that from that point on, the coding phase began to be less connected to my preconceived theories and more connected to the observation/interview data.

I was also able to make a shift in the way I approached the coding of the interviews by reflecting on my own process of making sense of the interviews. As I coded the interviews and reflected on the sessions, I became aware of the possibility that my interpretation process of the interviews and the therapists' judgment process of the clients during the therapy sessions were paralleling each other. It seemed as though the therapists' judgment process and my coding process were isomorphic to one

another. I thought about what was influencing my coding of the interviews and realized that similar factors such as preconceived theories, fundamental assumptions, personal experiences, previous clients I had worked with, as well as other factors were all playing a role in the way I made sense of the interviews. Reflecting on my judgment process of the interviews gave insights into how to conceptualize the judgment process of the clinicians. The insights enabled me to think in terms of process and assisted with the diagramming of the different judgment processes.

At this point, I want to highlight two memo excerpts to demonstrate the care with which I considered the issue of validity and clarify my concern that readers might perceive that pre-conceived theories may have been too influential in the coding process.

> (January 17, 1998) I think I now understand what Chenail and Maione (1997) were talking about when they mentioned that a problem for therapists-as-qualitative researchers is that they already have a sense of the clinical phenomena under study beforehand because of their previous clinical experience and exposure to the phenomena. What I am experiencing as I code the interviews is a difficulty separating my prior understanding from the process of interpreting the observations/interviews. I keep finding myself thinking about my own clinical experiences and how I have made sense of those experiences already. When I wrote chapter two I was really trying to make it clear what my prior understanding was in an attempt to not allow my understanding to influence the coding process. Perhaps there is a different way to approach the coding of the interviews which moves me away from the influence of my preconceived understanding ...

It was at this point that I began the mapping process to which I have already alluded. The excerpt illustrates that not only was the concern present when I wrote my proposal last summer, but my concern was present through out the coding process. As the next excerpt indicates, part of the shift that helped me to separate out my prior understanding from the coding process occurred when I began to reflect on my own process of interpreting the observations/interviews. I believe that mapping and reflecting on my own "judgment" process, that is to say equating coding with judgment formation processes, helped me move away from allowing prior understanding to influence the coding process.

(February 7, 1998) What is my "impression" formation process? How is my "judgment" about this clinician's process formed? My sense of this therapist is that the therapist views (him/herself) as the expert. Which I guess is my "judgment." That sense comes from the observation where the therapist said comments directly and to the point, and used a lot of "pathology" oriented language. I felt like the therapist was pretty distant and intentionally used a lot of silence to get the clients to talk. I'm using observation of therapist behavior; contrasting/comparing the therapist's behavior with my preconceived notion of a non-expert stance; my emotional experience of being in the room, ie: uncomfortable with the therapist's questions and style of questioning and my feeling distant from the therapist as we interacted during the interview; and listening to content. It seems that the process of clinical judgment is isomorphic to my process of forming judgments about clinicians' judgment processes. Is there a way that I can use this reflective process or isomorphic process to inform my coding of the observations/interviews? Is this consistent with a grounded theory method? I'm not sure. Sometimes I feel like the "method" keeps getting in the way of my process of making sense of the observations/interviews.

Some of this debate about the influence of prior understanding in research coding practices parallels the debates in the therapy literature about a "not-knowing" (Anderson & Goolishian, 1988) stance. A "not-knowing" stance in therapy means that the therapist asks questions out of a curiosity and desire to understand the client's experience. A "not-knowing" stance does not imply that the therapist has no knowledge or expertise in how to solve problems or help clients. A "not-knowing" stance means that the clinician is guided by an informed curiosity. The questions stem from knowledge and expertise gained from years of experience, however there is room for the client to inform and add to the knowledge and expertise of the clinician. The clinician desires to learn from the client. I feel as though I went into the coding process with a "not-knowing" stance. The questions, as well as the labels, categories, and connections between categories were constructed by an informed curiosity. I believe it is impossible to be a "blank slate" and believe that prior understanding influenced the coding process. My hope is that, consistent with the process of "bracketing," readers will be able to discern how prior understanding did and did not influence the coding process (Knaack, 1984).

A third issue which emerged during the data collection and analysis phase was the question of how far to pursue and explore existing categories. I struggled with

pursuing some of the existing categories because it felt like they were taking me away from my initial research question. There were categories I could have pursued further, but they weren't necessarily a part of my initial research question. Part of me believed that the pursuit of these categories would be a never ending process. I think what was happening, and I think I understand this as inherent within the qualitative research process, was that other research questions were emerging from the coding process. For example, there appeared to be two clinician judgment processes at work during therapy sessions. The one process involved the therapist's moment-by-moment interaction and experience while with the client and the other process involved a detached, reflective "theorizing" of what was taking place during therapy. I believed that as far as my initial research question was concerned, it was the moment-by-moment process that I was most interested in trying to describe and understand. Pursuing the reflective process would have moved me into another research question. I feel that additional observations/interviews would have enhanced my conceptualization of the reflective process, however the pursuit of the reflective process was not directly answering my initial research question. I had an understanding of how the reflective process fit with and related to the moment-by-moment process so that the reflective process enhanced my understanding of the moment-by-moment process, but I remain unclear about the details of the reflective process.

As far as the initial research question about how marriage and family therapists make decisions during therapy sessions was concerned, theoretical saturation was obtained. Theoretical saturation did not occur as far as the reflective process was concerned. Nor was theoretical saturation obtained with the third process which also emerged from the coding process. There appeared to be a developmental process at work such that the "theorizing" component of the reflective process became integrated into the moment-by-moment process of more experienced clinicians. In other words, "theorizing" was not a conscious, overt process during the therapy sessions, rather for more experienced clinicians theoretical reflections have become a part of who the therapist is in the room with clients. Thinking about theory while with clients appears

to have been something the clinicians did when they were just beginning their development as therapists. Similar to the reflective process, the details of the developmental process remain unclear at this point in time. Further exploration of the developmental process is another research question which is distinct from the initial research question of this particular project.

Sampling and Selection

Sampling involved the use of criterion-based selective sampling at the beginning of the study and theoretical sampling as the study progressed (Rafuls & Moon, 1996). Criterion-based selective sampling or purposive sampling originated from the guiding assumptions of the researcher and the initial research question (Rafuls & Moon, 1996). The research question required that the participants be marriage and family therapists. Pragmatic issues such as access to a sample of marriage and family therapists and opportunities for observation led to a selection of a convenience sampling of marriage and family therapists. The convenience sample consisted of doctoral students in Texas Tech University's marriage and family therapy program and practicing marriage and family therapists located in and around Chicago, Illinois.

Two guiding assumptions also determined the criterion-based selection of marriage and family therapists. First of all, I believe that persons are self-observers (Knaack, 1984) and interpretive beings (Anderson & Goolishian, 1988). This is essentially a constructivist assumption (Mahoney, 1988) which suggests that people actively construct reality or actively make sense of their experiences. As a marriage and family therapist, I have engaged in an active sense-making of my own clinical judgment experiences and found that other marriage and family therapists participated in a similar process. Furthermore, participants were able to describe their process. A second assumption was that marriage and family therapists engage in an active process of diagnosis or sense-making of client experiences. Since either explicitly or implicitly all models of marriage and family therapy have something to say about the process of diagnosis, problem definition, or the sense-making of client experiences (Gurman & Kniskern, 1991; Nichols & Schwartz, 1991), I believed that therapists used

of a particular model's explanatory system or their own explanatory system for making sense of client experiences.

Theoretical sampling refers to the selection of participants throughout the course of the study in an attempt to saturate emerging categories (Charmaz, 1983). Saturation refers to the point in the data collection and analysis process in which incidents of a particular category become repetitive and further data does not elaborate upon a category's meaning or definition (Charmaz, 1983; Turner, 1981). Since pragmatic concerns of finishing the dissertation in a timely manner and the exploratory nature of this study were of real issue to the researcher, the sample size was set at twenty participants. However, since saturation of categories can occur with as few as six participants (Searight & Young, 1994), I was open to the possibility that saturation may occur before I had collected data on twenty participants. Theoretical sampling occurred as the study progressed with an awareness of and open-ness to the saturation of categories. In fact, saturation of categories was obtained with ten participants.

Consistent with a grounded theory approach, all potential participants were contacted by letter (see Appendix A) and then followed-up with conversations to arrange for observation and interview sessions. Participation was voluntary and there was no penalty for not participating or withdrawing from the study. At the time of the observation and interview, participants were given and asked to sign a consent form (see Appendix B). There was no monetary or other forms of incentive for participating in the study.

Data Collection

Fundamental to the grounded theory approach is that data collection and data analysis proceed simultaneously (Charmaz, 1983). Thus, while the descriptions of the two processes offered in this paper are in two separate sections, the distinction is artificial since the two processes are intertwined. Consistent with a grounded theory approach, multiple sources of data collection were obtained in this study from observation of face-to-face interaction and semi-structured interviews (Turner, 1981). In fact, the use of multiple sources of data collection was an additional

way of enhancing the validity of the study (Maxwell, 1996). Multiple sources of data or triangulation reduces the risk of relying solely on one perspective when collecting data which leads to limited understandings of a given phenomenon. Triangulation requires that multiple perspectives of a phenomenon be obtained. Thus, triangulation allowed me to gain a holistic sense of the phenomenon and prevented myopic understanding.

Data was gathered through the use of a peripheral membership observational role (Adler & Adler, 1994). Even though I had membership as a marriage and family therapist, my role was peripheral because I did not participate directly in the therapy process. In fact, two of the observations of therapy sessions took place from behind a one-way mirror. Since the consent form used in the Family Therapy Clinic (see Appendix C) required clients to give consent to be observed by doctoral students in marriage and family therapy for the purposes of research and training, a separate consent form for clients observed during the course of data collection was not necessary for clients observed in Texas Tech University Family Therapy Clinic. Clients were told that a doctoral student was observing the session from behind the mirror and given opportunity to meet the researcher. The procedure followed the common procedure of the Family Therapy Clinic whenever students or faculty observe a session. The focus of the observation was on therapist-client interaction and the diagnosis process of the therapist.

For observations conducted in Illinois, observation took place while I participated as a "silent student-observer" during the therapy session. Clients who were a part of the observational procedure were given a consent form (see Appendix D) and told that my role as "student-observer" primarily involved observation of the interaction between the therapist and the client and the problem definition process of the therapist.

The data collection process proceeded through three phases. Initial observations of therapy sessions were descriptive, unfocused and general (Adler & Adler, 1994). The second phase of the observation process, which has been labeled "focused observation," involved focusing more clearly on the key process being studied (Adler & Adler, 1994, p. 381). Finally, during the "selected observation" phase of data

collection the elements of the process and the relationship between elements were clarified and refined (Adler & Adler, 1994, p. 381). Detailed field notes were kept of the observations throughout the data collection process.

A second purpose of the observational data collection procedure was to provide a context for the semi-structured interview which followed the observation (Adler & Adler, 1994). During the observation, questions were constructed which were then asked immediately following the observation as a part of the interview. Observing the therapy session allowed for questions such as "how did you decide to take that specific course of action?" or "what made you decide to ask that specific question?" with reference to the actual course of action or question asked during the session. The questions focused on the problem definition process observed during the session and got at factors and processes utilized by the clinician in making a judgment concerning diagnosis, or the sense-making process. It should be emphasized that the questioning process was done from a stance of curiosity or "not-knowing" (Anderson & Goolishian, 1988). Questions were asked to gain an understanding of what clinicians were experiencing during the session when they posed certain questions, made a suggestion or offered an interpretation to their clients. Questions were not asked in an attempt to confirm or support my pre-existing ideas on the topic of clinical judgment. I was motivated by a desire to add to and change my pre-existing knowledge of clinical judgment.

The first session of therapy was observed because of the prevalence with which the majority of marriage and family therapy models describe the first session of therapy as the session in which the therapist begins to develop hypotheses concerning the nature of the client's problem (Gurman & Kniskern, 1991). While the language may take on different forms depending upon the therapy model, most models incorporate some notion about the therapist's developing a sense of what it is that brought the client into therapy. Strategic approaches (e.g., Haley, 1976), the MRI brief therapy model (e.g., Watzlawick, Weakland, & Fisch, 1974), and structural approaches (e.g., Minuchin, 1974) are overt in their emphasis on the developing of a problem definition in the first therapy session. Narrative approaches (e.g., White &

Epston, 1990), solution-focused brief models (e.g., Walter & Peller, 1992), experiential approaches (e.g., Whitaker & Keith, 1981), and the intergenerational models (e.g., Bowen, 1978) are more implicit with which they describe the task of the first therapy session as the session in which problem definition takes place. Detailed analyses of therapy models has revealed that every model contains assumptions and presuppositions about diagnosis in one form or another (Nichols & Schwartz, 1991).

A second reason for the selection of the first therapy session for observation stemmed from my own experiences as a therapist and observations made while a doctoral student participating in practicum training experiences. I know that I begin to develop ideas about client experiences which may have brought them to therapy during the first session and have observed that other therapists pose questions and make statements which indicate that they indeed were forming ideas about what brought a client to therapy and how they might in turn be able to provide therapy for their client.

Semi-structured in-depth interviews, which ranged from one to two hours in length, were also used to gather data on the judgment process of clinicians. In accordance with grounded theory methods (Glaser & Strauss, 1967; Strauss & Corbin, 1990), the interviews were audio-taped and transcribed verbatim. Open ended questions were asked to invite participants to share their experience of the therapy session. Initial questions consisted of "what do you think was most important about the session today? and why?", "what ideas do you have about what is happening in the life of this client? and how did you arrive at that determination?", "what do you think brought the client in for therapy? and how did you determine that?" Appropriate cues such as "could you say more about that?" and "could you give me an example of that?" were utilized to assure that the interview was as concrete as possible. Asking for examples, asking open-ended questions and questions about experience assured that the interview had a storied nature. Questions derived from the observational procedure were included in the interview as appropriate cues after the initial open-ended question had been asked. Following the interview, clinicians were asked to fill out a demographic questionnaire (see Appendix E).

Data Analysis

Data analysis of the field notes and transcriptions followed Charmaz's (1983) interpretation and application of Glaser and Strauss' (1967) data analysis procedures. According to Charmaz (1983), the data analysis process consists of coding and memo writing. Coding is the initial phase of the analysis process and refers to creating categories, and sorting and organizing data through a process of interpretation. Grounded theorists also code for processes and assumptions asking such questions as "what are people doing? what is happening?, what kind of events are at issue here? how are they constructed? and what do these events mean?" (Charmaz, 1983, p. 112).

The coding process was divided into two sub-processes. Initial coding involved searching the data and attaching labels to lines or paragraphs of the data. Line-by-line coding (Charmaz, 1983) and paragraph-by-paragraph coding (Turner, 1981) were used for initial coding. Following Turner's (1981) lead, I asked questions such as "what categories, concepts, or labels do I need in order to describe the phenomena discussed in the paragraph?" (p. 232). At times, I constructed the labels whereas at other times I used the words of the participant, as long as the code described the data at a concrete level. The process of comparing pieces of data with each other for their similarities and differences also helped me construct codes.

Focused coding, in contrast to initial coding, moves the coding process to a conceptual and abstract level. When conducting focused coding, the researcher is no longer summarizing data, rather the researcher is constructing conceptual categories which subsume earlier codes, and/or develops subcategories. Occassionally an initial code was re-coded to represent a broader concept, however most often an initial code became a part of a category which was abstract enough to subsume it as well as other initial codes. Focused coding involved identifying properties of categories such as defining its characteristics and demonstrating the conditions under which it occurred. Existing research literature was used to generate further questions to ask of the data and as a source for comparison which helped interpret the data (Charmaz, 1983). Focused coding also involved searching for and explicating relationships and

interconnections among categories in an attempt to describe the clinical judgment process.

Data analysis also involved memo writing. Memos are written elaborations of ideas about the data and takes place while coding is being conducted. Memos tell what the codes are about by defining them at an abstract and theoretical level. Writing memos occurred at every point that I had an "ah-ha" experience about the data, theory, method, and included personal feelings and reactions. I took the categories and wrote about whatever ideas I had about the code. I also described the category and explained how it was or was not related to other categories. After writing the memos, and rather than sorting the memos, I began mapping the categories in an attempt to describe the clinical judgment process. Sorting is usually the point in the process where researchers place the memos into the phases of the process being analyzed. However, as I stated earlier, I was having a difficult time separating pre-conceived ideas from the coding process and found mapping to be more helpful than simply verbally describing interconnections among categories and sorting the memos. The last phase of the data analysis process involved integration. Integration involved writing memos which described the relationships between categories revealed through the process of mapping.

Data analysis can be thought of as consisting of two levels of analysis which include description and explanation (Strauss & Corbin, 1990). Following integrative memo writing, I had a description of the categories and their inter-relationships (Strauss & Corbin, 1990). Consistent with the goal of theory development or explanation, existing literature was integrated with the emerging description of the judgment process. The emerging description was compared with existing theories, as stated earlier the hermeneutic literature and the theoretical descriptions of clinical judgment offered in chapter two, for aspects of confirmation and contradiction (Martin & Turner, 1986). Because theoretical saturation occurred in this particular study, the data analysis process ended once categories and the relationship among categories had been explicitly described and a tentative, explanatory model had been constructed.

CHAPTER IV

FINDINGS

What is presented in this chapter is a description of the moment-by-moment processes which emerged during the analyses of the observations/interviews. Descriptions of the reflective and developmental processes are also offered in order to supplement the understanding of the moment-by-moment processes.

Descriptions of the Moment-by-Moment Processes

The moment-by-moment process is conceptualized as meta to the individual decisions that therapists made. The entire realm of possibilities for individual decisions of therapists has not been exhausted, and may not even be possible because of the number of contextual variables at work in any given session. Descriptions of a number of different individual decisions were obtained during the analysis phase, however not every decision will be presented in this chapter. What will be presented are descriptions of the meta process level of each decision which represents a different combination of categories at the meta process level. In other words, what is presented here is a picture of the meta process which is similar across decisions while the individual decisions within that process remain unique.

Coding of the observations/interviews revealed that there were two meta processes occurring during the moment-by-moment interaction between therapist and client(s). The first meta process that emerged from the coding process was a process in which the clinicians' judgments remained internal to the clinician. The judgment process was an internal process that was not brought forth or made overt during the therapy session. In contrast, the second meta judgment process which emerged from the coding of the interviews involved clinicians making overt their internal judgment process and incorporating that process in the therapeutic conversation with clients. The judgment that evolved in the second process was an interactional judgment which was created in the conversation between therapist and client(s).

Figure 1 is a composite of each of the individual judgments made by clinicians, both internal judgments and conversational judgments, and represents how the three categories of elements influenced the judgment processes. In the diagram, clinicians are represented by the circle on the left and the client(s) by the circle on the right. The label fore-structure represents what is in place within a clinician's internal judgment process prior to a clinician's interaction with clients. The category included: fundamental assumptions about therapy and people held by the clinicians; preconceived ideas the clinicians had about the client(s) or situation before interacting with clients; a prior knowledge base that the clinician carried with him or her which was learned through training and educational experiences; therapists' perceptions of their professional role; and the clinicians' perception of the nature of the referral.

It should be noted that the labels that I ended up using for the categories were borrowed from the hermeneutic literature. The meaning of the labels do parallel the meanings within the hermeneutic literature, however the meanings are not exactly the same. There are clear distinctions and differences between the meanings of the labels used for the categories and the labels used in the hermeneutic literature. The categories are clearly linked to and connected to the judgment processes of clinicians observed during the therapy sessions. The process of utilizing existing literature to expand and clarify codes is consistent with a grounded theory approach (Charmaz, 1983). Despite utilizing the hermeneutic literature to expand and clarify categories, the meanings of the categories were not forced on to the data. In other words, the data were not forced into "correct" interpretations, rather the literature helped clarify the meanings of the codes which remained consistent with and based upon the observation/interview data (Charmaz, 1983).

The term conversation reflects what becomes a part of the clinician's internal judgment process as a result of interacting with the client and what happens between clinician and client. It should be noted that the label conversation does not include the process of questioning and making statements by the clinician and the responses from clients. This circular interaction is represented by separate and distinct arrows on the diagram. The category of conversational process included: the clinician's own

experiences lens which referred to personal experiences which were brought forth as a result of interacting with the client; previous experiences the clinician had with other clients; the clinician's perceptions of the referral incident or reason for coming to therapy; the therapist's concerns about clients' perceptions of the therapist; reading clients' reactions to questions, statements, and the interaction between clinician and client; observing clients' behaviors; observing clients' interact with each other; the therapist's self-perceptions and experience of self during the session; the therapist's emotional experience during the session; the therapist's own professional growth issues; personalizing of clients' experiences; the therapist's desires for change and to be helpful; finding parallels in the popular literature; considering subtle and fleeting thoughts of theory; and the clinician's perceptions of the nature of the therapy contract.

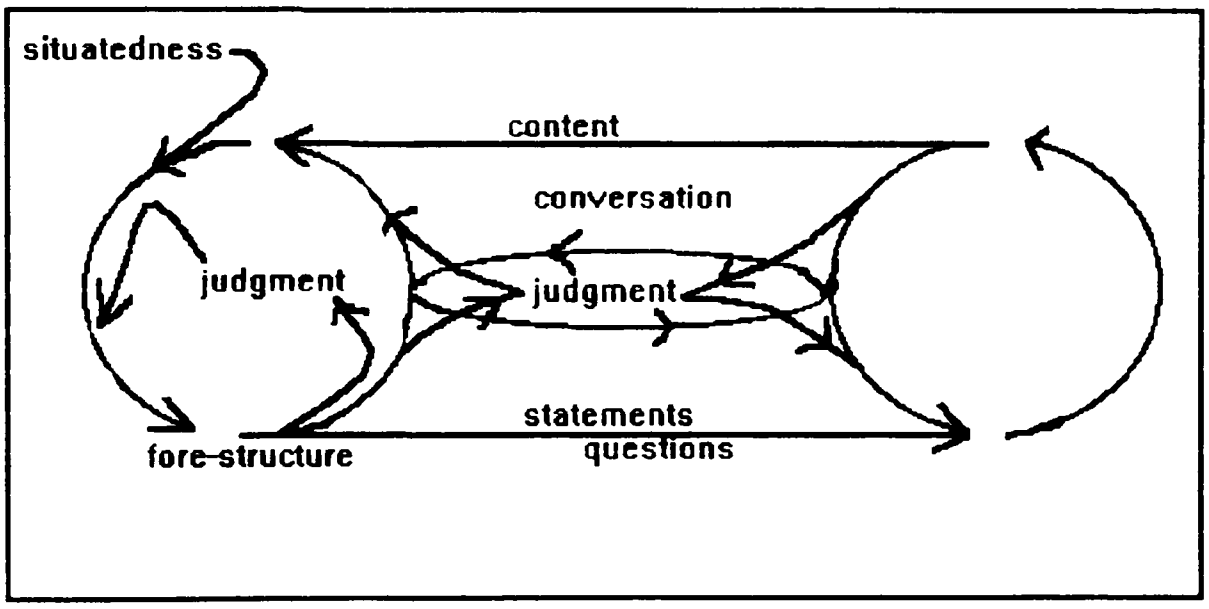

Figure 1
Composite Diagram of the Judgment Processes

The term situatedness represents the larger contextual factors which influenced the internal and conversational judgment processes of clinicians. The category of situatedness included: larger systems or contexts in which the therapy took place such as the court system, community mental health agencies, and hospitals; the physical location of the therapy session; the actual referral incident; the referral process; the referring person or agency and the expectations for therapy that came with the referral; and the nature of the therapy contract.

The same factors or elements may be present within both judgment processes, however within a conversational judgment process the elements are incorporated into the conversational process occurring between clinician and client. Thus, Figure 1 illustrates all the possible combinations of internal judgment processes, as well as all the possible combinations of conversational judgment processes. Throughout the rest of this chapter, examples of internal and conversational judgment processes are illustrated with diagrams and excerpts from the interviews in order to further clarify the processes of clinician judgments.

Descriptions of the Internal Judgment Processes

Figure 2 is a diagram of a particular individual judgment process which symbolizes and is representative of an internal judgment process which utilized the categories of fore-structure and situatedness. As such, the process is representative across individual judgments which involved fore-structure and situatedness. This particular judgment involved the clinician's feeling that the client was "minimizing the problem." The judgment was arrived at through a process of comparison of content being presented by the clients and the clinician's preconceived ideas of the client obtained from a police report that came with the referral. The clinician's fundamental assumption that a child this young should not have an extensive history of police involvement influenced the judgment formation process.

In terms of the situatedness of this judgment, the referral came from the police department and the nature of such referrals is that clients do not have to follow through because there are no consequences for not following through, although its

strongly encouraged. The clinician knowing the nature of such referrals understood that it was out of fear that the family came to therapy because "the police have more power in some peoples' lives than others." Thus given the context of the referral, the clinician determined that it was partially fear and having come to therapy "because the police told them" that led to a minimization of the problem.

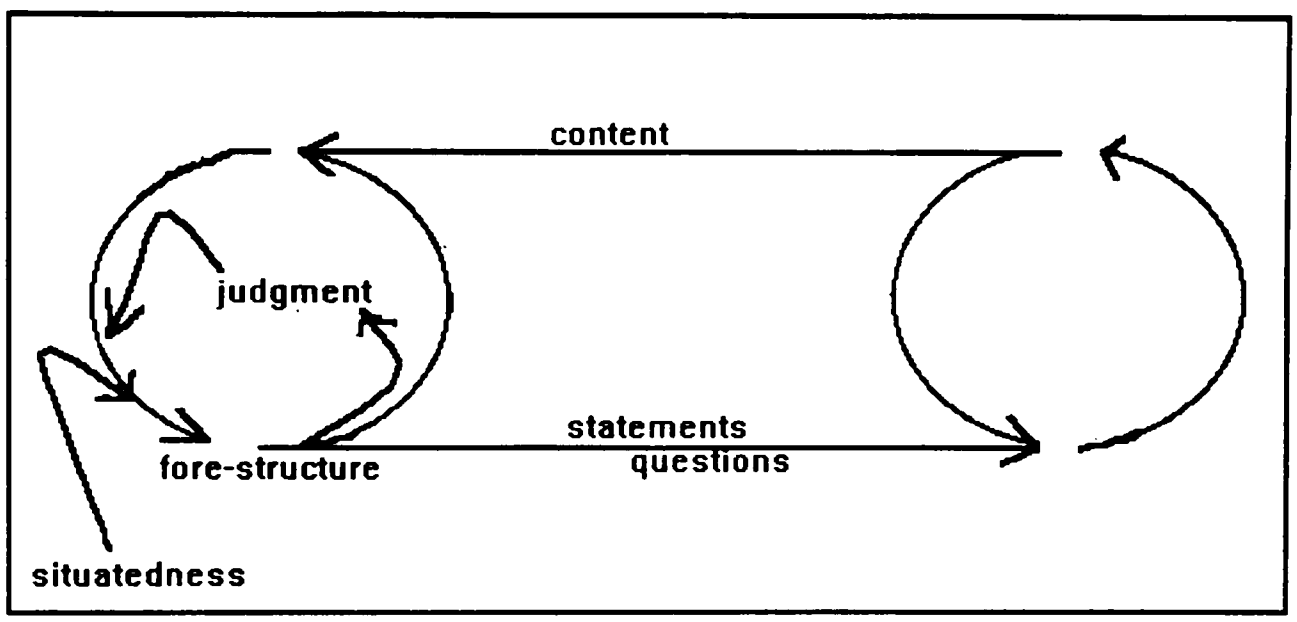

Figure 2
Diagram of the "minimization" Judgment Process

Interview Excerpt

Therapist: I think, part of me just at this point, its fear of the system, of what will happen if they don't follow through because the police told them. I guess I give the credit as the police have more power in some people's lives than others.

Interviewer: What made you think it was out of fear that they were coming?

Therapist: Because even mom said near the beginning when I was first asking, I can't remember what question I asked, I was asking, Oh I asked, she marked on

there about friends and said not so worried about his friends anymore and then she goes "well really this whole thing started with peer pressure" and **I just felt that she was really minimizing the problem** and she was saying there really isn't much of a problem anymore. And so why is she here if she doesn't feel it's a big problem anymore except to follow through with what's been referred or what she's been told.

Interviewer: And that conclusion that

Therapist: that its fear

Interviewer: that its fear or she is minimizing comes from where?

Therapist: Because I know in the report that I got from the police that there has been several priors on this kid like setting fires, stealing several things, and he's only ten and then she says this whole thing started with peer pressure and almost trying to pass it off as, I think she might have even said there's not much of a problem or something like that, and even stuff like "not any more" is like saying its kind of over. But, I already know he has a history and at his age to have a history like that is to me more of a concern than what she seemed to explain.

Internal judgments which included fore-structure often involved some kind of notion that the information that the clinician was getting from the client did or did not fit with the clinician's preconceived ideas about the client, prior knowledge, fundamental assumptions, or perceptions. Judgments which involved fore-structure did not always have negative connotations, as was the case with the previous example. In fact, some internal judgments which included fore-structure were strength or competency oriented. The following excerpt represents an internal judgment process with positive connotations. The clinician sensed that there was a strong connection between the partners and was a bit surprised to find that the way they interacted with each other and the baby contrasted the preconceived ideas the clinician had about the male partner. The preconceived ideas had come from a psychiatric assessment that the clinician had read prior to meeting with the clients. Part of the clinician's fore-structure which also influenced the judgement of connection was the prior knowledge base about a strength based genogram and a pre-determined decision to use this knowledge by looking for strengths in this couple. The situatedness of the therapy

session, in this case a hospital with the referring person being a psychiatrist, helped create an expectation of pathology in the client which was not met during the session.

Interview Excerpt

Interviewer: Was there something in particular you were picking up on that told you there was some connection there?

Therapist: There was just an easiness. With both of them, there was a comfort I thought with each other, in how they held their bodies and how they talked. It wasn't like a couple that came in and there was just intense hostility and overt stuff. And, I think they do get into that, but at the same time I just tried to see what I was sensing from them.

Interviewer: And that was?

Therapist: **I think what I sensed about them mostly was that there was a connection that was strong there**, but they are in a situation that is real difficult, and the stresses on them at that point - from outside, and also from his illness in particular and from her pregnancy - I think that kind of caring could get overwhelmed by all this other stuff.

Interviewer: Do you remember any particular thought or specific thoughts you were having when you said that you sensed that they were being comfortable with each other? Do you know what you were experiencing or thinking about at those times?

Therapist: I noticed her smile somehow. And, I was also thinking that he wasn't acting anything like the stuff I had read about him. So much of the psychiatric evaluation so far has been pathological, and emphasizing the times when he is at his most stressed and the bipolar thing is out of whack, and he is totally out of control and angry and violent, and I think those pieces are there in him. But his presentation was much more mild than I anticipated.

Interviewer: It didn't really match those kind of ideas?

Therapist: No. I had to pay attention to what that was and particularly with him and the daughter, the way he was holding her, there was a sweetness there that I didn't anticipate. And, I think that is why when we started (well part of the reason) with the genogram and trying to emphasize what their strengths were and kind of support things. I had just finished reading the book "In Support of Each Other," a book about families. She is a psychologist in Nebraska, and she has a wonderful section about what therapy can do and one of the things she talks about is the genogram. She has adapted the genogram to where she always includes the

neighbor down the street who is there, who needs someone to call, or the cousin who really is helpful, or the teacher at school, or the baby-sitter. Whatever the support things were, I thought it would be easy for these people to just get lost in the yuck stuff. There was enough bad stuff they were coming in with that I felt like I wanted to find out about strengths and the way they were interacting made me think there were some strengths in there that needed to be considered.

Interviewer: Were you thinking about the book at particular times in the session?

Therapist: I thought about it before I started, as I thought about what I wanted to do. I knew I wanted to start a genogram and as soon as I started thinking about that then I thought of the book, and how I might do that in a way that would sort of be a fuller picture.

This excerpt also included the category of conversational processes in the internal judgment process of the clinician. As the clinician interacted with the client, the clinician experienced an "easiness" with and between the clients. The clinician observed the way the couple interacted with each other and the way the male partner interacted with the child. The clinician also observed the behaviors of the clients in terms of "the way they held their bodies" and noticed that the female partner smiled at one point. Each of these conversational processes emerged into the clinician's awareness during the session as the clinician interacted with the clients. An important aspect of the conversational process is that there is a much more experiential aspect to these factors when compared to the elements which comprise the categories of fore-structure and situatedness. The entire judgment process is experiential and cognitive. However, the categories of fore-structure and situatedness were connected more to internal cognitive processes whereas the category of conversational processes was connected more to the interactional experience of the clinicians as well as their direct sensory experiences of their clients.

Figure 3 is a diagram of an internal judgment process which depicts all three categories and how they influence the judgment process. This particular judgment involves the clinician's impression of a client being "scared or just kind of back." In this case the clinician held a preconceived notion of how a ten-year-old boy would act and when the boy's behavior was contrary to the clinician's expectation, the clinician

got the impression that this client was wondering "OK what's going on?" or "what is this place?" Another element of the clinician's fore-structure which influenced the judgment process was the clinician's fundamental assumption that feeling safe is an important aspect of therapy. This assumption was influenced by the clinician's own personal experiences in which interacting with people the clinician felt safe with enabled the clinician to open up and become less defensive.

Part of the clinician's impression that this client was holding back and frightened by the experience of therapy came from conversational elements such as observing his facial expressions, and observing his behaviors which included "he was more quiet and he just kept his jacket on and just kind of like sitting back in his seat." Additional conversational elements which influenced this particular judgment included the clinician's awareness of previous clinical experiences during the session. Because of the clinician's previous experiences with police referrals, the clinician was able to draw upon previous client's experiences of the referral process and infer some things about this client's experience.

The situatedness of the therapy also played a role in the clinician's judgment process. The clinician had an understanding of the nature of the referral process between the agency and the police department. The clinician knew that there were problems in the way the referrals were handled which potentially could lead to feelings of fear and holding back on the part of clients. Thus, the clinician's fore-structure, the situatedness of the therapy, and the conversational processes which took place as a result of interacting with the clients led the clinician to determine that this client is probably frightened.

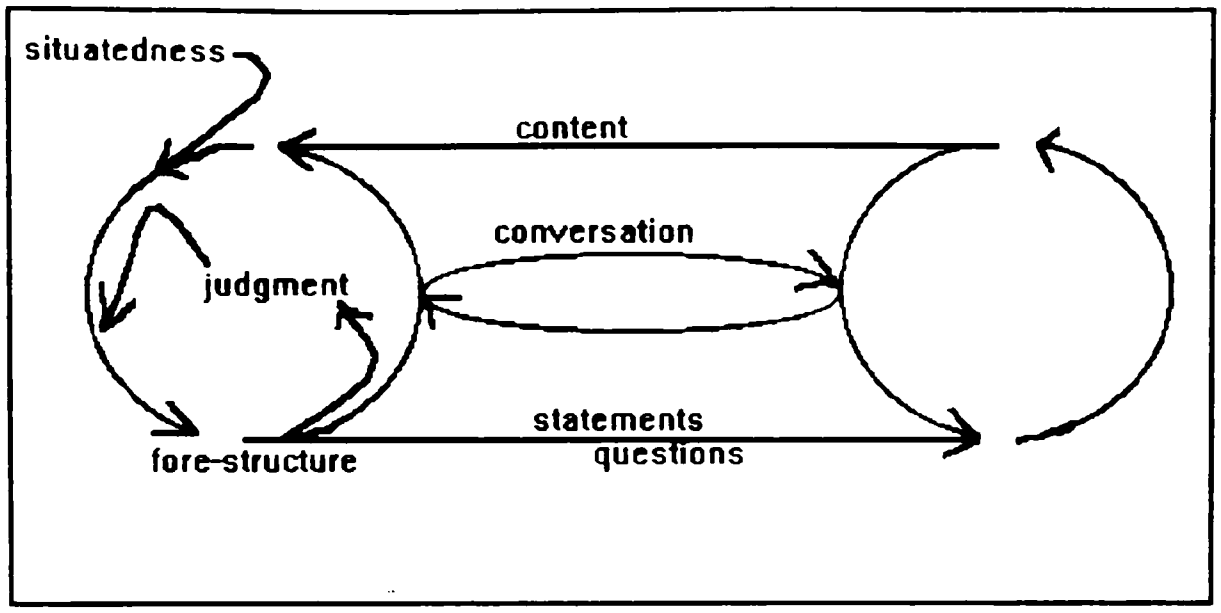

Figure 3
Diagram of the "scared" Judgment Process

Interview Excerpt

Therapist: **I got the impression that he was really, I don't know if it was scared or just kind of back and not really sure what this place was and it just seemed more than shy,** just like I'm here, why am I here kind of thing? and I know I'm in trouble. And so just try to basically establish some rapport with them and make him feel a little more comfortable about being here and talking with me and I felt like I was able to do that even though we only had a half hour, but I didn't want to dive into it.

Interviewer: Were you picking up on something in particular do you think that gave you that impression that he was like "what is this place?"

Therapist: Well, just from, just from the very beginning when I went out to give mom the paperwork and introduced myself and I shook mom's hand and then his hand and introduced who I was. But, just the look on his face, kind of like who is this woman that is shaking my hand and then in the beginning when he was more

quiet and he just kept his jacket on and just kind of like sitting back in his seat, he didn't seem really comfortable like a ten year old would normally be and how I pictured, could have been you know of course there's always just different personalities, but even you had said he came in and asked the date or whatever, that's different from my impression of seeming more "OK what's going on?"

Interviewer: Anything else you might have been thinking about or aware of that made you think that you need to make him feel more at ease?

Therapist: Well, I think the fact that it's a hard referral because its coming from the police station and they just call over or say you need to go there and there's nothing behind it except you just got into trouble so you need to go here. And so those referrals for me always feel a little bit like they don't really, how much do they have to be here? And yet the reason I'm calling is because they got into trouble with the police and so with those referrals I think I feel a little more like I want to join with them even more so because to keep them invested.

Interviewer: Where is that coming from for you? what gave you the impression that these police department referrals are more difficult?

Therapist: Oh, because I'm the one who gets the referrals from the police station when kids are stealing and stuff and there's not a clear set up between us and the police station about how that referral system works. Sometimes I've called and had to say "we got this referral from the police station" and parents haven't been aware of that and then it becomes awkward and so I'm telling them for the first time "well I'm calling cause your kid got into trouble and you need to come to counseling and that's what they're telling you," but they're not even aware of that.

... Interviewer: A couple of things based on what you just said, you mentioned earlier about making this a safe place for them, why is that idea important to you?

Therapist: That's such a big word of mine. Its important because I don't want counseling to be equivocated with the police station and the force out there whose out to find out everything they're doing wrong and punish them for that. And so I guess by making it a safe place and joining with them they have an ally who's able to hear the stuff and be on their side and be a person who can help them think through different situations instead of we have to pretend there's nothing wrong and its all okay.

Interviewer: So making this a safe place, that idea comes from where?

Therapist: It's almost like from my past experiences with other clients, that just seeing how when they first came in they were very skeptical and even just assume I was the system and looking at how that relationship is developed and once they

felt that I was safe and differed from them, then there was change that happened or what we talked about in therapy felt more productive in change but I don't know if that's the only thing, I know that's important in my own life.

Interviewer: In your own life, why?

Therapist: Well to me, I'm always talking about, in my own life its really important to have safe people to talk to about my private stuff and I don't have this big group of people I share everything with, I have a few safe people and there's ways that I know people are safe or not safe and that's definitely a word of mine, if someone can show to be trustworthy and everything then I'm more willing to open up so it probably does come from my own experience and knowing, unless I feel safe I feel much more guarded or defensive and then you can't really get into stuff.

... Interviewer: I guess I'm wondering what makes this is a usual practice for you or why you think using the genogram is important when you first meet with a family?

Therapist: Because I have had really good success with using the genogram as a way to, it's not why are you here and why are you in trouble or where did you screw up? Its kind of an easy way of getting everyone who's there involved and often to get the kids involved where they can give information and I can address some of the questions to them and its not threatening. Its basically whose in your family? and that's not necessarily a scary thing to do. So I have had good success with that as a good warming up, to just asking some questions and its not too big of a deal and its also cool too because I hear a lot of kids say "really I didn't know that" and they learn about their own family by doing this.

... Interviewer: Do you think using the genogram is related to the idea you said earlier about making it a safe place for people?

Therapist: Yes, because it's not a threatening thing to start with so it's like "Okay, this isn't going to be too bad," and if I can get them in that "Okay she's not going to beat me up?"

Each of the illustrations thus far have involved internal judgment processes which have included the clinician's awareness of and understanding of the situatedness of the therapy process. This next example represents an internal judgment process which does not include the category of situatedness. Figure 4 depicts a "parent education/self-esteem" internal judgment process. The clinician held two fundamental assumptions which directly influenced the judgments about the need for parent

education and increased self-esteem in the client. The clinician believed that "history affects parenting ... and we learn to be parent's" by the way we were parented. The clinician's second fundamental assumption was that no matter what type of family we grew up in "we all have issues" with our parents and these issues affect the way we parent. The clinician's fundamental assumptions were supported by the clinician's own life experiences as well as a prior knowledge base of how alcoholic families tended to function. Thus, the clinician's fore-structure provided a frame to compare and contrast information against as the clinician gathered information from the clients.

There were a couple of conversational elements present in this judgment process. The clinician was made aware of previous experiences with other clients as the clinician interacted with this family. A similar process of comparison went on in which the clinician compared the present family's experiences with the previous family's experiences. Similarities and differences between experiences aided in the judgment of parent education and self-esteem as areas to address in therapy. Finally, the clinician drew upon personal experiences which came to mind during the session. The clinician's own experiences served to reinforce the judgment that this parent needed parent education services and increased self-esteem in order to parent more effectively.

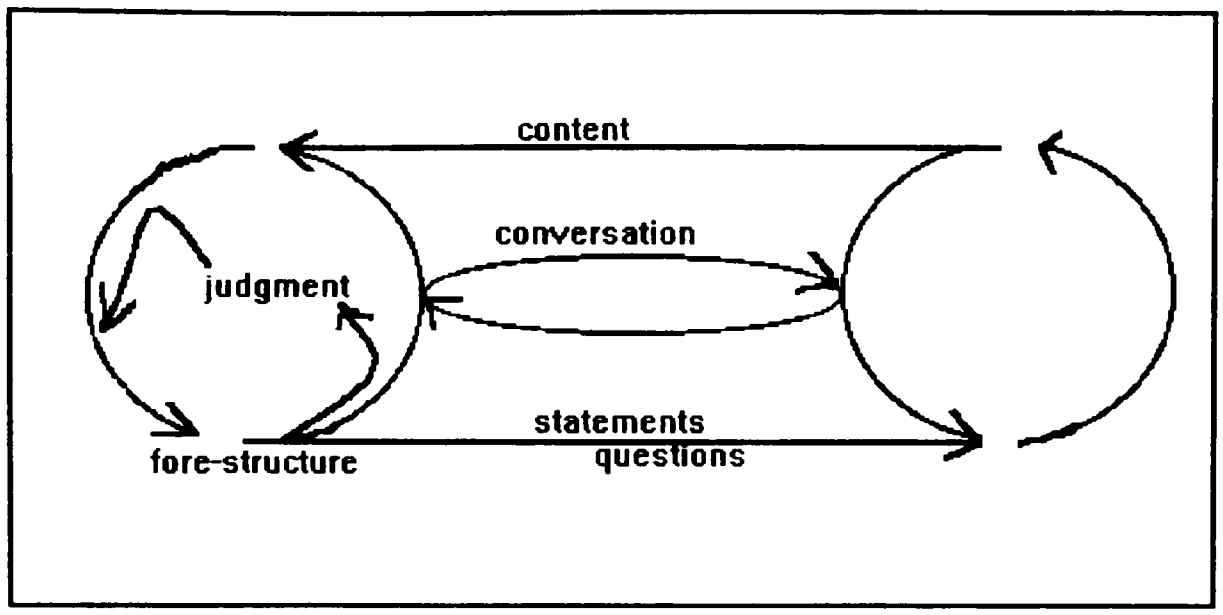

Figure 4
Diagram of the "parent education/self-esteem" Judgment Process

Interview Excerpt

Therapist: **I think offering support to mom and educating mom.** I thought of Active Parenting for mom, if she would be willing to drive to the school and participate in that, because I think she could use that. **Also giving mom self-esteem,** it seems like it would be nice if I could talk to mom alone, although her daughter seems to know everything about mom anyway, but to get some background on mom's personal history because her history affects her parenting.

Interviewer: Where does that idea for you come from that her past history influences her parenting?

Therapist: I believe that as a basic premise for people, that we are parented by, we are brought up by our parents and so that's how we learn to be parents and unless we have any other influences in our lives we're going to parent like our parents did. We all have issues even if we are brought up in the Brady Bunch family you

still have some issues with your parents because life isn't that easy. So if you go to therapy on your own and you work through those issues then you're less likely to go on with that cycle, because mom seems like she has low self esteem.

Interviewer: So where does that basic premise come from?

Therapist: Just life experience.

Interviewer: Were you thinking of any specific life experience as you were with this family or listening to them?

Therapist: Well, you know in counseling experience alone I was just thinking of other families and this reminded me of other families. It might be the typical alcoholic family kind of situation with dad, and her friends, you know that whole, well with mom, Mrs. H she was a push over and also wanted to protect her children at the same time and so that. And also personal experience and growing up in a dysfunctional family and then seeing my siblings, because I don't have any children but I have their children, and just seeing how my siblings parent.

... Interviewer: You mentioned the H's, were you thinking of, relating this to, like doing a comparison with the H's at all or what was happening?

Therapist: No, that was also happening. Well, because they're friends and then also this mom is stronger than the mother, Mom H, you know she has more of a backbone. But still there are some, like dependency, there are some similarities.

Interviewer: So there were things that you were picking up on, that made you think ...

Therapist: of the H's?

Interviewer: Right. Was it just because they had mentioned the name or do you think you would have done that even if they hadn't mentioned the names?

Therapist: Probably because they mentioned the names and so, and then I just started thinking about my work with the H's. I really liked Christine a lot, and Barb too, but you know I really, more Christine, we were really connected. Christine was less like Ann because she was a stone at first, like it took an entire year before she trusted me and then there was a connection with me, but I think Ann is obviously connected to me, its not that hard to connect with her.

A direct contrast between the internal and conversational judgment processes was provided to me at the end of one of the observations. It was an "ah-ha" experience for

me in terms of the coding process of the interviews. This experience helped crystalize the conceptualization of the contrasting judgment processes. The therapist was preparing to wrap up the session with the clients when one of the clients asked the therapist "does it sound like there is a lot of work?" The client was essentially asking the clinician to make overt the internal judgment process of the clinician that had been taking place throughout the session. The clinician paused momentarily and then expressed three impressions that the clinician had formulated during the course of the therapy session. There was some dialogue exchanged by the couple and clinician around the impression of "becoming a couple within her family." The couple seemed to find that impression as the most helpful and it became a goal of the therapy. It was at this point that I began to get a clearer glimpse of the conversational judgment process.

Interview Excerpt

> Interviewer: Right near the end he said "does it sound like there is a lot of work?" You were wrapping up and trying to schedule, and he just had a need to throw that out. Do you remember what your reaction was?
>
> Therapist: My first reaction was taking what he was saying as, do you have anything to help us? Challenging or questioning whether I had anything to offer them in terms of how to make their life better. Then as I thought about it, I was thinking that it didn't need to be a challenge so much as a question and it could be helpful because there was some engagement on his part, and it could be taken as an interest in what can happen. My sense was someone asking "Can this get better, is there any hope?" Once I framed it that way I could answer and say that there were some things that I thought we could work on.
>
> Interviewer: And you said, "how can they learn ways to talk about things together?" "Do they, through their conversations, ever feel hurt?" and "work on ways to be a couple within her family - in the sense that it was difficult to be a couple." Those were the impressions I guess that you had gotten during the session.

Descriptions of the Conversational Judgment Processes

In this next section of the chapter, I want to highlight four examples which illustrate the conversational judgment processes. The fundamental distinction between

the internal and conversational judgment processes was that the clinician was overt about the judgments being formulated during the session and incorporated those judgments into the therapeutic conversation. Figure 5 portrays a "normalizing/traumatic" judgment process in which the clinician was able to make overt some impressions about the clients' experience. Similar to the internal judgment processes described earlier, the categories of fore-structure, situatedness, and conversational processes were a part of the judgment process. However, it was the reflecting of the clinician's impressions into the conversational process and allowing for the clients to use the impressions in any way they chose that distinguished the conversational judgment process from the internal judgment process.

The "normalizing" judgment contained the category of fore-structure with the element of preconceived ideas. In fact, the clinician was aware of the influence of preconceived ideas obtained from information given by the in-take worker at the mental health center. The clinician had "the preconceived idea that this (therapy) was going to be some what difficult for them." Connected to the element of preconceived ideas, was the clinician's awareness of the influence of the larger system. The clinician's previous experience of working in this particular mental health system allowed the clinician to be aware of the impact the larger system has had on prior referral processes. The clinician knew that the larger system had a way of implying to clients that something was wrong or abnormal with them. The mental health system was simply another source of messages in the clients' lives which told the clinician that "a lot of people had been telling them they're not behaving normally."

Of special note with this example is the category of conversational processes because this is what distinguishes this example from the previous examples of internal judgment processes. Categories and elements did not differ from the examples of internal judgment processes. The difference between internal and conversational judgment processes was in the category of conversational processes where the clinician incorporated the internal judgment process into the conversation between self and clients. In this case, the clinician included the impression that something traumatic did indeed happen to this family. Furthermore, the clinician thought of the term post-

traumatic stress as a way of making sense of the family's experience. The clinician then made overt the thought of post-traumatic stress. Simply making the internal process overt was not the only distinguishing feature of a conversational judgment process. There was also a respect for the clients own determination of whether or not the clinician's impression or judgment was helpful. For example, the clinician stated "and if they had some words or labels or a syndrome to put on that (their experience), that may or may not be something that they could use as a normal sort of reaction."

The clients were able to respond to the clinician's making overt the impressions of post-traumatic stress and that their experience was indeed traumatic, similar to Vietnam veterans. In this case, the clients' found the impression helpful. The clinician utilized observation of client behavior as a part of the conversational judgment process to determine the helpfulness of the impression. The clinician stated "and unless I misread their reaction to that, when I alluded to the Vietnamese thing they both nodded their head, and said 'oh yea.' I think there was value in introducing that."

The rest of the conversational elements such as previous experiences with other clients and situations; the therapist's experience during the session; the therapist's perceptions of the referral incident; and reading the clients' reactions were found in internal judgment processes as well. The main distinction between internal and conversational judgment processes was the making overt of the clinician's impressions during the session and the attitude of the clinician which respected and gave value to the clients' ability to determine the helpfulness of a particular clinical judgment.

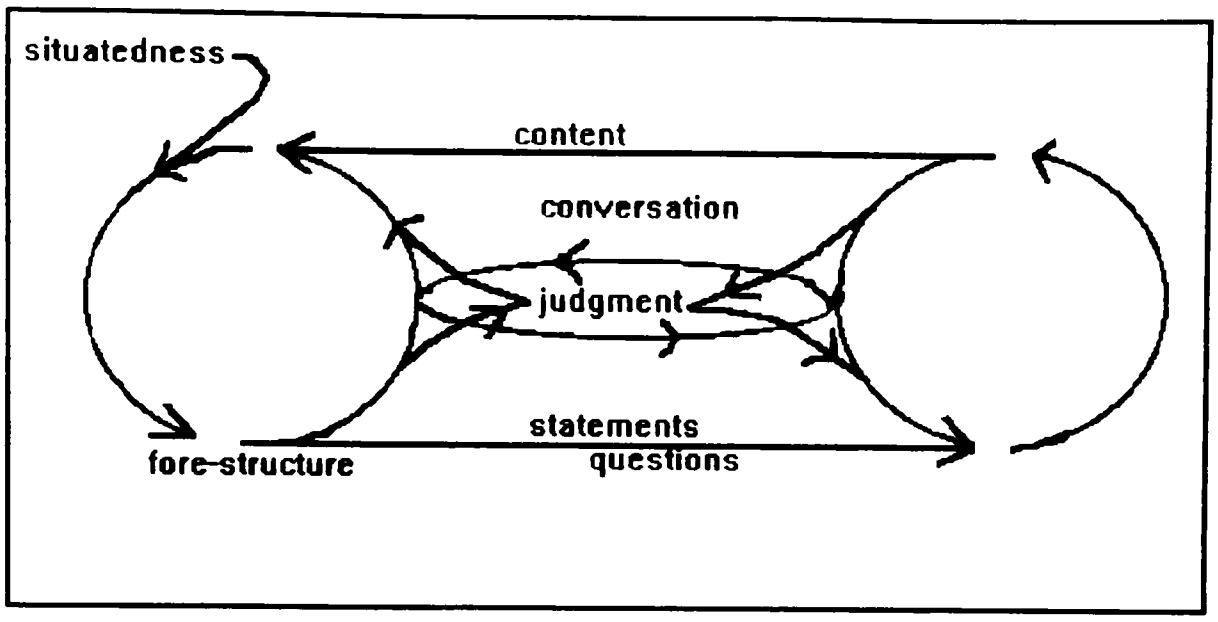

Figure 5
Diagram of the "normalizing/traumatic" Judgment Process

Interview Excerpt

... Interviewer: I remember you used the word "normalizing," and you did in reference to the tears, and the fear and the way they were reacting to the locking

of the doors, and I was wondering if you could just tell me a little bit about why you thought it was important to try to help them feel normal?

Therapist: A couple of things, first of all, **I had this feeling that it was difficult for them to come to the community mental health system. I think there were some vibes or stigma about being perceived as being crazy.** I've run into that with other families, and I think **my impression was that there was some feeling about that.** The in-take worker even mentioned that the daughter didn't want to do this, because she didn't want her friends to know. So I had a preconceived idea that this was going to be some what difficult for them, or they weren't sure, so I think one layer of the normal piece was the external system, about that. I think that was evidence early on to me that a lot of other people had been telling

them they're not behaving normally, "just to go back to work, go back to school, pretend like nothing happened in your life." *It seemed important for someone to say something traumatic happened in your life here, and you're having realistic responses to it.*

... Interviewer: One of the other things that stood out was, you used the phrase "PTS," can you tell me a little bit about what made you use those initials?

Therapist: To be something of the expert, to provide some sort of explanation or maybe some of my own need to feel like if I can offer some information to help normalize. **My main goal in this session was to normalize their experiences.** *I feel like I did a number of things that were pointed in that direction and if they had some words or labels or a syndrome to put on that, that may or may not be something that they could use as a normal sort of reaction.* And I think unless I misread their reaction to that, when I alluded to the Vietnamese thing they both nodded their heads, and said "Oh yea." I think there was some value in introducing that, I'm not sure if I would want to stay there very long, but that was one of my educational tid bits.

Another example further clarifies the difference between internal and conversational judgment processes. Figure 6 is a diagram of a judgment that represents the clinician's impression that support may be something this family needed. Once again, the categories and elements within the categories were found in both internal and conversational judgment processes. In this example, the category of fore-structure contained the fundamental assumption that support is helpful for family's struggling with a difficult experience. The category of fore-structure also included the clinician's prior knowledge base of self-defense training and previous exposure to other women who had been traumatized. Similar to the internal judgment processes, a comparison process took place between the clinician's fore-structure and the information being obtained from the clients during the therapy session. The clinician was able to draw upon knowledge of how others had responded to trauma and what they found helpful in dealing with their traumatic experience as a way to think about what might be helpful for this particular family.

The prior knowledge of the clinician was integrated with the conversational processes taking place between clinician and clients and played a role in the formation of the support judgment. For example, the clinician's own personal experiences came

to mind during the session and influenced the determination that support could be helpful for this family. The clinician's perceptions of the referral incident; self-perceptions during the therapy session; the therapist's perception of the clients' experience of the therapeutic relationship; the therapist's emotional experience during the session; as well as the therapist's perceptions of the nature of the therapy contract all played a role in the conversational judgment process.

The clinician was aware that there wasn't much that could be offered to this family apart from support and was able to incorporate into the conversation the impression that support could be the only thing that could be offered at this point in time. The clinician made overt the feelings of helplessness experienced during the session and made overt the thought that "there isn't an intervention that you can turn to a text book and say 'you know this is going to help these people.'" The clinician stated, "I was feeling pretty helpless about not knowing what to say or do. Because in this circumstance, a random act of violence what exactly can you offer people when that happens." The suggestion that support could be helpful stemmed from the clinician's feelings, personal experiences, and prior knowledge and was offered to the clients in a tentative, hesitant manner which was respectful of the clients' self-determination.

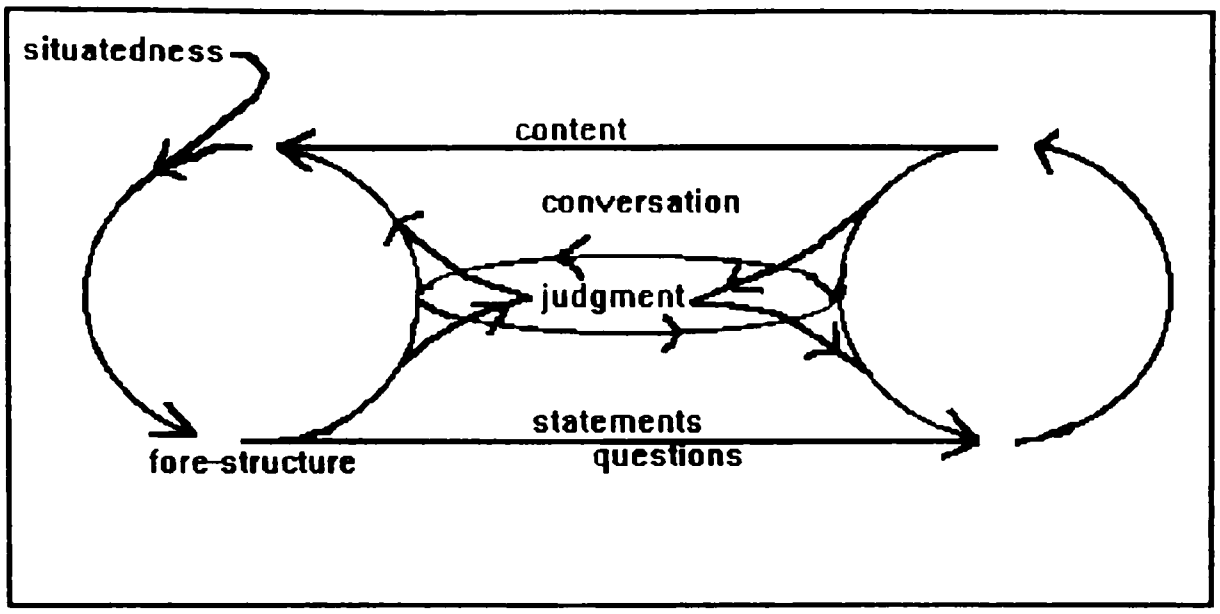

Figure 6
Diagram of the "support" Judgment Process

Interview Excerpt

... Interviewer: I guess, I also would be curious to know how you would see yourself being helpful to them?

Therapist: Well I'm not sure. I think that's in part why even in scheduling the next appointment that would look a little ambiguous. And that was really atypical for me to do it that way. Normally, I would have liked to left with the next appointment scheduled and I wouldn't have volunteered to see how it goes with other people and call me kind of thing. This whole situation has felt a little different because it deals with more like a crisis counseling kind of thing and I'm not as sure what my role is? I feel more uncomfortable with this family and their circumstances then I do a lot of others.

Interviewer: Where does the uncomfortableness come from?

Therapist: Because there isn't an intervention that you can turn to a text book and say, "you know this is going to help these people." I don't have the magic trick here, and I don't with a lot of people, but it seems bigger somehow. And their healing really is going to come from there own resilience. Certainly, **I might be able to offer some support** *but that is less clear to me at this point how that's going to happen than it might be with other people.*

... Interviewer: A real general question, how are you or how did you make sense of their experience? What did you draw upon to kind of make sense of what happened to them?

Therapist: That's a good question. I'm not sure. I'm not sure how I do make sense out of seemingly random acts of violence? I'm not sure sense can be made of that. I think I listened to their stories with a lens that came from my own experiences and self-defense training and things that I took and being exposed to some other women who had been severely traumatized in those classes or courses. And I remembered some fleeting thoughts consciously happening at one point and I almost started to tell some of my own experiences about that and then stopped because I was thinking the time wasn't right to do that kind of exposure. Yet, I think it will happen later if they do come back.

... Interviewer: ... What was behind the questions about "I think it would be important to find other people to talk to about this?" I'm wondering if you could tell me what made you ask those statements or questions?

Therapist: Certainly from some of my own experiences being exposed to those people who had tremendous awful stories to tell and were somehow able to draw strengths from other people surviving those. That was part of it. I guess, **I also felt sort of intuitively that the mom in particular didn't have very much social support, does she have a confidant or somebody who was really listening in a way that was meaningful to her.** I guess I was fishing there a little bit to see if there was anybody out there that she just hadn't told, or if she just didn't really have anyone to tell. My assumptions underlying that would be having a support system would be a good thing.

Interviewer: What were your picking up from her that made you think she didn't have?

Therapist: Well I think a couple of times she alluded to her past life and these other characters that were less than savory kind of people. It seemed to me that, I didn't know how long ago that had been. There was a sense of shame or something there that made me think this woman is probably pretty lonely.

... Interviewer: Were there times for you, and I'm just thinking where you asked a question where you really didn't want to ask a question?

Therapist: No I think it might have appeared that way from time to time, but I think I was feeling helpless about not knowing what to say or to do. Because in this circumstance, a random act of violence what exactly can you offer people when that happens. And I was just feeling a lot of I really don't know what to say.

Interviewer: Do you feel like you can say that to clients?

Therapist: *Yea, because I think I said that a couple of times, "I don't have a magic wand."*

Interviewer: Then you felt pretty good about that part of what you did?

Therapist: *I would rather have that be on the table and open, then pretending that I had some magical answer that I don't have.*

Interviewer: What about that were you drawing upon, maybe similar situations that really stand out or any parallels or common themes?

Therapist: I remember thinking at one point, that it reminds me a lot about women who have been battered, and how even when they're in a shelter and there's a lot of fear about is he going to come after me, you know, "how do I keep myself safe?" and remember thinking at one point there was a similarity and I almost suggested, would a support group be a good thing for her, I remember thinking that at one point, then I thought this is the first time I've met these people, lets not come in here with a guns blazing kind of thing.

A couple of other interview excerpts serve as examples of the tentative and respectful attitude of the clinician's who utilized a conversational judgment process. Part of what constituted the judgment processes as conversational was the clinician's respect for the self-determination of client's to decide whether a particular impression or judgment was helpful. The clinicians displayed the belief that it was the clients' responsibility to decide what would or would not be helpful. One clinician felt that it would be "haughty" to dictate what the client needed to work on or what the problem to address in therapy would be.

Interview Excerpt

... Interviewer: What about the way you asked it? Was there a particular motivation or reason for maybe not coming across like "I really think you need to start taking little steps in fact maybe this week you should?"

Therapist: See that would be inconsistent with my whole style, I think the few times I have been directive about that its fallen flat and people have not done what I've asked them to do and so I don't ask them that way anymore. I would rather just kind of toss something out, and if they want to grab it and go with it, fine, if they don't I'll toss something out another time. I guess I really see its really more the clients' responsibility to take what ever I have to offer in terms of a suggestion and that's their choice whether they want to do that or not. So if there was a positioning or conscious way of asking that, it was a way of offering a choice, rather than this hierarchical you can do this, this, and this or I'm not coming back.

Interview Excerpt

Therapist: I think goals is not a bad word. I wanted to get a sense of what she felt like she needed, what would be most helpful to her right now.

Interviewer: And you were actively trying to get that from her?

Therapist: Yes, or her ideas.

Interviewer: Is that something you usually do with people?

Therapist: Yes, I usually say it towards the end - "how do you think I can be helpful to you?"

Interviewer: What if she would have said something in direct opposition to or a contradiction to your idea about what needs to happen?

Therapist: She kind of did. She said I need behavior modification. Which to me, well if this woman was going out and running into trees, I would say she needed behavior modification - with really clear consequences and reality checks. But I think for her, it felt for me anyway, that that feels easier for her to say than "I think I just need some help." I get the sense it is just not very easy for her to ask for help, that this is a way to do it where she wouldn't have to ask for so much. She could do these things on her own, like homework assignments.

Interviewer: Why is it important to you to include the client in discussions about goals or the direction?

Therapist: Because that is half of the game. It feels like for me to say, well in my experience this is what works for people, is really haughty, and I don't find that that is helpful. And, I think different people want different things. It may be that what this woman is coming in for is some help and some working on her behavior, in which case that is what we will try and do.

Interviewer: I think at one point you came out and asked her "does that feel comfortable to you?" What was important about saying that?

Therapist: Well, I think with alcohol, and maybe with any problem, but certainly it feels to me with alcohol abuse that there is such a literature, and she has had experience obviously with two sisters who are sober in AA, she is not taking that route. But it makes me wonder, she has to have thought about it, why is she here with me? I want to make sure it sounds like a reasonable approach to her. But if she said "no I don't think that is going to work," I wanted to make sure she had a chance to say that.

...Interviewer: As she was talking about her experience at work, it was triggering some of those personal experiences?

Therapist: Yes, and I think that was sort of why I said that that was terrible and difficult. That was where that was coming from.

Interviewer: Did they play any role in how your sense of what the problem was, or why she came to therapy, or how you could be helpful?

Therapist: Yes, probably. I don't think so much about what the problem is, I have my own experience and I'm sure that influences it, but I think it is a way to connect to her, that I could feel what that feeling is like, and it feels terrible.

A distinction was drawn between the conversational judgment process described in this section and a mutual goal defining process that also occurred in some of the sessions. The term goal, while referred to during the interviews, doesn't quite capture the intent of the conversational judgment process. As the next excerpt describes, the "trust" judgment was offered as a possible goal for therapy and the clients agreed that trust would be something they would like to work on in therapy. While the judgment of trust was made overt by the clinician it was more of an internal judgment that was offered overtly to the clients as a validity check. The judgment was not formed as a part of an ongoing conversational process. As such, the example actually falls

somewhere between an internal and conversational judgment process. There is the aspect of making overt which is shared among conversational judgments, however there isn't the same degree of evidence of a belief in client self-determination. There isn't the same reliance upon the client's ability to state the problem definition or what would be helpful to work on. As the excerpt indicates, the clinician felt a responsibility for determining the judgment about the direction or goal of therapy. There wasn't a sense of a mutual construction of the judgment as there was with the conversational judgments cited earlier.

Interview Excerpt

Interviewer: How do you think you can be most helpful for this couple?

Therapist: It usually takes me a couple of sessions to get a really clear idea about - I don't call it a contract so much, that is just the best way to explain it. I don't have a formal contract with them but it is the way I think about it - what are we contracting for, what exactly do you want help with, and how exactly am I going to be helpful for you? So far it sounds like trust is a really big issue, and it is all mixed up with now, I just think this is going to be a really hard case just because he is telling me what he thinks I want to hear. The addiction is a problem and if he is not going to be honest it is not going to work. So I think I am going to have to be really hard with them. What did she say, he is playing you. You have to be really hard not to be so naive that they lead me down this garden path. I think I am going to have to be really up front and direct with them, and let them know that they can't pull one over on me. Then talking about the trust issue, that is so hard - an affair, that is one of the hardest things to deal with. How do you forgive someone for that? I guess just helping them to see that trust is important, I don't know that is a hard question to answer.

Interviewer: You said trust a couple of times. I think I had that pinpointed, a quote where you said that trust would be an issue to work on, or a good point to start would be the trust issue. It sounds like the main thing is the trust issue. I am wondering what you were picking up on or where that issue of trust came to the forefront?

Therapist: One thing I notice I do too in the first session is try to boil it down, and try to get it down to - I think I feel really uncomfortable being up in the air and not knowing where we are going to go with it. So I like to know, here is what we are agreeing that we are going to work on. So that is why I talked about trust, because overall that seemed to be the theme that everything pointed to trust.

So, OK we are not going to work on addiction, we are going to work on trust - is that agreeable to you, do I have it right? So, I wanted to check it out with them to see if I was way off base or if that was where they were going. And the reason I picked up on trust was because he talked about "well, I lied to her. She told me she didn't want me to do drugs and I go out and do drugs behind her back," and that is a betrayal of trust. Then talking about how he lies about everything - the drugs and other things - everything pointed to trust.

Interviewer: The idea about having to pinpoint or narrow down, where does that come from, what tells you that that is important to do in the first session?

Therapist: Because I feel really uncomfortable having everything up in the air. I think in some ways that can be good, but it can also be a hindrance. And I am not so rigid that that can't change, but I need to know where I am going with something, I can't just be floating around - I feel like that anchors me down. It is OK if that changes as long as I have a clear idea of where we are going, it keeps me focused. Otherwise if I don't have that we just go off on all these tangents and nothing productive happens. A part of it too is when you have a goal you know when you are making progress to get there and you know when you get there. Whereas if you never have that how do you know when your work is done? That is something I believe really strongly in. I don't want to say I don't like long-term therapy, but I think it is really easy to fall in the pitfalls, oh you just come in and talk for an hour and you never get anything done or make any progress. I think I need that for me because I am a goal oriented person, and I need a lot of feedback to know if I am doing what I am supposed to be doing, and I guess I assume other people are like I am. I think it is an ethical issue for me for them to know they are making progress, and for them to know when they are done. This is going off on a tangent, but I had a client once who had no goal and I kept asking her, well how do you know when we are done here? She said that she would never be done, and would be in therapy until she died. Eventually I couldn't see her any more because that was very unethical from my perspective, and I couldn't keep seeing her because our ideas about therapy were so different. I think that is unethical for someone to just bounce on for twenty years in therapy, and that is my bias, I just don't think that is ethical. Not that I am opposed to long-term therapy, but my model does tend to be more brief. I have had some long-term clients that I try to always be working on - what is the goal, how are we going to know when we get there, how are you going to know when you are done? So, I thought that in the first session.

Interviewer: So, the trust was kind of a goal formulation - establishing a goal direction?

Therapist: Exactly.

Interviewer: If I am hearing you correctly, that was from who you are as a person. You like to have goals for yourself, but I am wondering if that comes from other places too, or is it just an understanding of who you are?

Therapist: I think that just comes from me because I feel very uncomfortable if I don't have that. I think we are all a little bit egocentric and I too often assume that other people are like I am. So that part of it just comes from who I am. The ethical issues, I don't have the code of ethics memorized, but it seems like I read somewhere that it is ethical and responsible for you as a therapist to let people know. I don't know if it is a feminist perspective that people need to know how long therapy is going to last, that it is not fair if you have some idea about where you are going and they are just hanging out in left field trusting you a hundred percent. Not knowing where this is going, how long it is going to last, when they are done. So somewhere I have read that and I am thinking it is feminist theory, but somewhere I have gotten the idea about the ethical side of that.

Interviewer: Was that present with you in the session at all, about feminist theory?

Therapist: Oh no, not at all. That was coming from my own anxiety and my own personal thoughts about having this goal and knowing what direction I am taking. So, I was very aware of that.

In summary, an internal judgment process was a judgment which was formulated by the clinician, remained internal to the clinician and did not become a part of the conversational process between clinician and client. A conversational judgment process involved making overt the internal judgment process and incorporating that into the conversation between clinician and client. A conversational judgment process also involved the clinician's reliance upon the clients' ability to determine what will and will not be helpful in therapy and involved discussion about what the clients' would find helpful. It may be a matter of the clinicians' beliefs about who was responsible for determining the direction of therapy that further distinguished internal and conversational judgment processes. However, this distinction remains unclear because it did not fit the intent of this research project. Further study is needed to connect specific clinician assumptions to particular judgment processes. The intent of this study was to describe the judgment process of clinicians. In doing so, two other processes emerged from the observation/interview data which were not a part of the initial research question. The next section of this chapter briefly describes the

developmental and reflective processes as they relate to the internal and conversational judgment processes.

Descriptions of the Developmental and Reflective Processes

The descriptions of both the developmental and reflective processes were generated by the same set of questions in each of the interviews. One of the questions that I became curious about as the interviews proceeded was the question of whether or not theoretical reflection played an active role in the therapists' judgment formation process. As I listened to them talk about what informed their judgments, I heard a lot of references to personal experiences, previous experiences with other clients, and their own emotional experiences during the therapy sessions. Occasionally one of the therapists would make a reference to some kind of theoretical construct and would hint that it was there in his or her mind at some level, but not necessarily at an overt and conscious level during the session. A typical response to how theory influenced the clinician during the session was "in the moment, this session in particular was a much more gut driven kind of session. I wasn't consciously thinking about how I was forming the questions that would be in a particular style. I was simply responding to the moment."

Theoretical reflection is a different kind of process than the ones described earlier in this paper. Theoretical reflection was not a part of the clinicians' moment-by-moment judgment process. The following excerpt illustrates how a thought about a certain theoretical approach may be triggered during the course of the conversation with clients, however distinguishing between experience, intuition, and a conscious internal dialogue about how theory informs therapy is difficult and complex.

Interview Excerpt

> Interviewer: You said paradoxical intervention and you mentioned active parenting of teens. Do you remember being consciously aware in the session, during those times, of thinking this is theory, or theory tells me to do this. What was it that was telling you that this was something that was important, to at least check out,

to see what the kid does with it, or throw that out to the parents and see what they did?

Therapist: I think I wouldn't say theory as a be all and end all. I think not just theory, but theory combined with experience that has told me that the theory or the use of that intervention, or that idea, has been pretty useful and practical. It is not just because of the theory that I would use it, but the theory combined with past experience that says to me that that seems to make sense and that seems to work. That way of looking at it or that seems like a valid suggestion of how to look at something or how to change something, that's what would lead me to use it.

Interviewer: So were you actively thinking, that this fits with MRI theory, and this is why I would use a paradoxical intervention at this point?

Therapist: I don't think I would make those formal connections, especially with paradoxical intervention. I was more focused on the practical issue at hand that there is a problem with these two siblings fighting. What is the information that I need first of all to help understand that relationship better, and what are the various kinds of suggestions or interventions I could use to make a comment about it. So I wouldn't automatically think "I'll go MRI," I'd go the other way rather from the bottom up than the top down.

Interviewer: So there was something about the conversation you were having with them that made you say this fits here. How did you determine that at that point to throw that out was a good fit?

Therapist: Probably experience with just some of the similarities of hearing those problems, my experience of what makes sense to me. Knowing that now is a time that I can start talking about the remote control idea of somebody else controlling your feelings or pushing your buttons, now is a time when I can draw that idea that that brings up a red flag and I should address that issue that parents shouldn't be getting involved in the kid's problems, or one approach may be that you need to let them.

Interviewer: And so was it that you used it with another family here, and it seemed appropriate here? Or was it more of an intuitive feeling/sense of this is how to use it?

Therapist: Both of those things. More primarily intuitive, just a feeling or sense that this feels like the right time or right way to handle it.

The theme that theory becomes integrated with experience and intuition was also expressed by other clinicians. One clinician indicated that the integration of theory with experience resulted in feeling more real and genuine with clients because theory had become much more a part of who the person was as a therapist. "I've worked really hard trying to integrate theory in such a way that its just part of who I am. There's not much separation anymore." The concept of separation, that at some point in time theory was not integrated with experience into the person-of-the-therapist, was related to both the developmental and reflective processes. In terms of a developmental process, a number of the clinicians indicated that there was a time when they first began seeing clients that they were much more aware of a separation. As stated by one clinician, "cause I think back when I first started seeing clients and I think I had a much more conscious cognitive process about what kinds of questions I was asking. I thought about it more during the session and I would even plan what the next question would be, or think about it ahead of time and I don't do that anymore."

<u>Interview Excerpt</u>

Interviewer: You alluded to a little bit about feminism and feminist theory. Do you think theory played a role somehow in your formulations, or were you actively thinking theory at some points?

Therapist: I don't think I was actively thinking theory, but they were flowing through my mind. I think relational theory was really flowing, I was thinking about how is this woman connected to people in her life, and how is she disconnected. It felt like there were some contradictions, she feels like her husband is her best friend, and yet you didn't get the sense that he really understands and really gets it. She talked to him about her drinking and he says "well if you really think it is an issue go do something about it" - that bothered me a little, not bothered, but it was striking.

Interviewer: So was it like in this conversation, with what you said, and this is relational theory, and this says this or how was theory part of what you did?

Therapist: I was having an image of connections, what is this woman's web of relationships?

Interviewer: So, it wasn't like this internal dialogue that went on that said well relational theory says this, and that made you ask a question?

Therapist: No.

Interviewer: Do you ever do that at other times?

Therapist: No. I think I come much more out of what I am thinking.

Interviewer: Were you ever like that do you think?

Therapist: Yes, probably earlier in my training I was a little more thinking about how I need to ask about this person's development. Although it is still a relational model, how does one relationship influence another. I was probably more conscious of that earlier on.

Thus, the developmental process for clinicians was one of closing the separation or gap between theoretical knowledge and who they were as therapists in the room with clients. The developmental process involved integrating theory with experience so that it became a part of who they were as therapists. Each of the clinicians interviewed in this study were more experienced clinicians and had undergone similar transformations over the course of their development as therapists. The moment-by-moment processes described in the first part of this chapter depicted that each clinician was much more concerned about staying in the moment with clients, as opposed to engaging in theoretical reflection during the session.

The process of theoretical reflection is defined as a stepping back or away from the moment and consciously considering how theory relates to a particular situation or client. This type of stepping out of the moment did not occur during the sessions. As a number of clinicians indicated, "I was simply responding to the moment." The following excerpt illustrates that theoretical reflection often occurred after the session, during the interview. This excerpt also illustrates that an aspect of the developmental process of integrating theory with self involved finding theories which fit with who the person already was, rather than a process of conforming one's self to the ideals of a particular theory.

Interview Excerpt

Interviewer: And that kind of image of the cycle was coming from where do you think?

Therapist: I think I just see things that way, I just pick up on cycles. I think even before I was a therapist I have always seen things that way. The cybernetics stuff makes sense to me. But it wasn't that I read Cybernetics and then thought that way, it was that I have always thought that way and then there was somebody else who thinks the way I do. I even picture the little cycle in my head, I had a mental image of the cycle, and it is very easy for me to pick up when there is a cycle going on or to see how something might lead to a cycle.

Interviewer: You mentioned again cybernetics. Were you having conscious thoughts of theory during the session?

Therapist: No, it is because you are now asking me about it and I am having to pinpoint where I got that from.

The next excerpt also shows how the process of theoretical reflection took place after the session, during the interview, but in addition illustrates how theory has been internalized so that what happened in the session was more about who the clinician was as a person, rather than a rigid adherence to a particular theoretical approach. The interview process involved connecting what took place during the session to particular theories and involved stepping away from the moment-by-moment process. It was during the interview that clinicians actively tried to figure out how something in the session did or did not fit with a particular theory. When theory was present during the moment-by-moment process, it was internalized and integrated with experience.

Interview Excerpt

Interviewer: Do you think you were thinking of any theories during the session?

Therapist: I have trouble putting words sometimes to theory, and remembering who said what. But I think that a lot of the theories are internalized and comes out in a question or in something else, I don't always know where it is coming from to place it within a theory. But, I was thinking in some ways of family therapy and how this couple was interacting with each other and with the larger family. Where they were in terms of a developmental viewpoint. They are pretty young, 23 and 24, with two really little kids, an 18 month old and 4 month old,

that there were particular things that I thought about in terms of what they needed to do as parents with those kids, that came out of a more developmental family approach.

Interviewer: And that was during the session that you were thinking about that, or after?

Therapist: Probably after, more indirectly during the session. But those thoughts were there.

The next excerpt further illustrates that when theory did become present in the mind of the therapist during the session it occurred in subtle ways and was once again integrated with experience. The ambiguity and complexity of how theory was present during the session was reflected by the clinician's admittance that, "I don't know if I even mean theory." Thus, theoretical reflection was "not a real extensive, formal" process that was engaged in while with clients, but was a much more "subtle" and fleeting process.

<u>Interview Excerpt</u>

Interviewer: Then a real general question, how does theory fit into what you did in this particular session?

Therapist: I think the theory informs my intuition and influences my experiences of the past, or I can make sense of experiences of families I have worked with in the past, in light of certain theories. Or, I might think about how I have dealt with a family in the past and think about well now that I know this new way of looking at it, or this new theory, I wonder what would have happened if I had tried it this way, or looked at it that way. I do consider theory in the sessions, and I do consult with theory in my own mind at times to help me decide where I want to go. Because, I don't necessarily want to go completely on theory, I certainly don't want them to lead the session 100%. And I don't want it to be led just by my whims.

Interviewer: Do you remember a time today when a theory ran through your mind?

Therapist: Well, definitely talking about the siblings arguing and Dad interacting in that that got me into that whole issue, whether you call that theory or not, of active parenting which says that parents should do this in this situation. A lot of

> theory crossed my mind I think, in subtle ways about the family trauma, grieving as a general process, where the kid is at with that, where the parents are at with that. Just real basic theory about how many assets the kid has in his life and how I put some stock in the lack of assets leading to more risk. So I do consult with theory in my mind in the session, but not in a real extensive, formal way I wouldn't say necessarily. I don't know that I even mean theory.

In summary, the developmental and reflective processes that emerged from the observation/interview data were not a part of the initial focus of this research project. The developmental and reflective processes emerged from the interviews as new and different research questions for future study. The details and sublties of the developmental and reflective processes are not known, however what is known is how they relate to the moment-by-moment processes described earlier. The moment-by-moment processes reflect where clinicians are in their development as therapists. Theoretical reflection was not something that the experienced clinicians in this study actively engaged in during the sessions with clients. Theoretical knowledge had become integrated with experience so that what took place during the sessions stemmed from who the therapists were as persons. The process of theoretical reflection occurred during the interview process after the session in which clinicians often found themselves trying to explain how they arrived at certain judgments by attaching theoretical constructs to what they had done. When theory was present during the sessions, it was an element of the conversational process. Thoughts of theory were triggered during the interaction with clients, however clinicians did not engage in a process of theoretical reflection in that moment. The following excerpt summarizes the developmental and reflective processes and how they relate to the moment-by-moment processes.

Interview Excerpt

> Interviewer: Just some real final general questions. When you think about what took place in the session and what you did and the questions that you asked and what you were feeling and thinking about, what were you drawing upon the most in the moment?

Therapist: I think primarily past clients I have worked with that I've found helpful and also drawing a lot on personal experience. I think not every family I work with do I draw as much from personal experience, but for some reason some of the stuff that he was particularly going through I was drawing a lot from. Although I think of families as a system, in my mind I don't think of a theory that I try to match what I'm doing with.

Interviewer: So in the moment you were experiencing some reaction to things as you were talking to the family that made you think about other families that you've worked with or your own family experience?

Therapist: Yea, those two primarily.

Interviewer: How different is that, would you say, than what usually happens?

Therapist: I don't know how much I draw on my own personal experience, although I do. I'm noticing I draw more on my self than before in the past. I think early on I was a lot more theoretical than I am now. Now I'm much more aware of a process between the client and I, even though its an assessment, I feel its more of a relationship.

Interviewer: What made that shift for you?

Therapist: I don't know what made that shift, I don't know if it was my own selfishness, wanting, I don't know. I get more out of it if I relate to my clients, that's pretty darn selfish, I feel like I shouldn't be admitting that. I feel like I'm in the process, its a relationship, its not some type of heady, intellectual theory that I'm following, its more of an emotional connection. Its much more meaningful to me when its like that, its more personal.

CHAPTER V
DISCUSSION

In this chapter the implications of the findings are presented. First, there are implications for the conceptualizations of clinical judgment which were offered in chapter two. Furthermore, there are implications for marriage and family therapy training and supervision. Finally, areas of further study are presented which emerged from the coding of the data.

Implications for Clinical Judgment Conceptualizations

The implications for the conceptualizations of clinical judgment in chapter two are twofold. First, there are implications for the proposed grand dichotomy of contextualism and mechanism. Secondly, there are implications for the traditional conceptualization of clinical judgment and the research approaches historically taken to study clinical judgment.

Implications for the Grand Dichotomy

What is evident from the descriptions of the judgment processes in chapter four is that internal and conversational judgments cannot be neatly categorized into mechanistic and contextual judgment processes. For example, one of the characteristics of mechanistic judgments, as presented in Chapter II, was that mechanistic judgments involved a rigid adherence to preconceived ideas and a reliance on a predetermined way of conducting interviews and gathering information from clients. In other words, a rigid adherence to an assessment or diagnosis formula was characterized as inherent within a mechanistic judgment process. While some of the clinicians in this study held to a preformed diagnostic or assessment procedure, this alone did not determine whether the judgments made during the session were internal or conversational judgments. The following excerpt exemplifies what is meant by a preformed assessment procedure.

Interview Excerpt

Therapist: I don't know. I was thinking, as I was going over my little template in my mind of assessment questions, I was thinking depression, anxiety, and the other stuff like alcohol abuse I pretty much covered. I did depression, and then wanted to check out anxiety. I was surprised when she said she was the panic attack queen, that wouldn't have come up earlier.

Interviewer: You said the template, do you use the same template every first session?

Therapist: Yes. Certainly you tailor it, but I think that there are certain things I always ask about, about depression, anxiety, substance abuse, previous treatment, family history.

Interviewer: Is that template comprised of what? How did that template get there?

Therapist: That template got there, believe it or not, because when I used to be a crisis worker in the emergency room, we had a form that we filled out. I can actually see the form when I talk to people, have I got that area etc. and I sort of fill out the form in my head.

Despite the clinician's adherence to a preformed template, this clinician engaged in a number of conversational judgment processes during the session. If my characterization of mechanistic judgments had held to what was expected, a clinician using a preformed template should have engaged in a mechanistic judgment process. Part of the reason why I had expected a rigid template to preclude contextual judgments was because I had connected a template to certain theoretical assumptions that I only associated with the mechanistic paradigm. The judgment processes described in Chapter IV cannot be connected to any particular set of theoretical assumptions, at least at this point in time. Further study which focuses on connecting particular judgments to specific theoretical assumptions is necessary.

Another one of the distinctions between mechanistic and contextual judgments, as characterized in Chapter II, was that mechanistic judgments would rely solely on the subjective, internal judgment process of the clinician. Some judgments were categorized as internal judgments, however this was not because the judgment process only occurred within the individual clinician's cognitive structure. Internal judgment

processes were categorized as internal because they were not a part of an overt conversational process between clinician and client. Mechanistic judgments were said to take place within the clinician's intrapsychic processes alone, without a consideration of contextual or relational factors. This was not the case with the judgments observed in this study. The judgment processes categorized as internal often involved conversational processes and situational factors, besides that of the clinician's own intrapsychic processes.

Finally the grand dichotomy implied that there would not be an overlap between judgment processes. In other words, mechanistic and contextual judgments would be mutually exclusive. However, many of the judgments observed in this study involved considerable overlap of the same elements comprising the judgment processes. Each of the categories of fore-structure, situatedness, and conversational processes, as well as the elements within the categories, were found in both internal and conversational judgment processes. The distinction between internal and conversational judgments was the making overt of the clinician's internal judgment process and relying upon client self-determination to help construct the judgment. It is not my intent to create a new grand dichotomy of internal and conversational judgment processes. In fact, a grand dichotomy of internal and conversational judgments may not even be possible, as evidenced by the mutual goal formulation process described in Chapter IV. There was a grey area where judgments at times involved client inclusion in the judgment construction process, and yet the judgments were not considered conversational judgments because of the lack of reliance upon client self-determination.

It should be noted that some aspects of the conceptualization of contextualism and mechanism from Chapter II were evident in the judgment processes described in Chapter IV. For example, Gadamer, Baxter-Magolda (1992) and King and Kitchener's (1994) assertion that judgments can be formed through a relational, interactional, or communal process was indeed observed in some of the judgments made during therapy sessions. The judgments categorized as conversational occurred as a result of the clinician's attempts to make his or her internal processes overt and include them in the conversational process taking place between clinician and client.

A second aspect of contextualism observed in clinicians' judgment processes was a respect for the expertise of the client. The description of contextual judgments, in Chapter II, was in part based on the assumption that the clinician would value and respect the expertise of the client. Each of the conversational judgments displayed the clinician's belief that the client's determination about what would and would not be helpful was essential to the judgment formation process. Overt steps were taken by clinicians to try and elicit the client's expertise in constructing the judgment.

Finally, as Gadamer, Baxter-Magolda (1992), and King and Kitchener (1994) asserted, contextual judgments are constructed with a greater reliance upon an understanding of the contextual, embedded nature of judgments and a reliance upon a variety of sources of information. Conversational judgment processes tended to be more complex and involved more elements from each of the categories than some of the internal judgments. Some internal judgments were made with a large number of different elements, however there were some that involved very few elements. This was not the case with the conversational judgments. The complexity of conversational judgments displayed a reliance upon multiple sources of information which is consistent with the contextual judgment processes outlined in Chapter II.

Implications for the Traditional Conceptualization

Fundamentally, the findings from this study influence the reliance upon the information-processing model of the traditional approach to clinical judgment. The information-processing model assumes an "outside-in," linear flow of information, as well as a conceptualization of judgments constructed solely within the mind of the clinician. The descriptions of the judgment processes in Chapter IV indicate that judgments often involved interactional or conversational elements as a part of the judgment formation process. The conversational elements indicated that clinicians used more than information obtained from the client alone. At times the conversational elements themselves were reflected into the conversational process and became a part of the judgment formation process. As the conversational judgment

processes indicate, judgments were created between clinician and client and not just within the mind of the clinician.

The information-processing model, as conceptualized within the clinical judgment literature, neglects the influence of contextual or situational factors on the judgment formation process. It may be that judgments only involving a clinician's fore-structure, as conceptualized in this study, would be consistent with an information processing model. However, a judgment process involving a clinician's fore-structure alone was not observed in this study. In fact, the category of situatedness was very influential in a number of instances for clinicians as they formulated their judgments. Hypothetically, an information-processing model fits with the category of fore-structure within the processes described in this study. The conceptualization of the information-processing model within the traditional approach could be enhanced by incorporating contextual sources of information, as well as conversational sources of information, into its framework. There is a need for advocates of the information-processing model to move beyond the conceptualization of clinical judgments based solely on a linear flow of information obtained from clients.

A second implication of this study for the traditional approach is a move away from the research focus on outcome. Traditionally, researchers have focused on the accuracy of the outcome or the accuracy of a clinician's judgment as compared to some objective standard. This study focused more on the process of arriving at particular judgments, and did not contain an evaluative component as to the rightness or wrongness of the judgments. The avoidance of a focus on outcome allows the descriptions of internal and conversational judgments to simply be descriptions of different ways of formulating judgments. It was not the intent of this study to state that one mode of judgment construction is superior to another. Furthermore, no attempt was made to identify errors or pathologies within clinicians' judgment processes. A stance of understanding was promoted during the observations/interviews, rather than a stance focused on evaluating the effectiveness or accuracy of the judgment processes or individual judgments.

A focus on describing the process of clinician judgments inherently avoids evaluation. Since there are so many situational and conversational factors that are dependent upon client and context, judgments cannot be seen as totally stemming from the mind of the individual clinician. The information-processing model leaves the door open for evaluation because the judgment is seen as stemming from the individual mind of the clinician, which according to the information-processing model is inherently limited and deficient and in need of specific training or adherence to procedure to avoid error. An interactional understanding of clinical judgments removes the focus on the intrapsychic processes alone. Intrapsychic processes are a part of the judgment formation process of clinicians, but not the sole determinant of clinicians' judgments.

In summary, the implications for the conceptualizations of clinical judgment, as presented in Chapter II, center around the insufficiency of a grand dichotomy and the information-processing model to accurately describe the judgment processes of clinicians. Theoretical models which currently exist cannot capture the complexity of clinicians' judgment processes. The judgment processes observed and described in this study did not fit into the proposed grand dichotomy of mechanism and contextualism. I believe part of the inaccuracy of the grand dichotomy was inherent within the construction of a dichotomy in the first place. It is simply not possible for a dichotomy to contain and describe the entire realm of possible human experiences (Labouvie-Vief, 1994). The insufficiency of the traditional conceptualization of clinical judgment based on the information processing model was echoed once again by the findings of this study. Holt (1988) and Sarbin's (1986) criticisms of the information-processing model are supported by the descriptions of the processes in this study. As theorized by Holt (1988) and Sarbin (1986), contextual and relational factors played a role in clinicians' judgment processes.

Prior to this study, descriptions of the actual judgment processes of clinicians did not exist. The descriptions provided in this study make concrete what, until now, have been abstract, theoretical, and hypothetical descriptions of clinicians' judgment processes. Based on the findings of this study, clinical judgment is a complex process

of making-sense of and utilizing intrapsychic, contextual, and relational factors. In other words, judgments can be formed utilizing a variety of combinations of intrapsychic (fore-structure), contextual (situatedness), or relational (conversational) factors. This conceptualization of clinical judgment is consistent with the theorized and hypothetical description which was offered in Chapter II. Also consistent with the hypothetical description of a contextual judgment process was the finding that some clinicians did engage in a co-constructive judgment process. The conversational judgment processes resulted in mutually or co-constructed judgments because of the clinicians' reliance upon the client's determination of what would or would not be helpful. What is also consistent with, but was not theorized in, the hypothetical description of a contextual judgment process was the finding about clinicians' making overt their internal judgment processes.

The description of internal judgment processes was not theorized beforehand and is not consistent with the hypothetical description offered in Chapter II of a mechanistic judgment process. The only consistency with mechanistic judgments, which was not found in this study, may be the connection between an internal judgment process which utilizes clinician's fore-structure alone with an information-processing conceptualization of clinical judgment. The finding that some clinicians used an internal judgment process and what that process entailed was not anticipated. In fact, the picture of the processes which emerged from the data, including the categories and the entire realm of elements within each of the categories, was not anticipated.

Role of the Researcher and Related Concerns of Validity

I fear that consistencies between descriptions of the judgment processes in Chapter IV with hypothetical descriptions in Chapter II will be seen as evidence of the influence of my prior understanding on the coding process. Of course my prior understanding played a role, the simple fact that I drew upon the hermeneutic literature to enhance and clarify categories is evidence of my prior understanding playing some role in the coding process. However, I want to emphasize that the

evidence of consistencies does not negate that the findings were completely unexpected and unanticipated. My prior understanding of clinical judgment was changed as a result of the process of coding the observations/interviews. The clinicians were asked questions out of a genuine curiosity about how they made sense of how they arrived at clinical judgments. My curiosity and interpretation of their responses were guided by my prior understanding, but my curiosity and interpretations did not exclude being informed and changed by the clinicians. Similar to the clinicians' judgment formation process, my coding of the data involved my fore-structure (prior understanding), however I believe this enhanced the coding process, rather than hindered the process. Similar to the conversational judgment processes in which clinicians were reliant upon clients informing their judgment process, my coding process was reliant upon being informed by the clinicians and the observations/interviews.

Rather than the consistencies being seen as evidence of prior understanding having influenced coding to a fault, highlighting convergences and divergences between prior knowledge and findings is the product of a successful process of bracketing. Bracketing is designed to allow researcher and readers points of convergence and divergence, thereby assuring validity. Bracketing is based on the assumption that prior knowledge will influence the coding process. Bracketing simply allows researcher and reader to determine how prior knowledge influenced coding by highlighting where findings fit with prior knowledge and where findings varied from prior knowledge. The presence of divergences provides evidence that the data was not forced into a pre-existing framework. However while the presence of convergences can at times indicate a problem with validity, it does not automatically mean that data has been forced into a pre-existing framework. In this study, the self-reflexive process and a "not-knowing" stance guarded against convergences merely being a product of forcing data into a pre-existing framework.

Implications for MFT Training and Supervision

One of the most apparent implications for MFT training and supervision stemmed from the comments made by participants at the end of the interviews. The participants commented on the helpfulness of answering questions about how they arrived at judgments and the experience of reflecting on the therapy session immediately after the session. The interview process enabled the clinicians to make sense of their experience of the session and helped clarify their personal theories of therapy. The following excerpts illustrate the influence that asking questions had on their sense of themselves as therapists and the role the interview played in their sense-making process.

Interview Excerpt

> Interviewer: Anything else in general just coming to mind about the session, or this interview process now?
>
> Therapist: It was interesting, the interview process, to stop myself and say where did these things come from or how did I make this decision, when often it is not a conscious process. And it is not gone, so I can go back and think through what happened, and why I said this or that. Often I don't do that, to take time to go through that with each client.

Interview Excerpt

> Interviewer: Are there any other things that either stand out about the session or the interview itself that you would want to mention?
>
> Therapist: No, I don't think so. The interview was good because of being able to formally process. I found it fairly easy to answer the questions which tells me that maybe I do have some practice in assessing for myself what happened after a session. But, being able to do that with another person is helpful too, to tie things back together, bounce off ideas. You didn't do a lot of input about your impressions obviously, but just being able to formally consult or talk about things in order to make me think about the session. For me talking out loud sometimes helps me to formulate thoughts, and make sense of what happened.

When I think about my experiences as a supervisee, I recognize that the times that I found most helpful and felt most engaged in the supervision process were when the

supervisor asked questions in a way that called forth my own experiences and expertise. It was helpful to have an opportunity to "talk out loud" and have someone listen as I tried to piece together my experiences and make sense of a therapy session. The process also enabled me to more clearly articulate my own theory of therapy and become aware of some hidden assumptions and values that could not have otherwise been made known had someone not asked the questions. The interview process utilized in this study could be drawn upon to inform the way supervision is often conducted within the field of marriage and family therapy. Guided curiosity in supervision, which is similar to the qualitative research interview, can result in a questioning process that gives interviewees the chance to gain self-understanding (Weber, 1986, cited in Ellis, 1994); to find his or her voice, to feel heard, and feel worthwhile (Heath, 1993); and provide an opportunity for meaning-making or sense-making of personal experiences (Mishler, 1986, cited in Ellis, 1994).

Besides this study's implication for the way supervision sessions could be conducted, that is to say the stance from which questions are asked and the types of questions asked, training and supervisory models could also be enhanced. The emerging developmental conceptualization of the separation of theory from the "self" of the therapist to the integration of theory into who the therapist is as a person has direct implications for training models. Perhaps, most enlightening from a training stand point was the finding that theory integration resulted from finding theories which fit with who the person was already and not from trying to force therapists into particular models. Speaking from my own training experiences, often times it appears that supervisors and training programs are most interested in having supervisees adopt the supervisors' approaches to therapy rather than enhance the supervisees' development of personal theories of therapy.

Developmental Implications for MFT Supervision Models

Within the conceptualizations of MFT supervision, some models already incorporate an understanding of the developmental levels of supervisees. For example, the selection of supervision formats is often informed by an understanding of the

developmental level of the supervisee. Since beginning therapists need to learn to implement specific therapeutic theory and require specific training in applying therapeutic techniques (Protinsky, 1997; York, 1997), live and audio- or video-taped supervision is often the preferred mode of supervision. In contrast, middle-level and advanced supervisees can often benefit from case consultation formats because of their unique developmental needs (Stewart, 1997; York, 1997). Middle-level supervisees require training in more complex views of change and look to become more competent in a variety of theories while more advanced supervisees must learn to articulate their own personal theories of therapy. While there is a consideration of an understanding of supervisee development within MFT models of supervision, the incorporation of a developmental framework does not go beyond the beginning, middle, and advanced stages which were just described. The findings from this study expand the field's limited understanding of therapist development.

While further study is still needed to more clearly conceptualize the developmental process articulated in Chapter IV, the emerging conceptualization does have some implications for MFT supervision models. The process described in Chapter IV fits with the developmental conceptualization already in place within the literature in terms of the progression from an emphasis on theory and theoretical application for beginning therapists to the development of a personal theory of therapy for advanced therapists. However, the process in Chapter IV expands the existing framework by connecting developmental stages to judgment formation processes. As the clinicians in this study indicated, earlier in their development as therapists they tended to do more of an active, overt reflecting process during sessions about how theory could be used to make sense of what was happening. Further understanding of the reflective process could also allow supervisors to match specific supervision processes and techniques to better fit with the developmental stage and reflective process of beginning therapists. As I suggested earlier, questions which are designed to move clinicians into a reflecting position, such as the ones asked in this study, could be used to enhance the supervision experience of clinicians.

The process of integrating theory into "self," appears to fit with Labouvie-Vief's (1994) conceptualization of the developmental stage of integrated thinking. Labouvie-Vief (1994) has described a developmental process in which individuals learn to integrate contradictions or opposites into a coherent whole. Early on in a person's development, he or she thinks in dichotomous or dualistic terms such as mind-body, reason-emotion, and objective-subjective (Labouvie-Vief, 1994). Over time, as a result of life experiences, the individual learns to integrate the dualisms into united wholes such that mind-body, reason-emotion, and objective-subjective are seen as intrinsically related and connected. It is the experience of contradiction or cognitive crises that enables a person to develop integrative thinking.

I suggest that a similar dissonance is experienced by beginning clinicians when attempting to make sense of how theory fits with their experiences as clinicians and who they are as persons. Through clinical and supervisory experiences, clinicians are able to integrate theory into "self" so that there is no longer a tension between who one is as a person and the therapeutic theory one develops. Since each of the clinicians in this study alluded to a time when there was more of a tension between "self" and theory, it could be assumed that they experienced sufficient experiences to be able to integrate theory into "self." Supervision models and practices can benefit from understanding the integration process, for example experiences can be promoted which encourage integration of theory into "self."

An alternative conclusion for the lack of theoretical reflection which occurred in the sessions could be that theory simply did not play a central role in the therapeutic work of the clinicians observed in this study. As evidenced by the interviews, theory was not present in the mind of some of the clinicians throughout the course of their therapy session. It could be: that the clinician did not see theoretical reflection as relevant to that particular therapy session; that the clinicians valued staying in the moment with clients more than moving to a detached, somewhat distant position in order to reflect on theory; or, as stated earlier, theoretical reflection was simply not a part of the clinicians' therapeutic work with clients. Each alternative explanation is equally as valid at this point in time since the developmental process of integration

was not explored in detail within this study. Initial indications, based on comments made during the interviews, seem to indicate that the clinicians do value theory in their therapeutic work and that integration of theory into "self" did indeed occur in their development as therapists. However, conclusions must be offered tentatively since the understanding of the developmental process of intergation is limited and incomplete in its current description. Understanding the developmental process of integration is a much needed area of further study. Regardless of the explanation for the lack of theoretical reflection that occurred in the therapy sessions, the implication that supervision can be enhanced by providing experiences for the supervisee to reflect on theory and integrate theory into "self" remains.

The difference between internal and conversational judgment processes observed in this study can be thought about within a developmental framework. More specifically, Basseches' (1997) dialectical-constructivist view of human development can be used to make sense of the observed difference between internal and conversational judgments. While each of the clinicians was able to integrate theory into "self," the one difference which was observed was that some of the clinicians had integrated the concept of client self-determination into their theories of therapy. According to Basseches (1997), the incorporation of a consideration of client meaning-making processes with clinician meaning-making processes is representative of a dialectical thinking process. The aspect of client meaning-making processes observed in this study was the client's impressions about what would or would not be helpful to talk about in therapy. When forming conversational judgments, the clinicians overtly asked for client input and relied upon that input to construct their judgments. Thus, according to Basseches' (1997) framework, dialectical thinking therapists make use of conversational judgment formation process.

The development of dialectical thinking, similar to integrative thinking, requires particular experiences so that one can develop the capacity to think dialectically. Basseches (1997) suggested that fostering dialectical thinking in clinicians involves experience with multiple ways of understanding human experience and therapy process; exposure to the limitations of the multiple ways of understanding; exposure

through modeling of how to deal with the recognition of limitations; and support while trying to transcend the limitations of one's meaning-making. Within Basseches' (1997) framework, how to deal with and transcending the limitations of meaning-making schemes involves a mutual meaning-making process between clinician and client. Thus for Basseches (1997), the goal of supervision is the development of dialectical thinking which includes the goal of helping therapists engage in mutual meaning-making processes with clients. The description of conversational judgment processes in Chapter IV seems to fit with Basseches' (1997) description of mutual meaning-making processes. In fact, the descriptions of the conversational judgment processes in Chapter IV make concrete Basseches' (1997) abstract descriptions of mutual meaning-making processes. The value of this study is once again found in the putting forth of actual descriptions of how clinicians' make judgments which remains missing from the literature.

One distinction between Basseches' (1997) work and this dissertation project is that I'm not prepared to state that a conversational judgment process is to be preferred over an internal judgment process or a process which lies somewhere between internal and conversational judgments. Basseches' (1997) implied that a mutual meaning-making process is to be preferred because it avoids "theoretical abuse." Theoretical abuse refers to the imposing of the therapist's meaning-making scheme on a client in a manner that de-values, does not affirm and does not hear the client's meaning-making experience (Basseches, 1997). While I am intrigued by the concept of theoretical abuse, I am not prepared to say that the internal judgment processes which were observed in this study are in some way abusive to clients. I think effective and beneficial therapy can involve either internal or conversational judgment processes. Again as stated earlier, one of the values of this dissertation is that it moved the study of clinical judgment away from an evaluative focus. Basseches (1997) framework imposes an evaluative component on the concept of clinical judgment which does not appear to be appropriate to consider at this time. Further study which looks at the experiences of clients who were a part of the different judgment processes may shed

some light on the concept of theoretical abuse and possibly provide a means of evaluation.

My own clinical experience suggests that not all clients experience a therapeutic process which does not overtly involve mutual meaning-making processes as abusive. Some clients are very much looking for clinicians to be directive and "tell them what to do" because of a belief and faith in the expertise of the clinician. Basseches' (1997) implication that such experiences are abusive moves into the realm of personal values and assumptions. My own personal theory of therapy would be consistent with Basseches' (1997) approach, and yet I'm not willing to evaluate the judgment processes described in this dissertation. I experienced some of the clinicians who made use of an internal judgment process as extremely supportive, caring, and empathic. As Basseches (1997) stated, support and empathy, along with offering interpretations and enacting or reflecting upon novel interactions, have been linked to positive clinical outcomes. Interestingly, each of the aforementioned components of successful therapy moves beyond theoretical approach (Basseches, 1997) and for that matter judgment processes. Connecting judgment processes to client experience and clinical outcomes was not the intent of this project and may be an area of additional study. It should be noted that the judgment processes described in this study also moved beyond theoretical approach. Each of the therapists alinged themselves to different sets of theoretical approaches such that no two therapists were alike. Internal and conversational judgment processes seemed to occur independent of, or meta to the clinician's particular theoretical approach.

In summary, the developmental process observed in this study informs existing developmental frameworks within MFT supervision by suggesting that an overt goal of supervision should be helping supervisees understand the developmental process of integrating theory into "self." Achieving the goal of integration can be accomplished by providing experiences of contradiction, perhaps through the types of questions which are asked by supervisors, which encourages clinicians to integrate the contradiction into their "selves." Furthermore, the focus of integration should be on assisting the therapist to find the fit between "self" and theory, and not forcing the

supervisee to adopt the supervisor's preferred model of therapy. Supervision can also be enhanced, without evaluating processes, by understanding that the belief in client self-determination and use of conversational judgment processes may be more helpful for some clients than an internal judgment process alone. For example, the description of the client in Chapter IV who sought out the clinician's impressions and judgments at the end of the session exemplifies a situation where a conversational judgment process was perhaps more fitting or appropriate. Whether or not the supervisee incorporates client self-determination into his or her personal theory of therapy, supervision experiences which promote an understanding of conversational judgment processes could enhance a supervisee's ability to deal with clients who seek that type of process in therapy.

The Descriptions of Judgment Processes as a Model for Supervision

Apart from the developmental implications for supervision, training and supervision models can also be informed by the descriptions of the judgment processes offered in this dissertation. The descriptions can serve as frameworks within which to provide supervision and training. There are two key aspects of the descriptions in chapter four which have direct implications for supervision models. First, clinicians were consistently drawing upon personal life experiences, as well as prior clinical and supervision experiences to inform their clinical judgments. While beginning therapists may not have as much clinical and supervisory experiences to draw upon in their clinical work, beginning therapists do have life experiences that they can be encouraged to draw upon to make sense of clinical situations. Thus, one of the implications for supervision models is that each supervisee has a set of knowledge and expertise that he or she can be encouraged to draw upon and utilize in therapy sessions.

Often times I have observed within training and supervision settings that supervisees, particularly beginning therapists, are treated as though they are "blank slates" without any prior knowledge or experiences that could be used in their clinical work. I think part of the reason there is such a gap or separation for beginning

therapists between "self" and theory is because supervision models imply that supervisee's don't know anything until they have learned theory. It seems that supervisees are simply exposed to theories, without any understanding of the developmental process of integration. Thus, the message that is sent to beginning therapists is that this particular theory or that theory is the way to do therapy. Over time clinicians realize that who one is as a person is equally as important, if not more important than the theory they adopt or develop.

Secondly, whether clinicians were aware of or made use of the category of conversational processes when forming their judgments, the descriptions of the judgment processes bring to one's awareness that there is a process occurring between clinician and client. While clinicians differed in their degree of awareness of the different elements comprising the category of conversational processes when forming and reflecting on their judgments, each clinician experienced some aspect of the process between "self" and client at some point in the therapy session. Whether it was an emotional reaction, attending to client interaction, or an awareness of previous experiences, the process between clinician and client was readily apparent as I observed the sessions. In a discipline that prides itself on being relational and systemic in its orientation, there is little focus within supervision models on assisting supervisees to become aware of and utilize the relational and interactional process between "self" and client to inform clinical work. Much of the training and focus of supervision is on client functioning and interaction, without any understanding of the second-order nature of therapy processes. Second-order therapy processes refers to the idea that clinician and client create a new interactional system. Supervision models do not tend to focus on the clinician-client system. There is a need for MFT supervision models to expand their conceptualization of supervision to include a focus on the clinician-client system and not just the client system.

This dissertation project has been very influential in my own development of a personal philosophy of supervision. I offer a brief description of my personal philosophy of supervision to illustrate a model of MFT supervision which is based directly upon an understanding of the judgment processes described in Chapter IV.

As such, it emphasizes the aforementioned implications that supervisee's do have knowledge and expertise to draw upon in therapy and that an awareness of the process between clinician and client is a potential resource for clinicians. The implications fit conceptually within a supervision model which emphasizes the "self" of the therapist (Atkinson, 1997; Roberto, 1997).

"Self" of the Therapist Supervision

While supervision is not to be considered as therapy (Gardner, Bobele & Biever, 1997), supervision does involve some qualities that are therapy-like (Storm, 1991; cited in Atkinson, 1997). Supervision which focuses on the "self" of the therapist has been criticized for, perhaps at times, blurring the boundary between supervision and therapy (Atkinson, 1997). As long as a "self" of the therapist focus does not lose sight of the connection to the supervisee's clients, then generating alternative self-constructions; exploring supervisee experiences; and examining the way supervisee's values and beliefs affect therapy processes are appropriate topics for supervision sessions.

A "self" of the therapist approach to supervision is interested in the process of the supervisee's "self" development and focuses on his or her self-constructions (Gardner et al., 1997; Mahoney & Lyddon, 1988). Supervisees are encouraged to generate new views about themselves and their competencies (White, 1989/1990; cited in Gardner et al., 1997). Supervision involves identifying supervisee strengths and resources and exploring the supervisee's successful therapy experiences (Gardner et al., 1997). Utilizing meaning questions (Freedman & Combs, 1996) or self-description questions (Durrant & Kowalski, 1993) during supervision such as "how did you do that?" or "what do you think that says about you?" invites supervisees into a reflecting position from which they can regard different aspects of themselves, their experiences, and others (Freedman & Combs, 1996). Meaning questions ask about and require a naming of personal qualities, relationship characteristics, hopes, goals, values, beliefs, and accomplishments by the supervisees (Freedman & Combs, 1996). Thus, meaning

questions invite respondents to attribute competencies to themselves and their efforts (Durrant & Kowalski, 1993).

A "self" of the therapist focus also involves exploring the supervisee's experience with clients (Atkinson, 1997) and the therapeutic relationship between supervisee and client(s) (Gardner et al., 1997). Schultz-Ross and Gutheil (1997) stated that there has been a trend away from a focus on "self" of the therapist supervision. According to Schultz-Ross and Gutheil (1997), there is a need to return to a focus on exploring the process taking place between client and therapist during therapy sessions. A "self" of the therapist approach encourages exploration of the supervisee's emotional experience with clients because of the assumption that this process is integral to change in terms of the supervisee's own self-constructions, but also in terms of the therapeutic relationship with clients (Mahoney & Lyddon, 1988). Since a "self" of the therapist focus assumes that it is the sense of connection with the therapist experienced by client that promotes healing and change (Aponte, 1998), exploring the therapeutic relationship is essential. Exploring the therapeutic relationship and supervisee experiences allows the supervisee to become aware of personal strengths and resources. It also enables the supervisee to learn to draw upon in-session experiences to inform her or his understanding of his or her clients; and to formulate questions and interventions (Roberto, 1997).

According to Schultz-Ross and Gutheil (1997), there is also a need for supervisors to return to a focus on the values, assumptions, and beliefs of their supervisees and how these affect case conceptualization and the process of therapy. Supervision is fundamentally about shaking "the foundation of supervisees' beliefs and broadening their worldviews" (Martinez, 1994, p. 87). Supervision involves addressing the personal biases of therapists through a self-examination process facilitated by the supervisor. Exploring with supervisees where a conceptualization, question, and intervention during a therapy session came from, helps supervisees articulate their theories of change and moves them along in their development of personal theories of therapy (Todd, 1997).

Inherently connected with a "self" of the therapist focus for supervision is an emphasis on developing and utilizing reflecting processes in supervision. Supervision consists of trying to develop self-reflexive processes in supervisees (Todd, 1997), as well as increasing supervisees' awareness of relational reflexive processes. Self-reflection involves developing the supervisee's ability to reflect on her or his "self" which includes becoming aware of: (1) self-constructions and one's self-identity as a therapist; (2) one's emotional experience and reactions during therapy sessions with clients; and (3) the role that personal values and beliefs play in the therapeutic process. According to Lappin and Hardy (1997), "it is incumbent on supervisors to impart the capacity for self-reflection" (p. 54). The process of self-reflection creates opportunities for supervisees to access self-knowledge and give a voice to their experiences (Adams-Westcott et al., 1993). Often the reflection process allows for supervisees' to uncover alternative knowledges and experiences of self and world which promote feelings of personal agency and competence (Adams-Westcott et al., 1993).

As important as the self-reflexive process is for supervisees to learn, understanding relational processes is equally important and often neglected (Schultz-Ross & Gutheil, 1997). A "self" of the therapist approach attempts to assist supervisees in developing a capacity for reflecting on relational processes by relying on the concept of isomorphic processes. Not only have supervisors found that supervisor-supervisee relationships tend to replicate transgenerational processes of supervisor and/or supervisee (Roberto, 1997), supervisors have found that patterns get replicated across the supervisor-supervisee-client relationships (Cook, 1997). Reliance upon isomorphic processes allows the supervisor to intervene in ways during supervision sessions that can then get played out in the therapeutic relationship (York, 1997). Intervention into isomorphic processes can be done by commenting on the process and making the process overt (Cook, 1997) or more indirectly by attempting to relate to supervisees in ways that contradict the isomorphic patterns in the therapeutic relationship (T. C. Todd, personal communication, April 15, 1998).

Within a "self" of the therapist approach to supervision the hope is that the supervisee will adopt similar stances and styles of relating that reflect efforts to establish and maintain a "reflexive position" (Hoffman, 1991), or "not-knowing position" (Anderson & Goolishian, 1988) with clients (Westcott et al., 1993). Supervisors attempt to instill reflective processes within supervisees by incorporating reflective processes into the supervisory relationship (Roberts, 1997). A "self" of the therapist focus incorporates a second-order cybernetic conceptualization of the relationship between therapist and client (Atkinson & Heath, 1990). The supervisee is seen as a participating member of the therapist-client system (Hoffman, 1991). Likewise, the supervisor is seen as a participating member in the supervisor-supervisee-client relationship.

Part of the indirect modeling of reflective processes by the supervisor involves offering interventions tentatively and remaining constantly open to changing his or her understanding of the system (Atkinson & Heath, 1990). The supervisor is not completely wed to any of his or her ideas during a supervision session and the supervisor can reject any suggestions which are made (Atkinson & Heath, 1990). According to Hoffman (1991), questions and comments are marked by hesitancy and periods of silence and usually begun with "could be that? may be, or what if?" (p. 13). As a participating system member, the supervisor need not agree at all times with the supervisee's views and may choose to share his or her own views (Real, 1990).

As mentioned earlier, a "self" of the therapist perspective implies that the supervisee be aware of his or her own affective reactions, behavior, and thought processes during therapy sessions (Real, 1990). These aspects of self-awareness during therapy sessions affords the supervisee the opportunity to reflect his or her reactions and processes into the conversation (Epstein & Loos, 1989; Freedman & Combs, 1996). Similar experiences can and should occur within the supervision session. Supervisor suggestions and comments are offered within the context of the supervisor's personal experience (Freedman & Combs, 1996). Supervisors strive to be transparent by explaining enough about their situation and experiences that supervisee's understand the supervisor as a person rather than some expert of professional

knowledge (Freedman and Combs, 1996). An assumption is made that the supervisee is the expert about her or his experience of the clients (Anderson & Goolishian, 1992) and the supervisor is genuinely interested in understanding that experience. The aim is that supervisees will feel that their expertise is being acknowledged (Durrant & Kowalski, 1993).

It is not my intent to imply that this model of supervision is the way that all MFT supervision should be conducted. I offered the description to show how an understanding of the judgment processes described in Chapter IV could potentially inform supervision approaches. Supervision models informed by an understanding of internal and conversational judgment processes will include the following three aspects: (1) an emphasis on assisting the supervisee to become aware of and reflect upon his or her own "self" during and after sessions; (2) helping the supervisee become aware of how the "self" impacts the therapy process at any given moment; and (3) encourage the supervisee to draw upon her or his "self" to inform her or his therapeutic work with clients. In other words, supervisees can be encouraged to reflect their emotional reactions, previous experiences, and personal sense-making processes into the conversation with clients, or allow them to inform the questions that they ask or the suggestions they offer. It should be noted that the "self" that is implied in the description is a "self" that has engaged and continues to engage in the process of theoretical reflection and the developmental process of integrating theory into who one is as a therapist. Certainly therapy in which the clinician neglects theory and only relies upon emotional reactions, previous experiences, and personal sense-making processes, is a context in which "theoretical abuse" can occur and opens the door for liability and malpractice claims on the basis of gross negligence and incompetence. Similar to the concept of "informed curiosity," it is an "informed self" that is guided by theory and theoretical reflection.

Conclusion

The initial research question of "how do marriage and family therapists arrive at a problem definition in a first session of therapy?" has been sufficiently answered. The process of formulating a problem definition judgment involved, in varying combinations: (1) comparing and contrasting knowledge that existed in the mind of the clinician, prior to meeting with the client, with information obtained from the client during the session; (2) using an understanding of how larger contextual factors affected client and therapist experience during the session; and (3) having an awareness of what was happening between clinician and client while interacting during the session, and determining how the information from the client and experience of the client in the moment fit with other previous experiences. Clinicians engaged in two meta-level judgment processes. The distinction between internal and conversational judgment processes was that clinicians participating in conversational judgment processes: (1) made overt their impressions, judgments or sense-making process and incorporated those judgments into the therapeutic conversation; and (2) the clinicians relied upon client input about what would or would not be helpful in order to help construct their judgments.

In answering the initial research question, a number of other areas for further study emerged from the observation/interview coding process. Further exploration is needed of the developmental and reflective processes which emerged from the data. Studies designed to more clearly conceptualize the developmental and reflective processes may have significant implications, not only for the clinical judgment literature, but also for the way that training and supervision is conceptualized. Further study is also needed when it comes to trying to establish relationships between factors that may influence the ways in which clinicians formulate clinical judgments. Factors which need to be explored include the level of clinician development, age, gender, race/ethnicity and how those factors influence the process of judgment construction, as well as specific client and clinician assumptions about change, people and the world and how those assumptions influence judgment processes. Exploring contextual factors such as the location of therapy, the referral incident and process, and the role

larger systems such as schools, courts, and churches play in judgment formation processes could also inform existing understandings of clinical judgment and MFT training and supervision. Finally, examination of the outcomes of various processes including clients' experience of the differing judgment processes could also inform therapy practice and supervision, particularly if certain judgment processes are found to be associated with more positive clinical outcomes.

As for myself, I am most interested in continuing the research process which has already been established with this project, especially the question of how beginning therapists make judgments during a first session of therapy. Because of the constraints of wanting to finish the dissertation in a timely manner, the limited availability of my personal time at times to devote to the project, and the difficulty recruiting participants, I was not able to pursue as wide array of participants as I would have liked in terms of their developmental stages. Thus, a limitation of this study is that the findings are based on the responses of more experienced clinicians alone. Experience was defined by the approximate number of client contact hours the therapists had with the least experienced clinician having 500 hours and the most experienced clinician having 4000+ hours. Thus, the judgment processes described in this project are limited to clinicians at a more advanced developmental stage. Connected to this limitation, is my interest in answering the question "how does the developmental stage of the clinician influence clinical judgment processes?" Understanding the judgment processes of more beginning therapists will also shed some light on the developmental process of integration. Since I am interested in understanding the developmental process of how the integration of "self" and theory actually occurred for clinicians, questions designed to elicit responses from clinicians about the experiences they attribute to having helped them achieve integration could also be included in the interview process. It would also be interesting to see whether the judgment process varies by clinicians at different developmental stages, including clinicians that might have more experience than the clinicians in this study. Continuing this project with beginning therapists and even more experienced clinicians

would remove the limitation created by the narrow range of participants' developmental stage.

The limitations created by the characteristics of the sample move beyond that of the participants' developmental stage alone. Further limitations to drawing implications of the judgment processes for clinical practice stem from the homogeneity of the sample in terms of age and race/ethnicity. The clinicians ranged in age from twenty-six to thirty-seven and each clinician was Caucasian. Thus, it is not known whether the descriptions of the judgment processes in this study would hold true for clinicians from different racial/ethnic backgrounds or for clinicians who would be older than the mid-thirties. Additional studies designed to examine the influence of age and race/ethnicity on developmental and judgment processes may enhance the conceptualization of clinical judgment tentatively offered in this study. In contrast since both male and female therapists engaged in both judgment processes, the sample characteristic of gender does not appear to be a limitation of the study. However, specific conclusions cannot be offered about how gender affected clinicians' judgment processes. It should be noted that six female and four male clinicians participated in the study. Studies explicitly designed to explore how gender affects clinicians' judgment construction processes may add to the emerging conceptualization of clinical judgment.

One last limitation concerns the theme of "therapist-as-researcher" which has been mentioned throughout this project. As alluded to previously, determining where the data ends and the "self" of the researcher begins is often difficult to sort out. In this particular project, because I have had experience with and thought about my own clinical judgment processes prior to conducting the research project, it is possible that the findings and implications stem more from who I am as a "therapist-as-researcher" rather than the data. However, as has been discussed in previous sections entitled "Self-reflexivity and related concerns of validity," rather than being a limitation, this familiarity with clinical judgment has perhaps been a strength of this project. As was suggested, reflecting upon my own clinical experiences enhanced the coding process rather than hindered the process.

One of the difficulties when thinking about limitations within a qualitative research project is that limitations, in the quantitative sense of the word, do not fit within the contextual paradigm (Lincoln & Guba, 1985). Since this project was exploratory in design, that is to say what has been offered is a tentative, initial description of how clinicians make clinical judgments, and since I have tried to openly discuss my sense-making process; limitations associated with generalizability, sample size, measurement error and related issues of reliability and validity, and researcher biases do not need to be addressed as they would with a quantitative project. Limitations associated with generalizability have be taken into consideration within the exploratory design. Furthermore, limitations of sample size have been discussed in the context of theoretical saturation, while issues of validity and researcher biases have been addressed in the context of "bracketing" and self-reflexivity. All research is context bound and limited by the researcher's biases and prior knowledge, method, and sample (Lincoln & Guba, 1985); I knew that going into the project and did not try to overstate the implications of the findings. The intent of bracketing was to provide readers with the framework within which to state, "given the researcher's biases, the way the study was carried out, and the clinicians who participated in the project, what has been presented is one way to conceptualize and think about clinical judgment and this is how the conceptualization informs clinical practice and research."

REFERENCES

Adams-Westcott, J., Dafforn, T. A., & Sterne, P. (1993). Escaping victim life stories and co-constructing personal agency. In S. Gilligan & R. Price (Eds.), Therapeutic conversations (pp. 258-271). New York: W. W. Norton.

Adler, P. A., & Adler, P. (1994). Observational techniques. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 377-392). Thousand Oaks, CA: Sage.

Amundson, J., Stewart, K., & Valentine, L. (1993). Temptations of power and certainty. Journal of Marital and Family Therapy, 19, 111-123.

Anderson, H. (1996, April). Conversation, language, and possibility toward a postmodern therapy. Paper presented at 1996 Professional Workshop Series, Department of Continuing Education, Texas Tech University, Lubbock, TX.

Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. Family Process, 27, 371-393.

Anderson, H. & Goolishian, H. (1992). The client is the expert. In S. McNamee & K. J. Gergen (Eds.), Therapy as social construction. Newbury Park, CA: Sage.

Aponte, H. (1998). Spirituality: The transcendent and practical force. Paper presented at the Chicago Center for Family Health Conference, Chicago, Illinois.

Atkinson, B. J. (1997). What is the difference between personal therapy and person-of-the-therapist supervision. In C. L. Storm & T. C. Todd (Eds.), The reasonably complete systemic supervisor resource guide (pp. 152-154). Boston, MA: Allyn and Bacon.

Atkinson, B. J. & Heath, A. W. (1990). Further thoughts on second-order family therapy - this time its personal. Family Process, 29, 145-155.

Basseches, M. (1984). Dialectical thinking. Norwood, NJ: Ablex.

Basseches, M. (1997). A developmental perspective on psychotherapy process, psychotherapists' expertise, and 'meaning-making conflict' within therapeutic relationships: Part II. Journal of Adult Development, 4, 85-106.

Baxter Magolda, M. B. (1992). Knowing and reasoning in college. San Francisco, CA: Jossey-Bass.

Benack, S., & Basseches, M. (1989). Dialectical thinking and relativistic epistemology: Their relation in adult development. In M. L. Commons, J. D. Sinnott, F. R. Richards & C. Armon (Eds.), Adult development (pp. 95-109). New York: Praeger.

Berzonsky, M. D. (1994). Individual differences in self-construction: The role of constructivist epistemological assumptions. Journal of Constructivist Psychology, 7, 263-281.

Blashfield, R. K., & Haymaker, D. (1988). A prototype analysis of the diagnostic criteria for DSM-III-R personality disorders. Journal of Personality Disorders, 2, 272-280.

Bontekoe, R. (1996). Dimensions of the hermeneutic circle. Atlantic Highlands, NJ: Humanities Press.

Boss, P., Dahl, C., & Kaplan, L. (1996). The use of phenomenology for family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), Research methods in family therapy (pp. 83-106). New York: Guilford Press.

Botella, L., & Gallifa, J. (1995). A constructivist approach to the development of personal epistemic assumptions and worldviews. Journal of Constructivist Psychology, 8, 1-18.

Bowen, M. (1978). Family therapy in clinical practice. New York: Jason Aronson.

Cantor, N., & Genero, N. (1986). Psychiatric diagnosis and natural categorization: A close analogy. In T. Millon & G. Klerman (Eds.), Contemporary directions in psychopathology (pp. 233-256). New York: Guilford.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. Emerson (Ed.), Contemporary field research (pp. 109-126). Boston, MA: Little, Brown.

Charney, D., Newman, J. H., & Palmquist, M. (1995). "I'm just no good at writing": Epistemological style and attitudes toward writing. Written Communication, 12, 298-329.

Chenail, R. J., & Maione, P. (1997). Sensemaking in clinical qualitative research. The Qualitative Report, 3, 1-7.

Cook, M. (1997). Systems-oriented supervision in an agency setting. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 112-124). Boston, MA: Allyn and Bacon.

Dawes, R. M., & Corrigan, B. (1974). Linear models in decision making. Psychological Bulletin, 81, 96-106.

Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. Science, 243, 1668-1674.

Durrant, M., & Kowalski, K. (1990). Overcoming the effects of sexual abuse: Developing a self-perception of competence. In M. Durrant & C. White (Eds.), Ideas for therapy with sexual abuse (pp. 65-110). Adelaide, Australia: Dulwich Center Publications.

Durrant, M. & Kowalski, K. (1993). Enhancing views of competence. In S. Friedman (Ed.), The new language of change: Constructive collaboration in psychotherapy (pp. 107-137). New York: Guilford Press.

Einhorn, H. J. (1988). Diagnosis and causality in clinical and statistical prediction. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 51-70). New York: The Free Press.

Ellis, J. (1994). Narrative inquiry with children: A generative form of preservice teacher research. International Journal of Qualitative Studies in Education, 7, 367-380.

Epstein, E. S. & Loos, V. E. (1989). Some irreverent thoughts on the limits of family therapy. Journal of Family Psychology, 2, 405-421.

Falvey, J. E. (1992). Science or serendipity? What we know about clinical judgment in mental health. Journal of Mental Health Counseling, 14, 458-470.

Fonow, M. M., & Cook, J. A. (1991). Back to the future: A look at the second wave of feminist epistemology and methodology. In M. M. Fonow & J. A. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 1-15). Bloomington, IN: Indiana University Press.

Ford, M. R., & Widiger, T. A. (1989). Sex bias in the diagnosis of histrionic and antisocial personality disorder. Journal of Consulting and Clinical Psychology, 57, 301-305.

Freedman, J. & Combs, G. (1996). Narrative therapy. New York: Norton.

Friedlander, M. L., & Stockman, S. J. (1983). Anchoring and publicity effects in clinical judgment. Journal of Clinical Psychology, 39, 637-643.

Gadamer, H. (1960). Wahrheit und methode. Tubingen, Germany: Mohr (Siebeck).

Gall, M. D., Borg, W. R., & Gall, J. P. (1996). Educational research. New York: Longman Publishers.

Garb, H. N. (1994). Toward a second generation of statistical prediction rules in psychodiagnosis and personality assessment. Computers in Human Behavior, 10, 377-394.

Garb, H. N. (1996). The representativeness and past-behavior heuristics in clinical judgment. Professional Psychology: Research and Practice, 27, 272-277.

Garb, H. N., & Schramke, C. J. (1996). Judgment research and neuropsychological assessment: A narrative review and meta-analysis. Psychological Bulletin, 120, 140-153.

Gardner, G. T., Bobele, M., & Biever, J. L. (1997). Postmodern models of family therapy supervision. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 217-228). Boston, MA: Allyn and Bacon.

Gardner, W., Lidz, C. W., Mulvey, E. P., & Shaw, E. C. (1996a). Clinical versus actuarial predictions of violence in patients with mental illnesses. Journal of Consulting and Clinical Psychology, 64, 602-609.

Gardner, W., Lidz, C. W., Mulvey, E. P., & Shaw, E. C. (1996b). Comparison of actuarial methods for identifying repetitively violent patients with mental illness. Law and Human Behavior, 20, 35-48.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 266-275.

Gergen, K. J. (1994). The communal creation of meaning. In W. F. Overton & D. S. Palermo (Eds.), The nature and ontogenesis of meaning (pp. 19-39). Hillsdale, NJ: Lawrence Erlbaum.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine de Gruyter.

Goldberg, L. (1959). The effectiveness of clinicians' judgments: The diagnosis of organic brain damage from the Bender-Gestalt test. Journal of Consulting Psychology, 23, 25-33.

Goldberg, L. (1968). "Simple" models or simple processes? Some research on clinical judgments. American Psychologist, 23, 483-496.

Goldberg, L., & Werts, C. (1966). The reliability of clinician's judgments: A multitrait-multimethod approach. Journal of Consulting Psychology, 30, 199-206.

Gonzalez, R. C., Biever, J. L., & Gardner, G. T. (1994). The multicultural perspective in therapy: A social constructionist approach. Psychotherapy, 31, 515-524.

Greenberg, L. S., Heatherington, L., & Friedlander, M. L. (1996). The events-based approach to couple and family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), Research methods in family therapy (pp. 411-428). New York: Guilford.

Grove, W. M. (1987). The reliability of psychiatric diagnosis. In C. G. Last & M. Hersen (Eds.), Issues in diagnostic research (pp. 99-119). New York: Plenum Press.

Guba, E. (Ed.). (1990). The paradigm dialogue. Newbury Park, CA: Sage.

Gurman, A. S., & Kniskern, D. P. (Eds.). (1991). Handbook of family therapy. New York: Brunner/Mazel.

Haley, J. (1976). Problem-solving therapy. San Francisco, CA: Jossey-Bass.

Heath, A. (1993). Reading signs. In A. H. Rambo, A. Heath & R. J. Chenail, Practicing therapy: Exercises fro growing therapists (pp. 89-152). New York: W. W. Norton.

Hecker, L. L., Trepper, T. S., Wetchler, J. L., & Fontaine, K. L. (1995). The influence of therapist values, religiosity, and gender in the initial assessment of sexual addiction by family therapists. The American Journal of Family Therapy, 23, 261-272.

Hertz, R. (1996). Introduction: Ethics, reflexivity and voice. Qualitative Sociology, 19, 3-9.

Hoffman, L. (1990). Constructing realities: An art of lenses. Family Process, 29, 1-12.

Hoffman, L. (1991). A reflexive stance for family therapy. Journal of Strategic and Systemic Therapies, 10, 4-17.

Holt, R. R. (1988). Judgment, inference, and reasoning in clinical perspective. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 233-250). New York: The Free Press.

Ivey, D. C. (1995). Family history, parenting attitudes, gender roles, and clinician perceptions of family and family member functioning: Factors related to gender inequitable practice. The American Journal of Family Therapy, 23, 213-226.

Ivey, D. C. (1996). Family history and gender roles: Critical factors in practitioners' views of family interactions. Contemporary Family Therapy, 18, 425-445.

Ivey, D. C., & Scheel, M. J. (1997). A systemic-constructivist perspective of clinical judgment in couples and family therapy: Is the bridge too far? Unpublished manuscript.

Johnson, J. A., Germer, C. K., Efran, J. S., & Overton, W. F. (1988). Personality as the basis for theoretical predilections. Journal of Personality and Social Psychology, 55, 824-835.

Jordan, J. S., Harvey, J. H., & Weary, G. (1988). Attributional biases in clinical decision-making. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 90-106). New York: The Free Press.

Josselson, R., & Lieblich, A. (Eds.). (1993). The narrative study of lives. Newbury Park, CA: Sage.

Josselson, R., & Lieblich, A. (Eds.). (1995). Interpreting experience: The narrative study of lives. Thousand Oaks, CA: Sage.

Kahneman, D., Sloveic, P., & Tversky, A. (1982). Judgment under uncertainty: Heuristics and biases. New York: Cambridge University Press.

King, P. M., & Kitchener, K. S. (1994). Developing reflective judgment. San Francisco, CA: Jossey-Bass.

Kitchener, K. S. (1983). Cognition, metacognition, and epistemic cognition: A three level model of cognitive processing. Human Development, 26, 222-232.

Kitchener, K. S., & King, P. M. (1981). Reflective judgment: Concepts of justification and their relationship to age and education. Journal of Applied Developmental Psychology, 2, 89-116.

Kitchener, K. S., King, P. M., Wood, P. K., & Davison, M. L. (1989). Sequentiality and consistency in the development of reflective judgment: A six year longitudinal study. Journal of Applied Developmental Psychology, 10, 73-95.

Kleinmuntz, B. (1990). Why we still use our heads instead of formulas: Toward an integrative approach. Psychological Bulletin, 107, 296-310.

Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6, 107-114.

Kramer, D. A., Kahlbaugh, P. E., & Goldston, R. B. (1992). A measure of paradigm beliefs about the social world. Journal of Gerontology: Psychological Sciences, 47, 180-189.

Kramer, D. A., & Woodruff, D. S. (1986). Relativistic and dialectical thought in three adult age groups. Human Development, 29, 280-290.

Labouvie-Vief, G. (1992). A neo-Piagetian perspective on adult cognitive development. In R. J. Sternberg, & C. A. Berg (Eds.), Intellectual development (pp. 197-228). New York: Cambridge University Press.

Labouvie-Vief, G. (1994). Psyche and eros: Mind and gender in the life course. New York: Cambridge University Press.

Lappin, J. & Hardy, K. V. (1997). Keeping context in view: The heart of supervision. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 41-58). Boston, MA: Allyn and Bacon.

Leslie, L. A., & Clossick, M. L. (1996). Sexism in family therapy: Does training in gender make a difference. Journal of Marital and Family Therapy, 22, 253-269.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Livesly, W. J., Reiffer, L. T., Sheldon, A. E. R., & West, M. (1987). Prototypicality ratings of DSM-III criteria for personality disorders. Journal of Nervous and Mental Disease, 175, 395-401.

Loos, V. E., & Epstein, E. S. (1989). Conversational construction of meaning in family therapy: Some evolving thoughts on Kelly's sociality corollary. International Journal of Personal Construct Psychology, 2, 149-167.

Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. Psychological Bulletin, 106, 184-203.

Loring, M., & Powell, B. (1988). Gender, race, and DSM-III: A study of the objectivity of psychiatric diagnostic behavior. Journal of Health and Social Behavior, 29, 1-22.

Mahoney, M. J. (1988). Rationalism and constructivism in clinical judgment. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 155-181). New York: The Free Press.

Mahoney, M. J. & Lyddon, W. J. (1988). Recent developments in cognitive approaches to counseling and psychotherapy. The Counseling Psychologist, 16, 190-234.

Marshall, C., & Rossman, G. B. (1995). Designing qualitative research. Thousand Oaks, CA: Sage.

Martin, J. E., Silva, D. G., Newman, J. H., & Thayer, J. F. (1994). An investigation into the structure of epistemological style. Personality and Individual Differences, 16, 617-629.

Martinez, K. J. (1994). Cultural sensitivity in family therapy gone awry. Hispanic Journal of Behavioral Sciences, 16, 75-89.

Matarazzo, J. D. (1983). The reliability of psychiatric and psychological diagnosis. Clinical Psychology Review, 3, 103-145.

Maxwell, J. A. (1996). Qualitative research design: An interactive approach. Thousand Oaks, CA: Sage.

McCollum, E. E., & Russell, C. S. (1992). Mother-blaming in family therapy: An empirical investigation. The American Journal of Family Therapy, 20, 71-76.

Meehl, P. E. (1954). Clinical versus statistical prediction: A theoretical analysis and a review of the evidence. Minneapolis: University of Minnesota Press.

Meehl, P. E. (1957). When shall we use our heads instead of the formula? Journal of Counseling Psychology, 4, 268-273.

Miller, P. H. (1993). Theories of developmental psychology. New York: W. H. Freeman and Company.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Morey, L. C., & Ochoa, E. S. (1989). An investigation of adherence to diagnostic criteria: Clinical diagnosis of the DSM-III personality disorders. Journal of Personality Disorders, 3, 180-192.

Morse, J. (1991). On the evaluation of qualitative proposals. Qualitative Health Research, 1, 147-151.

Newman, J. H. (1993). A structural investigation of intellectual development and epistemological style in young adults (Doctoral dissertation, Pennsylvania State University). Dissertation Abstracts International, 54, 2786B.

Nichols, M. P., & Schwartz, R. C. (1991). Family therapy concepts and method. Needham Heights, MA: Allyn and Bacon.

O'Hanlon, W. H. (1993). Possibility therapy: From iatrogenic injury to iatrogenic healing. In S. Gilligan, & R. Price (Eds.), Therapeutic conversations (pp. 3-17). New York: W. W. Norton.

O'Hanlon, B. (1994). The third wave. Family Therapy Networker, 18, 18-29.

Oskamp, S. (1965). Overconfidence in case-study judgments. Journal of Consulting Psychology, 29, 261-265.

Pavkov, T. W., Lewis, D. A., & Lyons, J. S. (1989). Psychiatric diagnoses and racial bias: An empirical investigation. Professional Psychology, 20, 364-368.

Pepper, S. (1942). World hypotheses. Berkeley, CA: University of California Press.

Perry, W. G. (1970). Forms of intellectual and ethical development in the college years: A scheme. New York: Rinehart & Winston.

Pinsof, W. M., & Wynne, L. C. (1995). The effectiveness and efficacy of marital and family therapy: Introduction to the special issue. Journal of Marital and Family Therapy, 21, 341-343.

Protinsky, H. (1997). Dismounting the tiger: Using tape in supervision. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 298-307). Boston, MA: Allyn and Bacon.

Rafuls, S. E., & Moon, S. M. (1996). Grounded theory methodology in family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), Research methods in family therapy (pp. 64-80). New York: Guilford Press.

Real, T. (1990). The therapeutic use of self in constructionist/systemic therapy. Family Process, 29, 255-272.

Roberto, L. G. (1997). Supervision: The transgenerational models. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 156-172). Boston, MA: Allyn and Bacon.

Roberts, J. (1997). Reflecting processes and "supervision": Looking at ourselves as we work with others. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 334-348). Boston, MA: Allyn and Bacon.

Salovey, P., & Turk, D. C. (1988). Some effects of mood on clinicians' memory. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 107-123). New York: The Free Press.

Sarbin, T. (1986). Prediction and clinical inference: Forty years later. Journal of Personality Assessment, 50, 362-369.

Sawyer, J. (1966). Measurement and prediction, clinical and statistical. Psychological Bulletin, 66, 178-200.

Seaburn, D., Gawinski, B., Harp, J., McDaniel, S., Waxman, D., & Shields, C. (1993). Family systems therapy in a primary care medical setting: The Rochester experience. Journal of Marital and Family Therapy, 19, 177-190.

Searight, H. R., & Young, R. (1994). Qualitative research and family systems medicine: A natural fit. Family Systems Medicine, 12, 117-131.

Schultz-Ross, A., & Gutheil, T. G. (1997). Difficulties in integrating spirituality into psychotherapy. The Journal of Psychotherapy Practice and Research, 6, 130-138.

Slife, B. D., & Williams, R. N. (1997). Toward a theoretical psychology. American Psychologist, 52, 117-129.

Smith, A. F. (1988). Perceiving the client. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 73-89). New York: The Free Press.

Snyder, M., & Thomsen, C. J. (1988). Interactions between therapists and clients: Hypothesis testing and behavioral confirmation. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 124-152). New York: The Free Press.

Sprenkle, D. H., & Bailey, C. E. (1995). Editor's introduction. Journal of Marital and Family Therapy, 21, 339-340.

Stewart, K. (1997). Case consultation: Stories told about stories. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 308-319). Boston, MA: Allyn and Bacon.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Strohmer, D. C., Shivy, V. A., & Chiodo, A. L. (1990). Information processing strategies in counselor hypothesis testing: The role of selective memory and expectancy. Journal of Counseling Psychology, 37, 465-472.

Todd, T. C. (1997). Self-supervision as a universal supervisory goal. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 17-25). Boston, MA: Allyn and Bacon.

Todd, T. C. & Storm, C. L. (1997). Thoughts on the evolution of MFT supervision. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 1-16). Boston, MA: Allyn and Bacon.

Turk, D. C., & Salovey, P. (1985). Cognitive structures, cognitive processes, and cognitive-behavior modification: I. Client issues. Cognitive Therapy and Research, 9, 1-17.

Turk, D. C., & Salovey, P. (Eds.). (1988). Reasoning, inference, and judgment in clinical psychology. New York: The Free Press.

Turk, D. C., Salovey, P., & Prentice, D. A. (1988). Psychotherapy: An information-processing perspective. In D. C. Turk & P. Salovey (Eds.), Reasoning, inference, and judgment in clinical psychology (pp. 1-14). New York: The Free Press.

Turner, B. A. (1981). Some practical aspects of qualitative data analysis: One way of organising the cognitive processes associated with the generation of grounded theory. Quality and Quantity, 15, 225-247.

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. Science, 185, 1124-1131.

Walter, J. L., & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner/Mazel.

Watzlawick, P., Weakland, J. M., & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: Norton.

Werner, P., Rose, T., & Yesavage, J. (1983). Reliability, accuracy, and decision-making strategy in clinical predictions of imminent dangerousness. Journal of Consulting and Clinical Psychology, 51, 815-825.

Whitaker, C. A., & Keith, D. V. (1981). Symbolic-experiential family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), Handbook of family therapy (pp. 187-225). New York: Brunner/Mazel.

White, M., & Epston, D. (1990). Narrative means to therapeutic ends. New York: Norton.

Wylie, M. S. (1995). Diagnosing for Dollars? Family Therapy Networker, 19, 22-33, 65-69.

Wynne, L., Shields, C. G., & Sirkin, M. I. (1992). Illness, family theory, and family therapy: I. Conceptual issues. Family Process, 31, 3-18.

York, C. D. (1997). Selecting and constructing supervision structures. In T. C. Todd & C. L. Storm (Eds.), The complete systemic supervisor (pp. 320-333). Boston, MA: Allyn and Bacon.

Zygmond, M. J., & Denton, W. (1988). Gender bias in marital therapy: A multidimensional scaling analysis. The American Journal of Family Therapy, 16, 262-272.

APPENDIX A

CONTACT LETTER

Date

Dear _____,

I am currently a Ph.D. candidate in Marriage and Family Therapy at Texas Tech University and am writing to invite you to be a participant in my dissertation project entitled *A qualitative study of how marriage and family therapists make clinical judgments*. I am interested in observing your first session of therapy with a client and then interviewing you about how you came to make some of the judgments that occurred in the session. The interview will immediately follow the observation and will take approximately 1 hour of your time. The interview will be audiotaped and transcribed verbatim, however the information will be kept confidential and pseudonyms will be used for quotations. Participation is voluntary, and you may withdraw from the study at any time without penalty.

I believe you will make a valuable contribution to this project, and I am excited about the possibility of your participation. I will be contacting you by phone within the next 7 days to see if you are interested in participating in the study. Written consent will be obtained at the time of the observation. I also believe that there are benefits to participating in the study such as the opportunity to increase self-awareness about your theoretical conceptualization of your work, and to enhance your ability to reflect upon your work during a therapy session.

If you have any further questions please do not hesitate to contact me at 815-899-3163 or you may contact my dissertation advisor, Dr. David Ivey at 806-742-3000.

Sincerely,

Peter Jankowski

APPENDIX B

THERAPIST WRITTEN CONSENT FORM

I hereby give consent to participate in the project entitled *A qualitative study of how marriage and family therapists make clinical judgments* which is a Ph.D. dissertation being conducted by Peter Jankowski under the direction of Dr. David Ivey (806-742-3000). Peter has explained to me that the primary objective of the study is to describe how marriage and family therapists make clinical judgments during the first session of therapy.

I understand that data will remain confidential and that pseudonyms will be used in the reporting of verbatim quotations in the presentation of results. I understand that some of the questions will invite me to reflect upon my work as a marriage and family therapist and that being observed and interviewed may cause some discomfort because of the personal nature and vulnerability required in reflecting on my own therapeutic work. I do not hold this research project or the principal investigator responsible for any theoretical or practical changes I may make in my work as a result of having reflected upon my work as a therapist. I understand that I may not derive therapeutic treatment from participation in this study, that my participation is strictly voluntary, and that I may withdraw at any time without penalty.

It has been explained to me that the interview will last approximately 1 hour in length and will immediately follow the observation of the therapy session. I understand that the observation will consist of describing the interaction that takes place during the session and serve as a context for the interview questions which will follow the observation. I give my permission for audio-taping of the interview. I understand that only Peter Jankowski will have access to the raw data collected for this study and that any transcription of the interviews that may be done by a research assistant will be done anonymously, that is to say that the name, place of professional practice, and professional identification of the interviewee will not be disclosed to the research assistant.

Dr. David Ivey has agreed to answer any inquiries I may have concerning the procedures. I understand that I may also contact the Texas Tech University Institutional Review Board for the Protection of Human Subjects by writing them in care of the Office of Research Services, Texas Tech University, Lubbock, TX 79409.

If this research project causes any physical harm to the participants, treatment is not necessarily available at Texas Tech University or the Student Health Center, nor is there necessarily any insurance carried by the University or its personnel applicable to cover any such injury. Financial compensation for any such injury must be provided through the participant's own insurance program. Further information about these matters may be obtained from Dr. Robert M. Sweazy, Vice Provost for Research, 806-742-3884, Room 203 Holden Hall, Texas Tech University, Lubbock, TX 79409-1035.

Signature of Participant _____ Date _____

Signature of Researcher _____ Date _____

APPENDIX C

TEXAS TECH UNIVERSITY FAMILY THERAPY CLINIC CONSENT FORM

General Information

The Texas Tech University Family Therapy Clinic is a training and research facility and provides marriage and family therapy services. Our goal is to provide consistent and professionally competent services for our clients. In addition, we are interested in finding out how therapy benefits families such as yours. We have two ways to meet these goals. First, we routinely use videotaping or live supervision for therapy sessions. Videotaping, supervision, and consultation are used to assist the therapist in improving skills and in planning for future sessions.

A second way we meet our clinical research goals is with questionnaires. Members of your family will be asked to fill out questionnaires before you begin therapy and then again later in therapy. The questions asked about you, your relationship with your partner or family members and your thoughts about therapy. These questionnaires and videotapes will be used to enhance your therapy and as one basis for possible future research to better understand the therapeutic process. Videotapes are kept in a secured file and remain CONFIDENTIAL and identifiable by a code number only.

We hope this information helps you understand our method of operation and the reasons behind it. Do not hesitate to ask questions or discuss any part of our procedures with your therapist. Therapists, faculty supervisors, and the Clinic Director can be reached at the regular Clinic number (806) 742-3074.

Confidentiality

Your case records, including videotapes, will be kept confidential and private unless disclosure is authorized or required by law. Under current Texas law, what you say to your therapist is not protected completely as a "privileged communication." Texas law and ethical practice requires us to notify appropriate state agencies if we suspect or know of a child abuse situation or have cause to believe that an elderly or

disabled person is being abused. In addition to other disclosures authorized or required by law, we must also give case information in child custody cases that go before a court. In matters where disclosure is not authorized or required by law, confidential information will not be released without your written authorization. Any future use of material for research will require approval by the Texas Tech University Institutional Review Board for the Protection of Human Subjects.

Consent

I voluntarily consent to receive therapy services or have my child accept services provided at the Texas Tech University Family Therapy Clinic. I understand that services will be provided by marriage and family therapists in training under the supervision of clinical faculty. I further understand that Texas Tech University is a teaching institution and I agree to be a part of the teaching program. I understand the purpose and potential benefits of questionnaires, videotaping and supervision of my therapy services, and I voluntarily consent and agree to their use.

I understand that this consent to services will be valid and remain in effect as long as I attend the Family Therapy Clinic unless revoked by me in writing, with written notice provided to the Clinic.

If I have any questions or concerns now or in the future, I understand that I should consult with my therapist or the Director of the Family Therapy Clinic (806-742-3074).

I certify that this form, including the statements on the limits of confidentiality, has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I certify that I have legal authority to give consent for the treatment of all minor children that are included in therapy.

_____ _____

DATE TIME

X _____ _____

Client/Other Legally authorized Person Witness/Translator

_____ _____

Print Name and Relationship to Client Print name and translated language

X _____ X _____

Client/Other Legally authorized Person Client/Other Legally authorized Person

_____ _____

Print Name and Relationship to Client Print Name and Relationship to Client

APPENDIX D

CLIENT WRITTEN CONSENT FORM

I hereby give consent to participate in the project entitled *A qualitative study of how marriage and family therapists make clinical judgments* which is a Ph.D. dissertation being conducted by Peter Jankowski under the direction of Dr. David Ivey (806-742-3000). Peter has explained to me that the primary objective of the study is to describe how marriage and family therapists make clinical judgments during the first session of therapy.

I understand that the observation will primarily consist of describing the interaction that takes place during the session between myself and the therapist or co-therapist. I understand that the observation will also serve as a context for the interview questions which will be asked of the therapist following the observation. I understand that only Peter Jankowski will have access to the observational data collected for this study. I understand that the observational data will remain confidential and that pseudonyms will be used in the reporting of verbatim quotations in the presentation of results. I understand that my participation is strictly voluntary, and that I may choose to withdraw at any time without penalty.

Dr. David Ivey has agreed to answer any inquiries I may have concerning the procedures. I understand that I may also contact the Texas Tech University Institutional Review Board for the Protection of Human Subjects by writing them in care of the Office of Research Services, Texas Tech University, Lubbock, TX 79409.

If this research project causes any physical injury to the participants, treatment is not necessarily available at Texas Tech University or the Student Health Center, nor is there necessarily any insurance carried by the University or its personnel applicable to cover any such injury. Financial compensation for any such injury must be provided through the participant's own insurance program. Further information about these matters may be obtained from Dr. Robert M. Sweazy, Vice Provost for Research, 806-742-3884, Room 203 Holden Hall, Texas Tech University, Lubbock, TX 79409-1035.

Signature of Participant _____ Date _____

Signature of Participant _____ Date _____

Signature of Researcher _____ Date _____

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

Age ___ Gender ___

Year in school (if currently a student), please indicate with a check mark.

___ 1st year master's student
___ 2nd year master's student
___ 3rd year master's student
___ 1st year doctoral student
___ 2nd year doctoral student
___ 3rd year doctoral student
___ 4th year doctoral student
___ 5th year doctoral student

Year you expect to complete currently pursued degree _____

Academic Major _____

(If not currently a student) Please indicate your highest degree obtained _____ and state your academic major _____.

Marital Status (Please indicate which applies with a check mark)

___ Single
___ Married
___ Not married but living with a partner
___ Divorced
___ Separated

Do you have children? ___ If so, how many? ___ Ages _____

Hours of clinical contact:

(Please place a check mark on the line which reflects the **number of hours** you have of experience in clinical contact with clients for each of the following areas)

Individual Therapy Hours

___ 0 hours
___ 1-250 hours
___ 251-500 hours
___ 501-1000 hours
___ 1001-2000 hours
___ more than 2000 hours

Couples Therapy Hours

___ 0 hours
___ 1-250 hours
___ 251-500 hours
___ 501-1000 hours
___ 1001-2000 hours
___ more than 2000 hours

Family Therapy Hours

___ 0 hours
___ 1-250 hours
___ 251-500 hours
___ 501-1000 hours
___ 1001-2000 hours
___ more than 2000 hours

Please state how long you have been practicing therapy in the number of months ___.

Hours of clinical supervision:

(Please place a check mark on the line which reflects the **number of hours** you have been supervised by AAMFT approved supervisors or supervisors-in-training)

___ 0 hours
___ 1-50 hours
___ more than 200 hours
___ 50-100 hours
___ 101-200 hours

(Please place a check mark on the line which reflects the **number of hours** you have been supervised by non-AAMFT approved supervisors or supervisors-in-training)

___ 0 hours
___ 1-50 hours
___ more than 200 hours
___ 50-100 hours
___ 101-200 hours

Please place a check mark next to the theoretical orientation which is most consistent with your approach to therapy:

Behavioral ___ Cognitive-Behavioral ___ Cognitive ___

Psychodynamic ___ Client-Centered ___ Feminist ___

Solution-Focused ___ Brief-Systemic (MRI) ___ Structural/Strategic ___

Inter-generational ___ Constructivist/Constructionist/Narrative ___

Emotionally-Focused ___ Symbolic-Experiential ___

Other (please specify the name of your approach) _____